LAO PEOPLE´S DEMOCRATIC REPUBLIC

Peace Independence Democracy Unity Prosperity

National Committee for the Control of AIDS

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

Supported by: UNAIDS/WHO/AFD/UNICEF/UNFPA

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Table of contents

Acronyms

ADB	Asian Development Bank
AFD	French Development Agency
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ART	Anti-retro Viral Therapy
AusAID	Australian Agency for International Development
BCC	Behaviour Change Communication
BI	Burnett Institute
CBO	Community Based Organization
CHAS	Center for HIV/AIDS/STI
DCCA	District Committee for the Control of AIDS
DU	Drug User
FHI	Family Health International
GFATM	Global Fund to Fight AIDS, Tuberculosis, and Malaria
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IBBS	Integrated Behaviours and Biological Survey
IDU	Injecting Drug User
IEC	Information, Education & Communication
LCDC	Lao National Commission on Drug Control and Supervision
LNP+	Lao Network of PLHIV
LRC	Lao Red Cross
LSIS	Lao Social Indicator Survey
M&E	Monitoring & Evaluation
MARA	Most At Risk Adolescent
MARP	Most at risk Population
MCH	Maternal & Child Health
MoE	Ministry of Education
MoH	Ministry of Health
MoND	Ministry of National Defence
MoPS	Ministry of Pubic Security
MoPWT	Ministry of Public Works & Transport
MSM	Men who have Sex with Men
NASA	National AIDS Spending Assessment
NCCA	National Committee for the Control of AIDS
NPFA	National Partnership Forum on AIDS
NSAP	National Strategy and Action Plan
OI	Opportunistic Infections
OVC	Orphans & Vulnerable Children
PCCA	Provincial Committee for the Control of AIDS
PICT	Provider Initiated Counselling and Testing
PLHIV	People living with HIV
PMTCT	Prevention of Mother to Child Transmission
PPT	Periodic Presumptive Treatment
PSI	Population Services International
RAR	Rapid Assessment Response
SR	Sub-recipient
STI	Sexually Transmitted Infection
SW	Sex Worker
TB	Tuberculosis
TG	Transgender
TWG	Thematic/Technical Working Group
UNAIDS	UN Joint Programme on AIDS
UNGASS	United Nation General Assembly Special Session on HIV/AIDS
USAID	US Agency for International Development
VCT	Voluntary Counselling & Testing
WHO	World Health Organization

Glossary of Terms

Definition of key population groups defined in section 2.1

When developing prevention programmes, it is important to note that the key population groups outlined below are not mutually exclusive nor definitive but are all interrelated. Many people move and flow between groups and the numbers and needs are constantly changing and evolving. With regards to Low-Risk Men and Women, actual numbers of HIV infections appear quite high despite their 'low- risk' status but this is proportional to the general population as a whole, hence a low infection rate. However, other population groups listed are smaller in terms of total numbers, yet may have proportionally higher numbers of infections and, therefore, a higher infection rate.

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

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

- **Current Clients of FSW**
  This population includes men who frequent SW. They usually spend an average of 5 years as clients, after which time they become Low-Risk Men. Successful prevention programmes aimed at SW reduce the number of infections within this group. Clients are often married or in other sexual relationships.

- **IDU**
  Injecting Drug Users comprise both men and women who inject drugs and share needles. With the current HIV response rate, it is likely that the number of infections within this population will increase dramatically as this population is difficult to reach .

- **MSM**
  The MSM population is estimated at around 3% of the entire male population. This particular group of MSM represented in graph 1 comprises the 30% of men who have sex with men who engage in high-risk behaviours such as selling sex and unprotected casual sex, and live in urban areas where entertainment venues are located. There are many subgroups within this population including transgenders (katoeys) and straight and married men. With the current HIV response rate, it is likely that the number of infections within this population will increase.

- **High-Frequency SW (Entertainment based service women)**
  This population is defined by the environment in which they work, primarily in entertainment venues such as bars, clubs, hotels and guest houses. This group is easy to access as they are often found in the venues and can be monitored. They have more clients leading them to higher risk of HIV infection.

- **Low-Frequency SW(Non-Entertainment based service women)**
  This population is defined by the freelance mode in which they approach clients, usually using mobile telephones, not in establishments and majority of them having less clients. This group is difficult to reach and monitor and hence prevention efforts are not currently reaching this group effectively.

Preface

Even though the overall prevalence of HIV in the Lao PDR remains low, the epidemic is by no means under control. Although the Lao Government, with support of various international organizations, NGOs and bilateral donors, has made steps in responding to HIV in its early stages, the virus continues to spread and in specific segments of the population transmission is especially prevalent. The most recent data has resulted in increasing concerns of the possibility of a concentrated epidemic amongst more vulnerable groups in the society. This may suggest that efforts in the past to address the spread of HIV/AIDS have to be further strengthened, in terms of the quality, comprehensiveness and coverage of the programmes.

To prevent such a further expansion of the HIV epidemic in the Lao PDR, the National Committee for the Control of AIDS has given high priority to the national HIV response with the understanding that even though the overall prevalence of HIV in the Lao PDR remains low, constant efforts and attention are needed to build on previous achievements to contain the epidemic.

The new strategy is taking stock of accomplishment made by the Country in addressing the different issues related to HIV. The prevention efforts have branched beyond service coverage for female sex workers and men who have sex with men, extending to different groups of population through various means and approaches. In addition, there has been a major roll out of treatment care and support programs for people living with HIV, with expansion of facility based services.

The development of a HIV law and its endorsement by the National Assembly was yet another important milestone in addressing stigma, discrimination and gender inequity.

The new strategy is an integrated part of the 7th Health Sector Plan and the 7th National Socio Economic Development Plan and has set ambitious targets to reach universal access to prevention, treatment care and support and contribute to attain the MDGs by 2015.

This comprehensive package implies increasing coverage and quality of services in both prevention and treatment and as importantly the development of innovative strategies to address the rapidly changing environment with the epidemics are involving in the Lao PDR such as linkages and integration in the health system when ever appropriated.

Cost effectiveness is one of the three pillars of the new strategy. This is of essential importance in a time of financial scarcity, resource management needs to be exemplary and will not allow to any wastages.

I see this new strategy as a renewed call for coordinated actions from the public and privates sectors, civil society and international partners to indeed reduce significantly the number of new infections by 2015 a set in the MDG Targets.

Vientiane Capital, 28 DEC 2010

Minister of Health
Chairperson of the National Committee For the Control of AIDS

Dr. Ponmek DALALOY

Executive Summary

Purpose

The purpose of the NSAP 2011-2015 is to guide the national response to HIV/AIDS. The review and revision of the NSAP was participatory, and this document reflects contributions from government, civil society, people living with HIV and development partners. The NSAP is aligned with the 7th National Socio Economic Development Plan (NSEDP) 2011-2015, and the 7th Health Sector Plan. The National AIDS Policy and the National HIV/AIDS Law have provided the guiding principles and overall strategic direction for the development of the NSAP 2011-2015. WHO six building blocks framework has been brought into consideration for situation and response analysis in order to integrate HIV interventions into health system strengthening for the next year plan (see annex 8). On the other hand, the NSAP is also one among several efforts of the government that contributes to the national poverty reduction programme.

Situation and response analysis

The HIV prevalence in Lao PDR is low, even among most-at-risk populations. However, complacency is not justified, as there remains the potential of concentrated epidemics among injecting drug users, sex workers, and men who have sex with men.

Lao PDR has been responding effectively to the threat of HIV to human development, through strategic choices in line with international best practice around prevention, treatment, care and support services, and effective programme management. The current strategic focus remains largely relevant to meet the challenges predicted for the next five years: i.e. the potential emergence of concentrated epidemics among most-at-risk populations. Adjustments needed to sharpen the current focus are as follows: scaling up coverage, increasing the quality of interventions, ensuring financial and organisational sustainability of HIV services and increasing the capacity of implementing partners.

Based on the analysis of the epidemic and the response, the following recommendations have been proposed to adjust the national strategy for the next 5 years:

1. Maintain focus on most-at-risk-populations, and ensure that interventions address the specific contexts and are age appropriate
2. Integrate HIV treatment in general health services, and integrate care for PLHIV into social welfare services.
3. Health systems strengthening and community involvement.
4. Improve collection and use of strategic information, especially surveillance, management information systems (MIS), and a research strategy.
5. Increase the sustainability of the response.

Guiding principles for the national response

1. Interventions strategies based on evidence
2. Prioritised and result-based strategies

3. Respect for human rights
4. Gender considerations
5. Involvement of communities and people with HIV

The National Strategic Plan 2011-2015

Goal:
1. Maintain the present low level of HIV prevalence in the general population (15-49) below 1%
2. Ensure HIV seroprevalence among most-at-risk populations is lower than 5%.

Objective:
1. Scale up the national response in order to minimize the impact of HIV/AIDS on the social and economic development in the Lao PDR
2. Improve the quality of life of people infected with and affected by HIV

The strategy identifies the following strategic components

1. Increase coverage and quality of HIV prevention services, resulting in 60-85% coverage of most-at-risk populations.
2. Increase coverage and quality of HIV treatment, care and support services, resulting in 95% coverage of people in need of ART, and a treatment drop out rate of less than 10%.
3. Improve national programme management resulting in annual costed work plans, annual progress reports, two surveillance rounds, quality service delivery, and more effective performance on current donor grants.

The National Action Plan 2011-2015: outcomes

Specific outcomes by 2015 under the strategic components are provided below. (Strategies are described in chapter 8)

Component 1: Increase coverage and quality of HIV prevention services

1. Sex workers
   - HIV prevalence amongst sex workers is under 5%
   - 85% of estimated numbers of sex workers are reached through interventions
   - 80% of sex workers report consistent condom use with clients
   - Chlamydia/Gonorrhoea prevalence amongst sex workers is under 10% (baseline: 21%, 2008)
2. Men who have sex with men
   - HIV prevalence amongst high-risk MSM is under 5%
   - 80% of estimated numbers of high-risk MSM are reached through interventions
   - 75% of high-risk MSM report consistent condom use
   - Chlamydia/Gonorrhoea prevalence amongst high risk MSM is under 10% (baseline: 9%, 2009)
3. Drug users/ Injecting drug users
   - HIV prevalence amongst DU is under 5%
   - 60% of estimated numbers of IDU are reached through harm reduction interventions
   - 55% of IDU report safe use of injecting equipment

		• 55% of IDU report consistent condom use
4.	Men with multiple concurrent partners (clients)	• 70% of targeted mobile men (including civil servants, migrants, transport workers, business men, others) report consistent condom use with casual partners. • Chlamydia/Gonorrhoea prevalence amongst men with multiple partners is under 10%
5.	STI services	• 94 priority districts have at least one quality-assured site for STI treatment • 80% of high-frequency sex workers and male sex workers have accessed to quality-assured STI services as needed.
6.	Condom programming	• 90% of most-at-risk populations report easy access to condoms • 6 million condoms distributed annually until 2015
7.	Prevention of mother to child transmission (linking HIV and MCH)	• 50% of ANC attendants received Provider Initiated Counselling and Testing (PICT) • 90% of identified HIV-positive pregnant women received antiretroviral medicines to reduce the risk of mother-to-child transmission • 100% of infants born to identified HIV-infected mothers received ARV drugs
8.	Blood safety	• 100% of blood units screened for HIV with quality assurance
9.	General population and migrant labours	• 80% of young women and men aged 15–24 both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

Component 2: Increase coverage and quality of HIV treatment, care and support services

1.	Voluntary counselling & testing	• Quality-assured VCT services available in all 94 priority districts • 80% of most-at-risk populations report having received an HIV test and know the results in the last 12 months
2.	ARV and OI management	• Over 90% of adults and children who have advanced HIV infection receive antiretroviral treatment • ARV and OI treatment integrated in all provincial hospitals • 100% of HIV patients tested for TB (and vice-versa) by using PICT approach
3.	Home & community based care	• 90% of those diagnosed with HIV can access home and community-based care
4.	Positive health	• PLHIV support groups exist in all provinces • 100% of diagnosed PLHIV are referred to, and 90% access PLHIV support group at least once

Component 3: Improve national programme management to support service delivery

1.	Policy, legal reform & advocacy	• National HIV/AIDS Law and policies containing non-discrimination principles are broadly disseminated and implemented
2.	Strategic information	• Integrated behavioural and biological surveillance of MARP is undertaken on a regular basis and reported to measure outcomes and

	the impact of the response • Reporting on biomedical HIV services (including ART, PMTCT, condom programming, blood safety) is integrated into the MoH HMIS and reported regularly • HIV-related operational research is coordinated and prioritised by the Strategic Information unit at CHAS
3. Health system strengthening & community involvement	• HIV/AIDS is included in the training curriculum for all health workers • National guidelines and standard operating procedures exist for key HIV services, including testing & counselling, medical management of HIV, PMTCT, targeted prevention interventions and home/community-based care • Supportive supervision and quality assurance system for HIV services institutionalised • NGOs report increased organisational, financial and technical support from government as well as development partners
4. Coordination of a multisectoral, decentralized response	• Annual multisectoral operational plans developed jointly with implementing partners • Joint reviews undertaken of NSAP at mid-term (2013), and end of project (2015) • Coordination structures at provincial and district level reviewed and strengthened where appropriate • Partnership between public/private/civil society strengthened
5. Resource mobilisation & financial management	• Annual AIDS budget and expenditure increased based on budget needs to be mobilised externally • Proportion of annual plan supported by domestic resources increased • Costed operational plans developed each year.

The total estimated resource needs for implementing the NSAP are US$ 54.2 million for 5 years, increasing from US$ 7.3 million in 2011 to over US$ 14.6 million in 2015. These estimates will be updated annually at the time of each annual work plan development.

Implementation arrangements

Governance of the response is the role of the National Committee for the Control of AIDS (NCCA). In addition, the Country Coordinating Mechanism (CCM) is the governance body for Global Fund supported programmes on HIV (and Malaria and TB).

Management and coordination of the national response is the responsibility of the Centre for HIV/AIDS/STI (CHAS) in the Department of Hygiene and Prevention, Ministry of Health. At provincial and district level, multisectoral PCCAs and DCCAs combine coordination and implementation responsibilities.

Implementation of the response is the responsibility of several government and NGO partners, and includes service delivery, training, research and advocacy.

1. The health sector is one of the key actors in implementing service delivery for prevention, treatment and care.
2. Other important government partners for service delivery are the Ministry of Defence, Ministry of Public security; the Ministry of Education, Ministry of Labour and Social Welfare, Ministry of Culture and Information, and Ministry of Public Works and Transport.
3. Mass organisations and civil society that support the implementation of HIV services are the Lao Trade Union, the Lao Youth Union, the Lao Women's Union, the Lao Front for National Construction, and the Lao Red Cross.
4. NGOs and CBOs are important for service delivery for marginalised groups with little access to public services. The Lao networks of people living with HIV (LNP+) provides peer support and promotes greater involvement of people with HIV.

Capacity building through health systems strengthening and community involvement is a common thread throughout the national response and the NSAP 2011-2015,. Strategies include developing service standards and guidelines, training of service providers, supportive supervision and quality assurance as well as ensuring a supportive environment and legal framework.
Financial management and resource mobilisation is the responsibility of NCCA.

Monitoring and evaluation

National programme core indicators are presented in Annex 2. Indicators reflect internationally agreed indicators for national HIV/AIDS programmes.

CHAS is responsible for the monitoring and evaluation of the response, through the Surveillance Unit and M&E Unit. CHAS collaborates closely with the HMIS department in the Ministry of Health. Development partners will support specific studies for some of the national core indicators. CHAS will also organise annual joint reviews of the national response.

1. Introduction

1.1 Country Context

Lao PDR comprises 16 Provinces and one capital city, 143 Districts and 10,552 Villages. Over the last decade the government has undertaken public administration reform. The current governance system is centralised, with additional administration at the provincial and district level.

Around 27.6 percent (2007-08) of the population lives below the national poverty line[1]. The country faces many unique human development challenges, one of which is that the majority of the population (73 percent) live in rural and remote areas without access to basic infrastructure and services. Another challenge is ethnic diversity: 49 officially recognized ethnic groups are often remote, have different cultures, behaviours, languages and marriage traditions.

Although Lao PDR has experienced significant advances in social development in recent years and progress has been made towards the Millennium Development Goals (MDGs), the country is categorised as having a 'medium-low level of human development' and faces many associated challenges. Lao PDR currently ranks 133 out of 177 countries on the UNDP Global Human Development Index. There is strong government commitment towards achieving the MDGs. These goals guide the Seventh National Socio Economic Development Plan (NSEDP) 2011-2015.

The Lao PDR was a Landlocked and Least Developed Country. Geographic conditions restrict both the quantity and quality of agriculture, and pose difficulties in the development of trade, social infrastructure, and transport and communications links. Nevertheless, Lao PDR is capitalising on the potential of becoming a 'land-linked country' located in the centre of a dynamic and prospering region, and is developing regional transport corridors and increasing trade with its neighbours. In recent years the Lao PDR has experienced relatively good economic growth, (6.3 percent since 2002) and foreign investment in mining, agriculture and hydro-electric sectors, amongst others, has been stimulated.

Lao PDR demographic indicators

Indicator	Estimated Value[2]	Year
Total population	5.99 million	2010
Population growth rate	2. 1 % per year	2010
Population living in urban areas	27%	2005
Infant mortality rate	70 deaths per 1,000 live births	2005
Life expectancy at birth	65	2008[3]
GDP/capita (PPP)	US$ 986	2009
Population below poverty line	27.6 %	2008

[1] National Human Development Report, Lao PDR, 2009
[2] 3rd Draft, 7th NSEDP (2011-2015)
[3] 2009, UN Population Division. World Population Prospects

1.2 Development process of the National Strategy and Action Plan

The purpose of the NSAP 2011-2015 is to guide the national response to HIV/AIDS. The review of the 2006-2010 NSAP, and the development of the new strategy were guided by the National Committee for the Control of AIDS (NCCA). The Centre for HIV/AIDS/STI (CHAS) at the Ministry of Health coordinated the review and revision process. The NSAP development was participatory, and this document reflects contributions from government, civil society, people living with HIV and development partners. All these stakeholders participated in the Core Team for the NSAP review and revision, several technical working groups, consultation workshops and/or formal meetings. At the 2010 National AIDS Forum, Provincial AIDS Committees (PCCAs) reflected on the situation and response analysis and provided recommendations.

The NSAP 2011-2015 is aligned with overall and sectoral development policies, especially the forthcoming 7th National Socio Economic Development Plan (NSEDP) 2011-2015, and the 7th Health Sector Plan. The National AIDS Policy and the National HIV/AIDS Law have provided the guiding principles and overall strategic direction for the development of the NSAP 2011-2015. Finally, this strategy recognizes international agreements signed by Lao PDR, such as the Millennium Development Goals (2000), the UNGASS Declaration of Commitment (2001), and the Paris Declaration for Aid Effectiveness (2005).

2. Situation Analysis

2.1 Epidemiological scenarios: potential for a concentrated epidemic

The HIV prevalence in Lao PDR is low, even among most-at-risk populations. The HIV prevalence among adults in the general population is estimated at 0.2%, the total number of people living with HIV estimated at 9,000[4].

A first wave of HIV affected international labour migrants, started in the 1990s, and is presently fading out. It is postulated that this HIV epidemic affected international migrants, mainly returning from neighbouring countries, and resulted in a truncated epidemic in rural areas, with secondary infections among spouses and children, but not leading to further spread. This early wave explains the larger number of diagnosed HIV cases, than can be explained through epidemic-modelling-based HIV surveillance. Through the same reasoning, it explains the larger than expected need for treatment, care and support, not only in the urban, but also rural areas. Although international labour migration still takes place, the HIV prevalence among migrants has decreased, probably through the combined effect of lower HIV prevalence in neighbouring countries and prevention interventions among migrants.

A second wave of HIV infections in Lao currently takes place among most-at-risk populations, but so far there is no clear evidence of a concentrated epidemic, as recent surveillance found HIV prevalence lower than 1% among sex workers (0.43%), their clients (0-0.8%[5]), and men who have sex with men (0%[6]). However, complacency is not justified, as the danger remains and more evidence is still needed among injecting drug users, sex workers, men who have sex with men. Indeed, one survey in Vientiane Capital City among men who have sex with men sampled in entertainment setting, found 5.6% HIV prevalence[7], another survey found 1.5% HIV prevalence among drug users in two Northern Provinces[8]. The absence of concentrated epidemics is probably the result of early start and effective targeting of prevention interventions, and low background levels of HIV.

Epidemic projections are made difficult because of the low prevalence experienced by the Country. The Asian Epidemic Model (AEM) was used to projects future HIV trends based on the population sizes and risk behaviours and has provided detailed information on how new infections are distributed among different key populations in the Lao PDR.

The present lack of sufficient data to apply the model has brought a note of caution about the accuracy of the projection with the understanding that as national data collection systems strengthen in the near future, epidemic projection accuracy will improve.

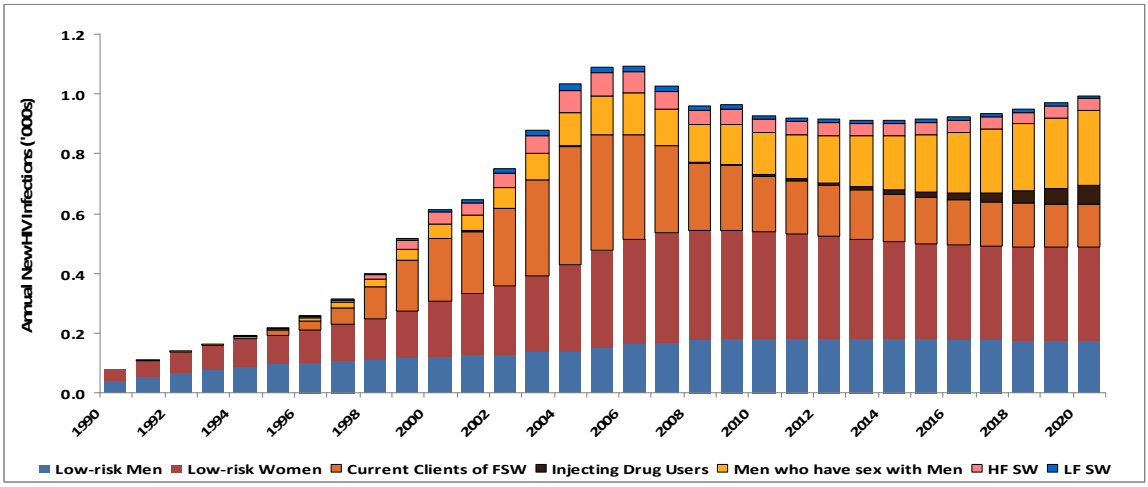
The graph below shows the possible trend of the epidemic in 7 key populations at high risk of HIV for the next 10 years assuming that the national HIV programme will be kept at the present level

[4] CHAS, 2010 Epidemic Projections
[5] CHAS, IBBS report 2008: military (0%), transport workers (0%) and electricity workers (0.8%)
[6] CHAS, MSM survey in Luangprabang province, 2009
[7] CHAS & BI, MSM survey in Vientiane Capital, 2007
[8] CHAS & LCDC, Survey among drug users in 2 northern provinces, 2010

and quality. The sub-population groups observed are as below (for detailed definitions, please refer to the glossary of terms).

- Lower-risk general population women/men (general population)
- Males who are clients of sex workers
- High-frequency sex workers
- Low-frequency sex workers
- Injecting drug users (IDUs)
- Men who have sex with men (MSM)

Graph 1: Annual estimated new HIV infection by risk groups



The AEM indicated that, despite a decreasing trend, low-risk men and, more significantly, low-risk general population women will continue to represent more than half of the new HIV infections. New infections among SW and current clients of SW will stabilise but a significant increase in new infections is expected in both IDU and MSM. Similar patterns are reported in neighbouring countries and there is the potential for concentrated epidemics among sex workers, men who have sex with men, and IDU. In order to reverse the epidemic, the National AIDS Authority has designed new strategies and set new ambitious targets for prevention, treatment care and support for the 5 years to come.

The geographical spread of HIV, risk behaviour and service needs are not homogeneous across Lao PDR, and this needs to be reflected in the new national strategy for prioritising service coverage. Commercial sexual networks are concentrated according the geography of clients' demand, i.e. where 'mobile men with money' congregate: in urban areas, along transport corridors and any place where men migrate for work without their families: e.g. mines and, construction sites. Transgender and gay-identified men tend to form sexual and social networks in urban areas. The geographical spread of drug use is according to choice of drug: methamphetamine type substances (Yaba) mainly in urban areas, and opiates (opium and heroin) in rural areas along the northern borders with Myanmar, China and Vietnam.

2.2 Vulnerable populations: Most-at-risk populations

People who have multiple concurrent sex partners and/or inject drugs, are at risk and need to b targeted to ensure prevention measures. Second generation surveillance has established that some groups of sex workers and men who have sex with men have unsafe sex and multiple concurrent sexual partners. At highest risk are sex workers with many clients, little access to condoms, and not working in entertainment establishments (e.g. sex workers soliciting in streets, or through cell phones servicing migrant workers). Among men who have sex with men, those engaging in unprotected anal sex with multiple partners, such as transgender and male sex workers, are at highest risk.. Spouses and regular sexual partners of most-at-risk populations are also susceptible to HIV infection, especially since condom use within spousal relations and regular partners appears to be lower than with casual or commercial partners.

HIV prevalence among Most-at-risk populations

Population	year	prevalence (%)	Notes
Sex workers	2004	2.02 (0.0-3.9)	5 provinces
	2008	0.43 (0.0-2.1)	6 provinces
Clients of sex workers			
Truckers	2004	0.0	3 provinces
Military	2004	0.0	6 provinces
Electricity workers	2004	0.2	4 provinces
	2008	0.3	4 provinces
MSM	2007	5.6	Vientiane
	2009	0.0	Luangprabang
Drug users	2010	1.5	2 provinces

Clients of sex workers are a heterogeneous group, and are at intermediate risk of HIV. Mobile men with money are typically those who purchase sex. These men include a variety of professional groups, such as migrant and immigrant workers, transport workers and business travellers. Surveys have indicated relatively high awareness, knowledge and condom use among these professional groups, and low levels of STI/HIV.

Young people have increased vulnerability to HIV if they have multiple concurrent partners or inject drugs. Recent research by UNICEF[9] also indicates that most sex workers and high-risk MSM are young (some even underage), and thus extra vulnerable biologically and socially due to more peer pressure and fewer negotiation skills.

The general population is at low risk of HIV infection. Even if HIV awareness and knowledge remain low among certain rural and ethnic populations and condom use is negligible within spousal relations, the chance of an average Lao person getting infected with HIV is low

Population size estimates, needed for planning service delivery, have been updated for the next NSAP. During the development of the NSAP 2006-2010, population sizes were estimated based on regional averages, and used for determining Universal Access targets. The 2010 re-estimation indicates that some population sizes are underestimated (e.g. injecting drug users), and subgroups need to be defined for better targeting (e.g. high vs. Low-frequency sex workers, high-risk vs. low - risk MSM). Other, large groups need to be better defined through formative research (e.g. clients of sex workers). The estimates for PLHIV and people in need of ART have also been updated in 2010[10].

[9] UNICEF assessment report 2010
[10] CHAS, EPP worksheet, 2010

Population size estimates for most-at-risk populations[11]		
	2010 (base)	2015
Sex workers	13,510	15,340
High frequency	10,810	12,270
Low frequency	2,700	3,070
Men who have sex with men[12]	49,330	56,440
High risk	16,440	18,810
Low risk	32,890	37,630
Male sex workers (incl. in HR MSM)	1,640	1,880
Injecting drug users	1,150	1,320
Clients of sex workers	98,660	112,880
Male remaining *	164,430	188,130
Female remaining *	50,680	57,540
* only males/females who engage in casual sex		

Estimates for people in Need of ART and PMTCT[13]		
	2010 (base)	2015
PMTCT need (HIV+ pregnancies)	280	410
PLHIV	9,000	14,000
ART need (Total)	2,010	7,390
Male	1,220	3,940
Female	790	3,450
Adult	1,810	6,980
Children	200	410

2.3 Drivers of the epidemic: Multiple concurrent partners and drug uses

Despite the low prevalence, one or more concentrated epidemics could emerge in Lao PDR through sexual networks and/or networks of injecting drug users. Risk behaviours are the drivers of the Lao HIV epidemic: in essence, engaging in multiple concurrent (unsafe) sexual partnerships, and sharing injecting equipment. Multi-partner sexual relations are common in Lao PDR, but injecting drugs is not very common, and it is not known to what extent drug injectors share their equipment. There appears to be little overlap between risk behaviour groups, which limits the potential for HIV spread. For example, there is little evidence that sex workers inject drugs or that drug users are buying sex from sex workers.

Trends in cultural, social and economic factors influence risk behaviours, positively as well as negatively. Several factors are likely to increase the demand for commercial sex in the next five years. First, as Lao PDR is turning from a land-locked into a land-linked country, where new road and infrastructure and related economic development increases the number of mobile men, both Lao migrants and migrant labourers from neighbouring countries with higher HIV prevalence. Second, cultural and gender norms continue to allow Lao men to engage in extramarital relations, especially during pregnancy of their wives. Third, sex work, same-sex relations and drug use remain criminalised and/or stigmatised, which makes it harder for these marginalised people to access health services and health information. On the other hand, there are several contextual factors at play in Lao PDR that seem to reduce transmission: sex workers have relatively few clients, high rates of condom use, good negotiation skills and they stay in the business for a short period, compared to many of their regional colleagues. Also, condom programming has resulted in good availability and relatively frequent use.

[11] Estimates based on Asian Epidemic Modeling undertaken in 2010.
[12] Includes transgenders
[13] Estimates based on EPP/Spectrum modeling undertaken in 2010.

2.4 Focus on new infections

In conclusion, Lao PDR has been able to maintain a low level HIV epidemic, but the potential of a concentrated epidemic among most-at-risk populations is real. The first wave of infections amongst migrant workers and their families will result in an estimated 7,390 people in need of antiretroviral treatment, and many more in need of care and support services, spread across many provinces. But the course of the HIV epidemic will be determined by the emergence (or prevention) of one or more concentrated epidemics among injecting drug users, sex workers or men who have sex with men, in selected provinces and districts. This has clear implications for the focus and priorities of the response in the next 5 years

3. Response Analysis

Lao PDR has responded to the HIV epidemic with relatively high (reported) coverage of HIV prevention services for sex workers and men who have sex with men, and high levels of ART coverage for PLHIV with advanced disease. Lao PDR has provided HIV prevention and care services guided by national plans since the late 1980s. The country is signatory to the 2001 UNGASS declaration of commitment, and developed Universal Access targets for HIV prevention, treatment, care and support interventions. These coverage targets guided the implementation of the national response in the period 2006-2010, and targets as well as progress were reviewed in 2008 during the mid-term review. However, the reported service coverage must be viewed with caution, given the weak reporting and recording system. Annex 7 provides an overview of the coverage of HIV interventions in the years 2006-2009.

3.1 Prevention services

Prevention services for sex workers have been scaled up in coverage as planned; effective service models need to be replicated. As of December 2009, almost 6,600 sex workers (out of 13,150 high and low frequency sex workers) had been registered by the CHAS has having received comprehensive prevention services. The prevention interventions called "100% condom use programme", consist typically of behaviour change communication (through peer educators), condom distribution, STI management, VCT, and in some cases a drop-in centre to create a space for community building. Prevention services are delivered in some districts through NGOs, and in others through the provincial AIDS committee (PCCA). External reviews have proposed the following recommendations 1) scaling up prevention to other groups of sex workers, especially low-frequency sex workers outside entertainment establishments; 2) providing standardised STI services for sex workers though drop-in centres; 3) strengthening structural interventions to create an enabling environment for sex workers to increase condom use and improve STI health-care seeking behaviours 4) development of national standards and guidelines for quality services, building capacity of service providers, including ongoing technical support, supervision and quality assurance, and 5) developing information management systems for better coordination across technical areas, between implementing partners and the national, provincial and local levels, and between national programmes.

Prevention services for men who have sex with men have scaled up, and intervention models need to be adjusted and further scaled up. As of December 2009, more than 1,360 MSM, mainly transgender, are registered as having benefit for prevention services, which is on target (68% of 2,000) but the NSAP target is short of the estimated 16,000 high risk MSM who need services. MSM prevention interventions are similar to sex work interventions and include behaviour change communication, condom distribution, STI management, and sometimes drop-in centres. MSM services are also delivered through NGOs as well as provincial AIDS committee (PCCA). Lessons learnt are that transgenders and other men who have sex with men have differing needs in terms of behaviour change communication and STI screening; that MSM face barriers attending drop in centres; and that especially transgender programmes need to be designed and implemented age-appropriately, as many are young. The recommendations from the external reviews of the 100% condom use also apply to MSM transgender programming.

Some critical most-at-risk populations (e.g. drug users groups,...) are not yet sufficiently reached, and more formative research is needed to assess vulnerabilities and design interventions. Drug users, especially those injecting and dependent on opiates, have been identified as an important target population for prevention. Formative research has been undertaken with international technical support, and discussions are underway on effective harm reduction approaches.

For some current target audiences for HIV prevention (e.g. ethnic groups, students, migrants), insufficient evidence of their vulnerability is available. Ethnic groups, young people and migrants are large populations, consisting of many subgroups, and targeting them all with comprehensive prevention services is not cost-effective.. Recent research on most-at-risk adolescents highlights the need for formative research to identify such subgroups and the contextual factors leading to higher-risk behaviours (such as multiple concurrent partners or drug use) so that effective interventions can be designed and implemented. Where evidence shows low levels of risk behaviour, these groups can be reached through mass media, and need not be targeted separately.

In the health sector, prevention services have mixed coverage, and further progress relies on health systems strengthening. Blood screening for HIV is almost universal, and access to safe blood has increased from 8 sites in 2006 to 17 in 2009, through efforts of the Lao Red Cross Society. There has also been an increase in sites for voluntary counselling and HIV testing (VCT), from 32 to 110 by the end of 2009. Reports on actual use of VCT services are mixed, and it appears that the VCT uptake target of 95,000 for 2010 might not be reached. Given the low HIV prevalence in Lao PDR, promotion of VCT should be targeted at most-at-risk populations to ensure efficiency. Counselling and testing of pregnant women appears low, reflecting low access to antenatal service in general (28.5%[14]), and the low-risk profile of most ANC clients. However, around 14% of HIV+ pregnant women have received prophylaxis, mainly through the ART centres[15]. Training of health workers in STI diagnosis and treatment has been scaled up over the years and STI service coverage has increased. Although data are now available for STI prevalence among sex workers, MSM and drug users, general prevalence data are limited. This reflects some structural challenges in the health sector, such as weak HMIS, especially in the private sector, where most STI patients seek treatment.

In conclusion, lessons learnt have identified scaling up coverage and quality, targeted interventions as key components of prevention services. First, maintain and sharpen focus on most-at-risk populations, and scale up to 60-85% coverage; focus on sex workers & clients, MSM, injecting drug users, and their sex partners, and be aware of subgroups within these larger groups. Second, target only at-risk youth (i.e. young MARPs), as most Lao youth are categorised as low risk. Third, improve the quality of prevention services, through the development of national guidelines and standards, better formative research on risk behaviours and contexts, capacity building, quality assurance and supervision.

3.2 Treatment, care and support services

One of the major successes in the response has been the scale up of HIV treatment services, in terms of coverage and quality. Presently, 1,345 people are receiving ART (including 95 children), out of 3,659 people diagnosed with HIV up until January 2010, and an estimated 9,000 people living

[14] MoH, 2005 Laos Reproductive Health Survey
[15] CHAS/UNAIDS, UNGASS Country Progress Report 2010

with HIV as of 2010[16]. Treatment with ARV is free, although transport costs remain a barrier to access. Adherence and survival rates are reportedly good. Since 2006, ART centres have been scaled up from 2 to 5 regional sites (plus 3 satellite sites in 2 additional provinces). National Treatment guidelines for adults were developed in 2005, and are regularly updated with support from WHO. Challenges remain, including capacity building of health providers, monitoring and quality assurance of services, and supply chain management of drugs and reagents.

The main challenge for HIV treatment is to sustain coverage and quality in the face of health systems challenges and increasing need for ART. It is estimated that in 2015, as many as 7,390 PLHIV with advanced disease will need ART, and many more care and support services. Currently, ART relies on external finances, and HIV medical management is delivered in special ART clinics. In order to sustain access to treatment and expand services geographically, HIV medical management needs to be integrated in the public health sector in a phased manner, and health systems will need to be strengthened, including health financing, human resource development, HMIS, quality assurance and supply chain management.

Home and community-based care has been scaled up, and models of good practice need to be documented and expanded. By the end of 2009, 1,400 people were reportedly registered to receive outreach, income generation, and/or stipends. However, lessons about models and effectiveness of community and home care have not been documented and shared between service providers, and national care and support guidelines are needed. Five support centres for PLHIV have been established at ART regional sites. LNP+, the national network of PLHIV, has been supported financially and technically to link with self-help groups in 11 provinces, and to provide peer counselling in ART sites.

The continuum of care has been strengthened but clarification on roles and responsibilities is needed. Linkages between HIV and TB services are developing, resulting in a doubling of TB patients screened from 2008 to 2009 (594). Developing linkages between prevention and care services remains a challenge, for example promoting VCT with most-at-risk populations, and positive health counselling for PLHIV.

3.3 Project management: coordination, policy and strategic information

The NSAP 2006-2009 contained three cross-cutting strategic components in support of increasing coverage and quality of HIV prevention and care services: 1) policy, legal reform and advocacy; 2) surveillance and research, and 3) programme management.

3.3.1 Policy, legal reform and advocacy

HIV has been included in national development policies and specific legislation has been developed to facilitate HIV interventions and responses. HIV has been addressed as a development challenge in both the current 6th NSEDP and the 7th (draft) National Social and Economic Development Plan. HIV/AIDS is also included in the 6th (and 7th draft) health sector strategy. A specific Law on HIV/AIDS Control and Prevention approved by the National Assembly will address the rights of most-at-risk populations, although sex work remains illegal. A general AIDS Policy, developed several years ago, was updated in 2009, and addresses stigma and discrimination, and justifies targeting IDU and MSM for prevention. Supportive public policies for HIV programming that were developed in the last five years include the 2007 Law on the Protection and Rights of Children

[16] EPP and AEM estimates June 2010

(which specifically addresses children affected by HIV); the Tripartite Declaration on HIV in the Workplace, and legislation further enabling NGOs to work in the Lao PDR. An important achievement was the establishment of a taskforce on HIV and drug use under the Lao National Commission for Drug Control and Supervision (LCDC) to initiate harm reduction programmes. The challenge for the next five years will be to operationalise the supportive policies and develop sectoral decrees, train law enforcement agencies and service providers on the implications of these policies, and monitor implementation and adherence.

3.3.2 Surveillance and research

The Surveillance and M&E units within CHAS have been strengthened and a National HIV/AIDS Monitoring and Evaluation Framework has been drafted but work remains to finalise and operationalise this document. GFATM have supported financial and technical assistance to establish an M&E unit in CHAS, a national M&E strategy and a national HIV/AIDS database. Additional staff has been recruited, the M&E strategy has been drafted and work is ongoing on the database. UNGASS and GFATM grant indicators serve *de facto* as national core indicators. The location of the Surveillance and M&E Units in different CHAS departments is a challenge to a comprehensive approach to 'strategic information' in terms of 1) monitoring outcome and impacts (surveillance); 2) monitoring programme outputs and service statistics (MIS); and 3) operational research.

The draft M&E strategy provides a framework for monitoring programme outputs, but the scope needs to be widened. The current management information system is called the Monitoring, Evaluation and Reporting System (MERS), and includes software for reporting from PCCAs to CHAS. MERS however includes only those HIV activities that require reporting to the Global Fund (GFATM), and the system's scope is limited to the health sector response. Second, reported data are currently not verifiable, as they rely on ad hoc analyses of progress reports from the provinces. Finally, indicators (e.g. "coverage of sex workers") are not clearly defined, nor uniformly applied in reporting, resulting in inaccuracies. In finalising the national HIV M&E strategy, the management information system (MIS) could usefully harmonize all national programme outputs, including activities in sectors beyond the health sector, and those financed from funding sources other than GFATM. The strategy should also include a system for providing feedback to service providers and support for analysis at decentralized levels.

In terms of impact and outcome monitoring, second generation surveillance has been implemented regularly and successfully since 2001, with international technical assistance. The last round of integrated behavioural and biological surveillance (IBBS) and behavioural survey were in 2008 and 2009 and included sex workers based in entertainment sites, and men who have sex with men. A separate survey among drug users in the Northern provinces was completed and disseminated. The most recent IBSS recommended to include an HIV module in the Demographic and Health Survey (DHS), and to complement surveillance with qualitative research on the contexts of risk behaviours, including mobility of sex workers.

Implementing partners have undertaken and documented a great number of research studies, in the last five years, but there is a need to systematically identify research priorities, and disseminate research findings to policy makers and programme planners. Most research is epidemiological and socio-behavioural, reflecting the priorities of the response in terms of identifying drivers of the epidemic and populations at risk. There is little operational research in terms of effectiveness evaluation of prevention interventions.

3.3.3 Programme management

Lao PDR has established a strong organisational structure for the HIV/AIDS response, and further work is needed to clarify roles and responsibilities, and to build capacity at all levels. The National Committee for the Control of AIDS (NCCA) has multisectoral membership from twelve line ministries and national organisations, and is responsible for governance of the response. CHAS serves as the NCCA Secretariat, and is responsible for programme management and coordination of the national multisectoral response. As a unit in the Department of Hygiene, Ministry of Health, and sub-recipient of GFATM funding, CHAS also has implementation responsibilities, e.g. training and surveillance. At times there is tension between the two roles of implementer and coordinator, and human and financial resources for the latter role are considered insufficient. At provincial and district level, multisectoral PCCAs and DCCAs also combine coordination and implementation responsibilities: for example PCCAs are responsible for management of the sex worker prevention programmes. A recommendation for the next NSAP is to increase clarity on roles and responsibilities at all levels, and develop action plans for regular meetings and coordination activities.

Some Sectoral HIV strategies have been developed, and civil society is increasingly involved in the response, and there are additional opportunities for multisectoral responses. The Lao Women's Union, the Transport sector, and the Public Security sector have developed HIV strategies in recent years. However, funding and human resource constraints are barriers to implementation. Within the health sector, HIV is incorporated in the Maternal and Child Health strategy, TB programme, and blood transfusion services. Civil society involvement has increased: mass organisations are involved (Youth Union, Trade Union, Women's Union and Lao Front for National Construction), as well as local and international NGOs. LNP+, the network of PLHIV, is member of committees like the CCM and NCCA. Organisational and personal capacity building is needed to capitalise on these opportunities.

A National Partnership Forum on AIDS (NPFA) has been initiated to bring together all partners in the response, and several Technical Working Groups have been established. TWGs exist for MSM, sex work interventions, treatment and M&E, and advise CHAS and partners on programming. CHAS experiences challenges to provide support, and to remain informed on non-health sector initiatives, in terms of organising regular meetings, resources for meetings, and clarifying roles.

Fund raising has been a major achievement in the last five years, but sustaining current resource levels during the next period will be a challenge, due to global resource constraints for HIV programming. Lao PDR has been successful in applying for GFATM grants in rounds 1, 4, 6, 8 and RCC4. Resources available for the response are 5 to 6 million US$ annually, with 2 percent of expenditure coming from the national budget, and the vast majority from GFATM. The challenge is to maintain current funding levels, diversify funding sources, and increase domestic contributions to the response.

CHAS has coordinated training programmes, mobilised international technical assistance and developed guidelines, however human and organisational capacity and quality assurance of services remain challenges to effective service delivery and programme management. Despite many distinct capacity building activities, supported by INGOs and development partners, there is no system for training needs assessments or capacity appraisals across implementing partners, nor an overall capacity building strategy or plan.

4. Challenges to Scale up Coverage and Quality of HIV Services

Below is an overview of the main challenges as identified in the situation and response analysis above. The National HIV/AIDS Strategy 2011-2015 will include specific strategies to address these challenges.

4.1 Reaching most-at-risk populations

To maintain the low prevalence and avoid a concentrated epidemic among sex workers, drug users, men who have sex with men and their sexual partners, the challenge is to monitor risk behaviours, understand the predisposing factors to these behaviours, and better identify those sub-groups with the highest risk and vulnerability, and those hardest to reach (for example due to young age, gender or location). This requires strategic information, especially surveillance and formative research. The second challenge is to reach out to most-at-risk populations, many of whom are known not to access public sector health services due to stigma and criminalisation of their behaviours. Therefore, civil society and the private sector may be in a better position to reach out to them.

4.2 Maintaining effective HIV treatment, care and support services

Scaling up HIV-related health services will require a paradigm shift towards integrating HIV management into the public health system. It is estimated that in 2015, Lao may have 14,000 people living with HIV, and 7,390 in need of ART. Scaling up and maintaining quality will rely on developing a continuum of care framework with strong referral systems, allowing for decentralization of HIV management to province and district level where feasible, such as for treatment of opportunistic infections, and pre-ART management. Strong public-private partnerships with NGOs for community and home-based care are also needed. CHAS will also need to coordinate with other concerned sectors to fully incorporate HIV. This applies to sectors who have clinical responsibilities for HIV services (for example Medical Department, TB, MCH, National Blood Center, Medical Supply & Product Center, Laboratory and Epidemiology Center, Dermatology Center, Human Resource Development Department, others). Furthermore, HIV should be integrated with nutrition programme to better response to ARV treatment.

4.3 Increasing quality and effectiveness of interventions

Besides coverage, the main challenge is to ensure that prevention and care interventions are relevant, effective and efficient. One regularly expressed need is for quality assurance and quality improvement of services, especially 100% condom use interventions and home and community care interventions. To achieve this, national guidelines for services have to be developed on the basis of a review of current national and regional good practice, and evaluation of current interventions for effectiveness. This could usefully be done in the context of ongoing health system reform that makes provision for the development of quality assurance.

4.4 Decentralisation and sectoral mainstreaming

Services need to be delivered across many provinces and districts, but given the low prevalence and the exceptional nature of HIV programming, many PCCAs and DCCAs do not have the capacity and experience to design and coordinate local responses. Besides, the sustainability of these bodies is limited as they depend on external funding. Similar technical and financial challenges exist

in priority non-health sectors to address HIV, and for health departments to incorporate HIV in their strategies. Another challenge is to engage with the Lao National Commission for Drug Control and Supervision (LCDC) . In the health sector, the challenge is to mainstream HIV medical management into regular health services. Although decentralisation of HIV services relies on progress in health sector decentralisation, opportunities exist in initiatives like 'Model healthy village' and health volunteer training.

4.5 Technical and organisational capacities

Another challenge is the implementation capacity of service providers in the public and NGO sector, and the demands for supportive supervision of all implementing partners. As mentioned above, capacity to coordinate implementing partners and provide leadership to the response needs to be strengthened at all levels: NCCA, CHAS, PCCAs and DCCAs. An overarching challenge is the absence of a national capacity building strategy that would identify and prioritise training needs.

4.6 Strategic information

Several challenges exist in the area of strategic information. First, the national surveillance needs to monitor the emergence of concentrated HIV epidemics, and provide an early warning system on risk behaviours in most-at-risk populations. Second, formative research is needed to better understand the context of risk behaviours to inform intervention design. Third, a challenge is to monitor service statistics across sectors and at a decentralised level, through MIS (which is best done in close coordination with current developments in strengthening the health sector MIS). A related challenge is to analyse output data and disseminate findings back to service providers and up to funders and policy makers. The overarching challenge is to finalise a National M&E Strategy, including national core indicators and an operational plan to guide implementation.

4.7 Sustainability

In the context of the global economic crisis, and shifting donor priorities away from disease-specific funding towards global health funding, a major challenge is to sustain the current financial resource for the response. In practice, it will require a strategic approach to resource mobilisation, combined with long-term strategies to increase domestic funding and reduce the cost (or increase cost-effectiveness) of HIV interventions, as well as linking and handing over planning and budgeting for (now vertical) HIV services to the health sector or other line ministries (e.g. education).

5. Recommendations for the National Strategy and Action Plan

5.1 Maintain and sharpen focus on most-at-risk-populations

1. Sex workers and their clients need to remain a priority for targeted interventions. More attention is needed for sex workers outside the entertainment establishment environment, who are potentially more at risk, especially young, street-based, and transgender sex workers, informal sex workers using cell-phones and the Internet and sex workers in the border provinces servicing migrant workers.
2. Clients of sex workers are important to target, but more evidence is needed on the actual risk behaviour of specific client groups, mainly mobile men with money.
3. Men who have sex with men need to remain a priority. Better targeting is needed for those subgroups with the highest-risk behaviour, i.e. multiple partners and unprotected anal intercourse. Transgender need different intervention approaches to male-identified MSM
4. Drug users need to be urgently targeted, especially those using opiates, as international evidence indicates that they are prone to injecting. More evidence is needed on the link between Yaba use and HIV risk, before these users are targeted.
5. Young people need to be targeted and their special needs addressed, but only if there is evidence of risk or vulnerability. In general, school-based interventions for student youth do not reach most-at-risk adolescents who are better reached though targeted interventions for sex workers and MSM
6. CHAS to update population size estimates of all target populations for prevention, and identify realistic targets for service coverage based on international guidance[17]

5.2 Integrating treatment, care and support services in health services

1. Develop a comprehensive "continuum of care" strategy, including voluntary counselling and testing (VCT) services, medical treatment of HIV, home and community care services, and linkages to TB and antenatal care services (for PMTCT)
2. Ministry of Health to incorporate HIV management in regular health care services, and reduce reliance on vertical systems for HIV management
3. Prevention services for most-at-risk populations need to include promotion of voluntary counselling and testing (VCT) services to increase earlier diagnosis of HIV
4. Ministry of Social Welfare to increase access to social welfare services for HIV-affected families and individuals
5. Ministry of Health to monitor carefully ART treatment outcomes, including adherence, and use this strategic information to strengthen services

5.3 Ensuring the quality of services

1. Develop national guidelines for comprehensive prevention services, to be used to train existing and additional NGOs, public sector, and private sectors service providers, and scale up services
2. These guidelines need to be developed on the basis of an evaluation of good practices (e.g. peer education approaches, periodic presumptive treatment for STIs), and international and regional guidelines on intervention design.

[17] UNAIDS/WHO guidelines recommend 80% coverage in order to impact on HIV transmission

3. Quality assurance systems for interventions in civil society, the public sector, and private sector need to be designed an implemented. This is best done with the support of international NGOs (e.g. FHI, PSI, BI) and technical agencies (e.g. UNICEF, WHO) and will include supportive supervision of implementing partners.
4. Develop national guidelines for home and community-based care services, based on assessments of current good practices and international guidelines.

5.4 Building capacities of managers and implementers

1. Commission a capacity appraisal/training needs assessment across all implementing partners of the national response
2. Develop a national capacity building strategy to complement the NSAP 2011-2015, and develop and update annual capacity building work plans, in coordination with implementing partners, technical agencies and development partners
3. Commission a functional task analysis, in order to assess capacity building needs, and plan capacity strengthening activities
4. Align the HIV capacity building strategy with the MoH human resource development strategy[18], based on the 2007 human resource situation analysis[19]
5. Follow up the technical assistance (TA) needs assessment for PCCAs that was undertaken in 2009, and develop a capacity building strategy and plan for PCCAs and DCCAs
6. Use national guidelines for HIV interventions (see 5.2) as the basis for capacity building of service providers in NGOs, public sector, and private sector and for supportive supervision
7. Engage international technical assistance, for example through INGOs, to build the capacity of local NGOs/CBOs and private sector service providers (i.e. clinics and pharmacies)

5.5 Improving collection and use of strategic information

1. Finalise the national M&E strategy, and develop an M&E operational plan with specific roles and responsibilities and timelines for activities
2. Propose national core indicators, as part of the NSAP, to be monitored throughout the NSAP period
3. Further strengthen the M&E unit, and consider merging the M&R and Surveillance units into one 'strategic information' unit
4. Maintain second-generation surveillance for impact/outcome monitoring, and continue to engage international technical assistance for design and analysis.
5. Propose to the National Statistics Center to include an HIV module in the next Demographic and Health Survey or Social Indicator Survey
6. Broaden the scope of the MERS, and ensure alignment of the broader 'HIV MIS' with the health sector MIS and other sectoral (e.g. education) MIS
7. Develop a national HIV research strategy, including a system to determine annual research priorities, and for dissemination of research findings to policy makers and programme planners

[18] MoH , 2002 Master Planning study
[19] MoH, 2007 HR for health situation analysis

5.6 Increasing sustainability of the response

1. Develop a resource mobilisation strategy as part of the next NSAP
2. Make explicit choices on priority actions for the next NSAP, in the event of funding shortages on the basis of cost-effectiveness analysis
3. Proactively use the opportunity of the Global Fund (GFATM) round 11, through the National Strategy Application process, and use the NSAP 2011-2015 for that purpose
4. Proactively engage with existing and new development partners, and the Ministry of Planning and Investment for additional resources, for example through encouraging NCCA to attend the 'round table meeting' process and align with the 'Aid Effectiveness Agenda'
5. Develop strategies for reducing the cost of HIV services, and/or mainstream these services to the workplans and budgets of health or social sector departments
6. To improve sustainability of the response, increasingly mobilising the existing private sector.

5.7 Innovations in the strategy for the next 5 years

5.7.1 New initiatives

1. **Working on drug use**. Recognising the potential of a rapid spread of HIV among drug users, CHAS will work closely with the Lao National Commission on Drug Control and Supervision (LCDC) and other partners to design and implement comprehensive services.
2. **Targeting subgroups of most-at-risk populations**. Prevention interventions will be prioritised for sex-worker subgroups with high client turnover and those working outside entertainment establishment environments. Interventions targeting transgenders will be designed differently to those for male-identified men who have sex with men, recognising their different needs, sexual identities, behaviours and contexts.
3. **Focusing on young MARP, instead of targeting all young people.** Interventions will be designed age appropriately for sex workers and transgenders, recognising that many of these people are very young and extra vulnerable. Young people will (only) be targeted based on evidence of vulnerability, while the education sector will further integrate HIV into existing life skills education initiatives

5.7.2 Strengthening partnerships and coordination with other sectors

1. **Community systems strengthening**. Community groups, CBOs and NGOs will be supported to engage in the response, based on the new legal opportunities and their comparative advantage in reaching marginalised groups with little access to public and private services.
2. **Working with law makers**. Law makers will be engaged proactively through advocacy to build on the HIV/AIDS law, and further improve a supportive public policy environment for effective and sustainable responses.
3. **Strengthen partnerships between public, private sectors and civil society**.

5.7.3 Integrating HIV into Health systems

1. **Mainstreaming treatment into general health services.** HIV clinical management that currently relies on tertiary care will be gradually integrated into primary and secondary health services, based on a 'continuum of care' strategy specifying roles and referral linkages.
2. **Building linkages with health departments**. CHAS will proactively engage in the ongoing health sector reform, and seek opportunities to collaborate with clinical departments (MCH,

TB, blood banks) and supportive departments (human resources, HMIS, medical educations, etc.)

3. **Building linkages with the private health sector**. As many most-at-risk populations seek testing and treatment for STI/HIV in the private sector, the role of the private health sector is being recognised.

6. Guiding Principles for the National Response

The national strategic plan has been developed according to the following principles.

6.1 Interventions strategies based on evidence

Evidence is needed to ensure that all activities are effective, i.e. contribute to the national goals of preventing new infections and improving the lives of those affected. Given limited resources, there is also a need to establish cost-effective interventions to ensure rational allocation of resources. Formative research is a national priority to understand and quantify risk behaviours and vulnerabilities, including population size estimates and to provide baseline data for future evaluation. Evaluative research will be emphasized to demonstrate effectiveness and cost-effectiveness of all prevention and care interventions.

6.2 Prioritised and result-based strategies

The essence of each strategy is that priorities (based on evidence) are clear, so that the strategy focuses programme planners and implementers towards priority and cost-effective interventions, especially in the event of a shortage of human or financial resources. The overall strategy and each of the components are results based; all outcomes and outputs have clear, realistic and measurable indicators of success, so that progress of the national response can be monitored.

6.3 Respect for human rights

The national AIDS policy recognises the intimate link between HIV/AIDS and human rights. People who are most at risk of HIV infection are often the most difficult to reach because commercial sex work and drug use are illegal, homosexuality remains a social taboo and drives men who have sex with men underground and trafficking is problematic to track effectively. The NSP and the National AIDS Policy mirror the constitution in taking universal human rights and the dignity of all Lao people, including their sexual and reproductive rights, as guiding principles. There should be no discrimination on the basis of gender, disease status, sexual behaviour or sexual orientation. HIV testing without prior informed consent is never acceptable (unless anonymously unlinked for screening purposes) and it is essential that every HIV test result remains confidential.

6.4 Gender considerations

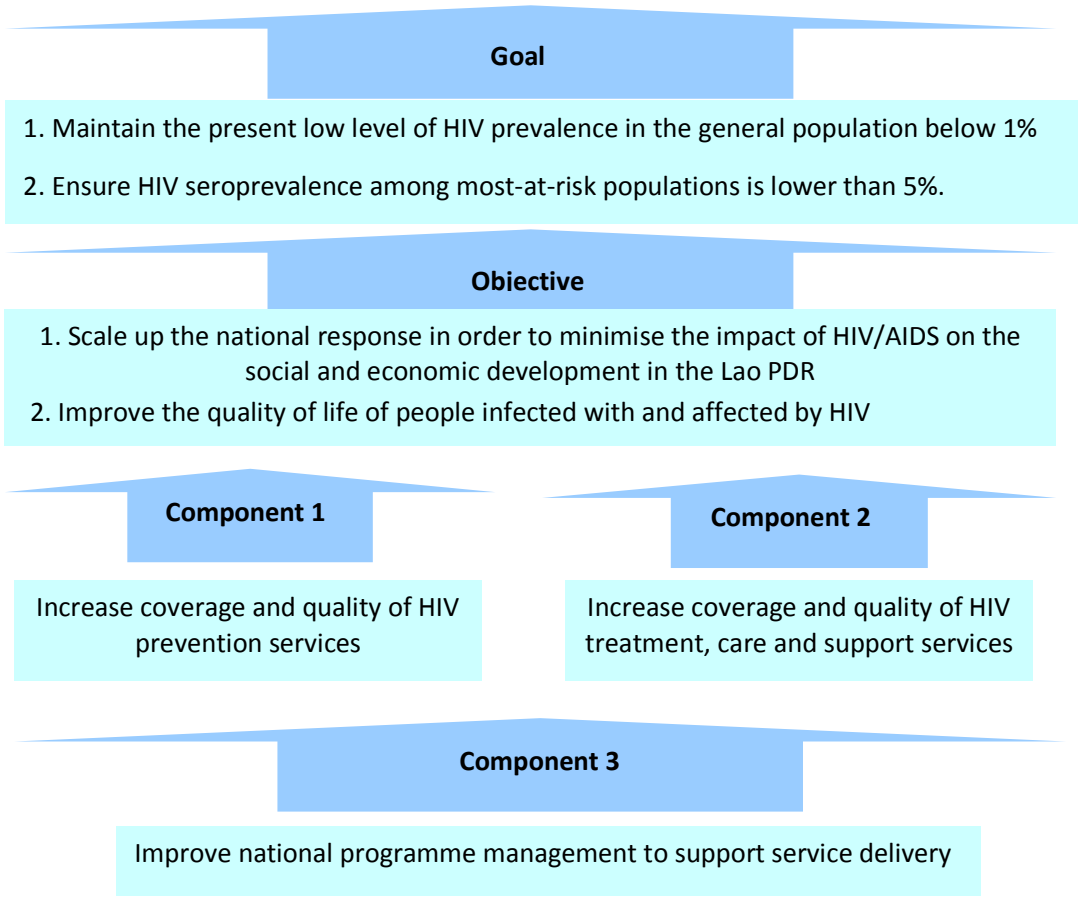
Women are biologically more susceptible than men to sexual HIV transmission; Women are less likely to be able to negotiate conditions of sex or the use of condoms by their sexual partners due to the power constructs of the relationships between themselves and their male partner. Women may also have more limited access to services and are more likely to suffer stigma due to HIV infection. Research also indicates relatively high levels of sexual violence against women. For these reasons, a gender analysis framework must be applied to all planning, service delivery and research processes.

6.5 Involvement of communities and people with HIV

Behaviour change interventions are most effective if based on real needs, and delivered by peers. The NSP recognises the importance of the participation of communities in the design, implementation and evaluation of services. People living with HIV (PLHIV) and affected people have an important role in prevention and care, and their experiences and involvement make interventions more effective and relevant. The NSP promotes meaningful involvement of PLHIV and affected people.

7. The National Strategic Plan 2011-2015

7.1 Results Framework

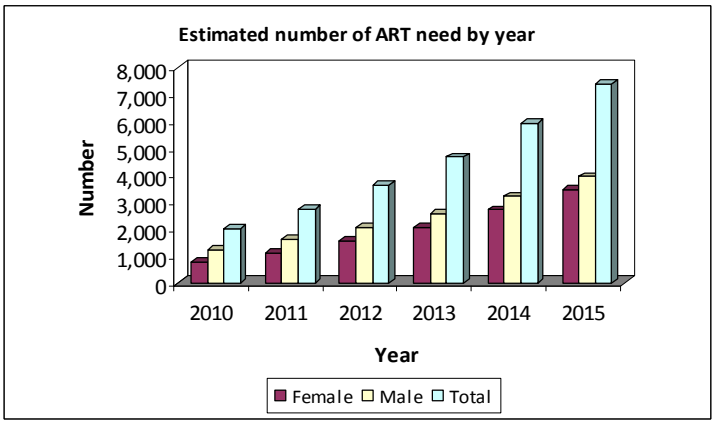


7.2 Priority Components

The strategy identifies the following detailed strategic components (see annex 4):

1. **Increase coverage and quality of HIV prevention services, resulting in 80% coverage of most-at-risk populations.** The focus for prevention will remain on most-at-risk populations (sex workers, men who have sex with men, drug users and their sex partners), ensuring sufficient coverage to ensure impact on reducing HIV transmission. Prevention services will be comprehensive and include peer education for behaviour change, condom promotion, STI treatment, and addressing the contexts leading to risk behaviour. Harm reduction approaches will be promoted for drug users (see annex 5). Standard guidelines for prevention interventions will be developed and/or updated and implementing organizations will be trained and supervised to ensure quality.

2. **Increase coverage and quality of HIV treatment, care and support services, resulting in 90% coverage of people in need of ART, and a treatment drop-out rate of less than 10%.** The focus for care and treatment services is to maintain the current high coverage of

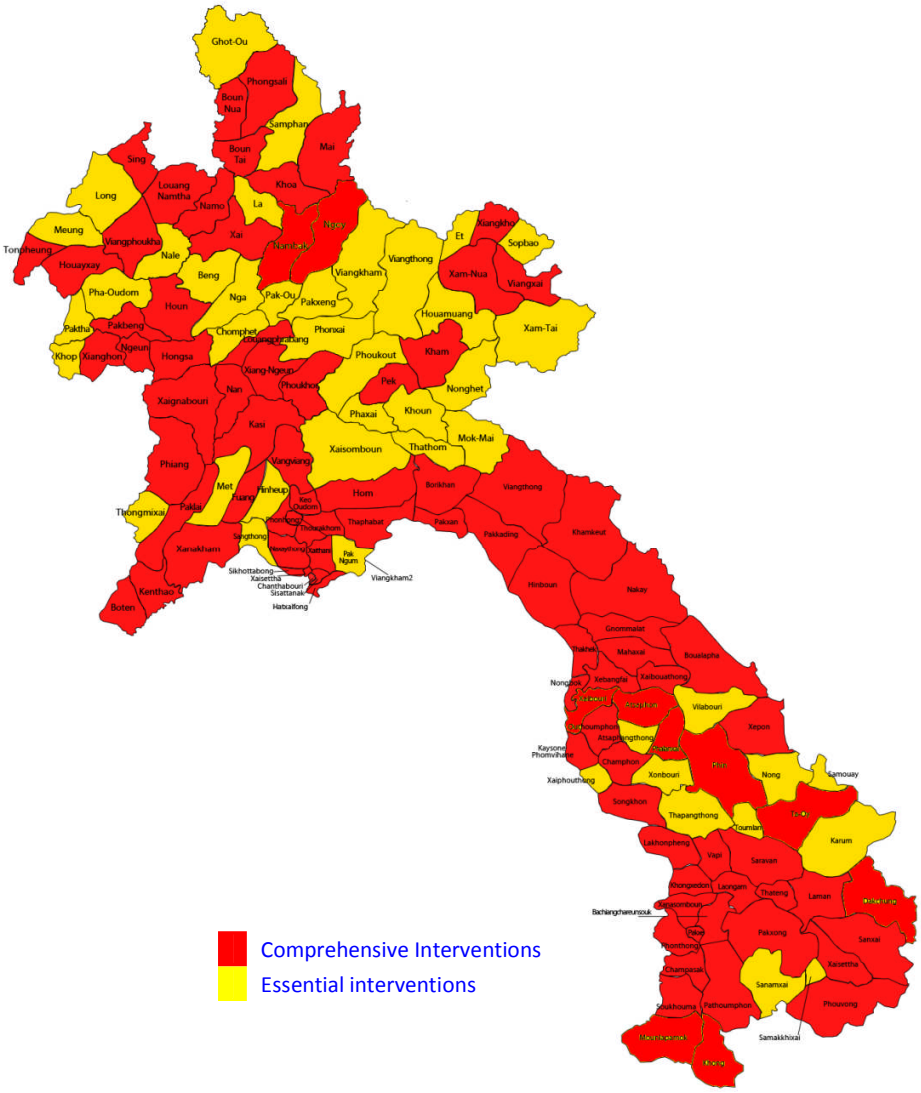


ART and treatment for opportunistic infections, and the low drop-out rate. As over 7,000 people will need treatment by 2015, the emphasis will be to strengthen health systems to deliver quality care through a continuum of care and referral networks. For home and community care services, standard guidelines will be developed, and services will be contracted out to NGOs and other civil society organisations.

3. **Improve national programme management to support service delivery, resulting in annual costed work plans, annual progress reports, two surveillance rounds, and satisfactory performance on current donor grants.** The emphasis for national programme management will be to strengthen the capacity of implementing partners through quality assurance, supportive supervision and coordination. The Monitoring and Evaluation strategy will be revised and implemented by all Partners under coordination of CHAS. Maintaining current resource levels will be a challenge, requiring cost-effective measures as well as resource mobilisation from donors and the government. Strengthening links with the health sector and strengthening health systems will be a priority to ensure sustainability of HIV services.

7.3 Focus provinces and districts

Since the 2006-2010 NSAP, provinces and districts have been prioritised on the basis of relative vulnerability, in order to maximise the use of limited resources. Likewise, 94 of the total 143 districts have been prioritised for comprehensive prevention based on the following characteristics:



- Presence of most-at-risk populations or hot spots, such as entertainment establishments, transport hubs, construction or mining sites with large numbers of migrant workers, drug trafficking areas, etc.
- High prevalence of HIV
- Population density

Annex 6 (A, B, C) provides an overview of the priority districts for each province, as well as vulnerability and current service coverage.

During the next five years, focus will be also be placed on the development of a continuum of care system with clear referral linkages for primary, secondary and tertiary HIV care, integrated into the general public health services. In addition to the existing five ART reference centers and three satellites, all provincial hospitals will be equipped with continued ARV and OI treatment services.

8. The National Action Plan 2011-2015

8.1 Increase coverage and quality of HIV prevention services

8.1.1 Sex workers

Expected outcome by 2015

- HIV prevalence amongst high-frequency sex workers is under 5%
- 85% of estimated numbers of sex workers are reached through interventions
- 80% of sex workers report consistent condom use with clients
- Chlamydia/Gonorrhoea prevalence amongst sex workers is under 10% (based line is 21%, 2008)

Key issues and challenges

- Poor reach of sex worker subgroups with high vulnerability, including street-based sex workers and sex workers using cell phones.
- Effective intervention approaches (including drop-in centres, treatment for STIs, and peer education) need to be documented and replicated through standard operating guidelines, training and supervision. Peer-led interventions and drop-in centres should be evaluated.
- Operational research is needed to better understand contextual factors of vulnerability, such as age, nationality, migration history, etc., and to inform innovative intervention design.
  Many sex workers are young, and therefore more vulnerable. Interventions need to be age and gender appropriate in design and implementation.

Strategies

- Scale up comprehensive sex worker interventions to all priority districts, under guidance of PCCAs and DCCAs
- Build capacity of implementing partners and provide supportive supervision
- Establish formal structures and a range of informal processes that will engage target groups and civil society organisations in intervention design and implementation, including national NGOs, private health providers and owners of entertainment establishments
- Include freelance sex workers (e.g. street-based and mobile phone groups) in the IBBS system to identify behaviours and to inform innovative intervention design.

8.1.2 Men who have sex with men

Expected outcome by 2015

- HIV prevalence amongst high-risk MSM is under 5%
- 80% of estimated numbers of high-risk MSM are reached through interventions
- 75% of high-risk MSM report consistent condom use
- Chlamydia/Gonorrhoea prevalence amongst high-risk MSM is under 10% (based line is 9%, 2009)

Key issues and challenges

- The population of MSM is estimated to be much larger and risk behaviour is more prevalent than earlier anticipated.

- MSM has many subgroups with different identity, behaviours and networks. Each subgroup need to be approached differently for HIV prevention
- Drop-in centres may be effective but costly. Community-based and community-led interventions appear effective in all subgroups of MSM. Peer-led interventions and drop-in centres should be evaluated.
- Insufficient evidence about location, population sizes, sexual networking and contextual factors of vulnerability of several subgroups of MSM.

Strategies

- Scale up comprehensive interventions that are appropriate for high-risk MSM to relevant districts, based on formative research
- Commission formative research to guide intervention design and evaluate effective models of practice
- Build capacity of implementing partners and provide supportive supervision
- Engage private sector and civil society, including community-based organisations to deliver products and services and implement interventions.

8.1.3 Drug users/Injecting drug users

Expected outcome by 2015

- HIV prevalence amongst DU is under 5%
- 60% of estimated numbers of IDU are reached through harm reduction interventions
- 55% of IDU report safe use of injecting equipment
- 55% of IDU report consistent condom use with their sexual partners.

Key issues and challenges

- Opium use is common in Northern provinces, and traditional opium users are shifting to heroin. The National Drug Control Master Plan 2009-2013 reports approximately 12,000 people as opium users and 40,000 peoples as ATS users.
- HIV has been identified among drug users, who are mainly male, married, sexually active but do not use condoms regularly
- The potential for rapid transmission of HIV among injecting drug users is real and can result in outbreaks of HIV with high prevalence, as experienced in many countries.
- Drug users who normally inhale or smoke opiates, may occasionally inject, depending on factors like price and purity of the drug and peer influence. This means all drug users need to be targeted with prevention interventions, not only current injectors
- Recreational drug use among adolescents and young people is increasing in many areas, putting them at risk of HIV infection, e.g. unsafe sex practices

Strategies

- Urgently design and establish HIV prevention interventions targeting (injecting) drug users based on harm reduction principles, including their sex partners
- Continue advocacy on harm reduction approaches with relevant departments, including the Lao National Commission for Drug Control and Supervision (LCDC), Public Security and local authorities
- Commission formative research to gather additional evidence on injecting and sexual behaviours among drug users and contextual factors of vulnerability
- Build capacity of implementing partners and provide supportive supervision.

8.1.4 Men with multiple concurrent partners (clients)

Expected outcome by 2015

- 70% of targeted mobile men (including civil servants, migrants & transport workers and business men) report consistent condom use with casual partners
- Chlamydia/Gonorrhoea prevalence amongst men with multiple partners is under 10%.

Key issues and challenges

- Frequent casual and/or commercial sex has been reported among mobile men who spend extensive time away from their families, e.g. civil servants, migrant and transportation workers and business men (both Lao and foreigners working in Lao PDR)
- A workplace policy has been agreed, and the military, police and transport departments have developed HIV strategies. However, insufficient human, financial and technical resources hamper HIV programming.

Strategies

- Continued advocacy with relevant sectors, e.g. military, security, private sector, tourism, infrastructure development and agriculture
- Build capacity of relevant sectors to design strategies, mobilise resources and technical assistance and implement HIV prevention services
- Scale up workplace interventions for professional groups, including behaviour change communication, condom promotion, STI treatment, and voluntary counselling and testing.

8.1.5 Sexually transmitted infections services

Expected outcome by 2015

- 94 priority districts have at least one quality-assured site for STI treatment
- 80% of high frequency sex workers and male sex workers have accessed to quality-assured STI services as needed.

Key issues and challenges

- STI rates amongst sex workers have halved, in part due to on-site period presumptive treatment as part of the comprehensive interventions in drop-in centres.
- National guidelines for syndromic STI management are not applied universally by public sector and private health providers, despite the availability of pre-packaged STI drugs.
- STI surveillance, including STI aetiology and gonorrhoeal antimicrobial susceptibility monitoring, needs strengthening.

Strategies

- Strengthen quality of STI services for sex workers, MSM through inclusion of screening and/or periodic presumptive treatment when needed
- Strengthen STI services for men and women at risk, and continued training of health workers and pharmacies on syndromic management.
- Support the maternal and child health (MCH) programme to introduce antenatal syphilis screening.
- Strengthen design and implementation of STI surveillance, including sex and age-disaggregated data

- Improve coordination with the private sector

8.1.6 Condom programming

Expected outcome by 2015

- 90% of most-at-risk populations report easy access to condoms
- 6 million condoms distributed annually until 2015

Key issues and challenges

- Only PSI implements condom social marketing; CHAS is in charge of condom distribution to HIV interventions, and the Ministry of Health (MCH) coordinates condom distribution for family planning. Forecasting of condom requirements, procurement, distribution and warehousing systems are segmented and patchy.
- Barriers to condom use include myths, misconceptions about quality and stigma. These barriers need to be addressed while promoting both male and female condoms as neutral, dual protection devices.
- Complaints about condom quality and condom breakage are reported, and there is a need for quality control.
- Levels of consistent and correct condom use are still too low among vulnerable groups

Strategies

- Reinforce the Condom Programming as a responsibility of the Prevention Technical Working Group
- Promote “condom dual protection” approaches
- Establish Condom Quality Assurance Mechanism
- Demand generation through Condom Social Marketing and other interventions
- Improve condom logistics through linkages with the private sector

8.1.7 Prevention of mother-to-child transmission (linking HIV and MCH)

Expected outcome by 2015

- 50% of ANC attendants received Provider Initiated Counselling and Testing (PICT)
- 90% of identified HIV-positive pregnant women received antiretroviral medicines to reduce the risk of mother-to-child transmission
- 100% of infants born to identified HIV-infected mothers received ARV drugs

Key issues and challenges

- The number of positive pregnancies is estimated at 300-400 per year
- The number of HIV-positive pregnant women receiving anti-retroviral prophylaxis to reduce the risk of mother-to-child transmission has remained low (around 20 in 2009). Most of these women were diagnosed in the ART centres, not through antenatal care services
- PMTCT guidelines developed in 2007 are incorporated in the maternal health strategy, and have been piloted in 6 provinces. However, implementation is hampered by poor access and use of antenatal care (28%), drop out after counselling due to referral for HIV testing, and confusion among health workers about reporting requirements.

Strategies

- The maternal and child health (MCH) centre to further implement the PMTCT guidelines as part of the essential antenatal care package (including rapid HIV testing at antenatal service sites)
- HIV prevention interventions for sex workers and other most-at-risk women to incorporate family planning, reproductive health and PMTCT services
- The MCH centre to increase male involvement in PMTCT, and in antenatal care in general.

8.1.8 Blood safety

Expected outcome by 2015

- 100% of blood units screened for HIV with quality assurance

Key issues and challenges

- The Lao Red Cross - National Blood Transfusion Centre has scaled up blood centres to all provinces and will extend to some districts.
- Strengthening quality assurance standards and systems for blood screening and blood product development are a priority for the next 5 years.
- Further increasing voluntary and non-remunerated blood donations, and further rationalising medical use of blood products are necessary.

Strategies[20]

- Secure and maintain an adequate supply of safe blood for patients in need
- Ensure all blood collected is correctly and systematically screened
- Ensure systematic quality management based on internal procedures and international standards
- Promote the importance of blood and its safe and effective use
- Strengthen programme management and technical skills of personnel at central, provincial and district levels.

8.1.9 General population and migrant labours

Expected outcome by 2015

- 80% of young women and men aged 15–24 both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

Key issues and challenges

- Although the majority of the population has low or no risk of HIV infection, all Lao people need to be knowledgeable about HIV, and able to reduce their chances of HIV infection
- According to the national HIV and AIDS case reporting, a number of HIV infections were identified among the general population, e.g. housewives, farmers and migrant labour
- All young people need to be aware of HIV and sexual/ reproductive health issues before they become sexually active, and possess life skills to reduce their vulnerability not only to HIV, but also to sexual violence and unwanted pregnancies.

[20] Source: Lao Red Cross, Blood Transfusion Service Strategy 2009-2013

Strategies

- Mass media communication for (subgroups of) the general population, with focus on awareness, knowledge about HIV, STI services, and supportive attitudes towards people living with HIV
- Ministry of Education to expand life-skills education in schools, and include HIV and sexual health, based on recent evaluations
- Expand outreach interventions by sector concerned (e.g. LYU) for out-of-school youth and disadvantaged children based on the recent MARA assessment
- Ministry of Health, especially hospitals to promote universal precautions to avoid nosocomial infection
- Ministry of Labour and Social Welfare will provide pre-departure package for migrant workers and post-package interventions for returnees, including VCT.
- Expand HIV workplace interventions in line with Tri-partite Declaration on HIV in the workplace.
- Ministry of Labour & Social Welfare and Ministry of Public Works & Transport to negotiate with the companies to ensure budget allocation available for HIV interventions.
- Create opportunities for strengthening cross border cooperation.

8.2 Increase coverage and quality of HIV treatment, care and support services

8.2.1 Voluntary counselling confidentiality and testing

Expected outcome by 2015

- Quality-assured VCT services available in all 94 priority districts
- 80% of most-at-risk populations report having received an HIV test and know the results in the last 12 months.

Key issues and challenges

- Despite the establishment of 160 VCT sites in 77 districts across all provinces at hospitals, drop-in centres and TB clinics, quality assurance of VCT services is needed, on the basis of national protocols and guidelines
- The percentage of most-at-risk populations that have received an HIV test and know the results is limited (15% sex workers, 14% men who have sex with men)
- Shortages in the supply of testing reagent
- No national HIV prevalence data among TB patients.

Strategies

- Further scale up VCT sites to all district hospitals and prioritised primary health care centres
- Build capacity of VCT service providers, through review and revision of national guidelines, training and supportive supervision
- Establish and implement quality assurance system for VCT services
- Promote Provider Initiated Counselling and Testing (PICT) according to WHO guidelines
- Review rapid test and set up quality assurance protocols.

8.2.2 ARV and OI management

Expected outcome by 2015

- Over 90% of adults and children who have advanced HIV infection receive antiretroviral treatment
- ARV and OI treatment integrated in all provincial hospitals
- Strengthened continuum of care for treatment adherence of PLHIV in prioritised districts.
- 100% of HIV patients tested for TB and vice-versa by using PICT approach, according to VCT guidelines

Key issues and challenges

- In 2015, an estimated 7,000 people will need ART, while currently five ART sites manage 1,345 patients and are overburdened. Physical access to care services needs to increase
- HIV medical management is vertical in ART centres; integration and referral linkages with the public health services (general hospitals, TB control services, maternal and child health) are limited
- Medication for HIV and opportunistic infections is free, but 100% dependent on external funding, which is a challenge for sustainability
- Maintaining the high adherence rates for ART will be hard as treatment is scaled up
- A high proportion of people come to ARV treatment sites with advanced stage HIV infection and opportunistic infections, especially TB (40%).

Strategies

- Develop a continuum of care system with clear referral linkages for primary, secondary and tertiary HIV care, and integrated into the general public health services
- Develop early warning indicators to monitor treatment failure
- Capacity building of all relevant health workers and institutions, through development of national guidelines and service protocols, training, and supportive supervision
- Design and implement a quality assurance system for HIV management services and monitor HIV medical management
- Update ARV guidelines regularly
- Develop national HIV and TB management guidelines
- Develop Standard Operating Procedure for implementing of "3Is" in continuum of care setting[21]

8.2.3 Home and community-based care for people infected with and affected by HIV

Expected outcome by 2015

- 90% of those diagnosed with HIV can access quality home and community-based care.

Key issues and challenges

- In 2015 an estimated 14,000 people will be living with HIV, and more people will be affected, i.e. orphaned or widowed

[21] Three Is: Intensified TB case finding (ICF) among PLHIV and their household contact; Isoniazid Preventive Therapy (IPT) for PLHIV unlikely to have active TB; and Improved TB infection control (IC) measures at Continuum of Care and home-base care setting

- HIV remains a cause for stigma and discrimination, and reduces peoples access to health, education and social welfare services
- Several home and community care models have been piloted, but there are no national standard guidelines.

Strategies

- Develop standard guidelines for a range of care and support services, based on national and international experiences, including referral linkages to VCT and medical care
- Support civil society organisations with capacity building and resources to reach PLHIV, orphans and widows with home and community care services
- Ministry of Social Welfare to reduce barriers to access to social welfare services for HIV-affected people
- Ministries of Education and Health to reduce barriers to access to education and health services for HIV-affected people
- Design and implement a quality assurance system to monitor home and community care services and monitor public and civil society providers.

8.2.4 Positive health

Expected outcome by 2015

- PLHIV support groups exist in all provinces
- 100% of diagnosed PLHIV are referred to, and 90% access, PLHIV support groups at least once
- Lao Network of PLHIV (LNP+) established and approved by the government.

Key issues and challenges

- Involvement of people infected with and affected by HIV is limited in design and implementation of the national response, including prevention and care services
- The technical and organisational capacity of PLHIV to engage in the national response is limited due to protocol regarding seniority and low levels of education. .

Strategies

- Provide technical, organisational and financial support to PLHIV self-help groups in all provinces and to the national network of PLHIV groups
- Ensure the involvement of PLHIV groups in the design, implementation and evaluation of treatment, care and support services, including development of service standards
- Promote positive health among PLHIV to avoid further infection and transmission.

8.3 Improve national programme management to support service delivery

8.3.1 Policy, legal reform and advocacy

Expected outcome by 2015

- HIV/AIDS Law and policies containing non-discrimination principles are broadly disseminated and implemented.

Key issues and challenges

- Despite a supportive national AIDS policy, stigma and discrimination around HIV remain prevalent in communities, workplaces and social services.
- The legal environment does not facilitate interventions among certain most-at-risk and marginalized groups (e.g. sex workers and drug users)
- HIV/AIDS has to compete with other development and public health issues for policy and funding priorities.

Strategies

- Support relevant ministries to develop supportive sectoral policies on the basis of the national AIDS law and national AIDS policy, for example the ministries of health, education, Labour and social welfare
- Advocacy and capacity building of social service providers to eliminate discriminatory practices and increase access of services for PLHIV and marginalised groups like sex workers, men who have sex with men, drug users, migrant workers, ethnic groups etc.
- Provide organisational and technical support to community-based organisations of marginalised groups and young people, so that they can contribute to the national response and advocate for their needs.

8.3.2 Strategic information

Expected outcome by 2015

- Integrated behavioural and biological surveillance (IBBS) of MARP are undertaken on a regular basis and reported to measure outcomes and the impact of the response
- Reporting on biomedical HIV services (including ART, PMTCT, condom programming, blood safety) is integrated into the MoH HMIS and reported regularly
- HIV related operational research is coordinated and prioritised by the Strategic Information unit at CHAS.

Key issues and challenges

- IBBS relies on external funding, and is crucial for monitoring outcomes and the impact of the national response
- Reporting of HIV services is scattered and weak, and not aligned with the HMIS system of the ministry of health
- There is a need for a national research agenda to prioritise and coordinate social science, biomedical and evaluative research related to HIV.

Strategies

- Develop and implement IBBS; regular size estimates of target populations, and formative research on sexual networking, vulnerabilities and risk
- Include an HIV section in the Lao Social Indicator Survey to inform the response
- Integrate HIV service reporting with the new HMIS system of the ministry of health
- Ensure all HIV service statistics are analysed, documented, disseminated and fed back to all relevant stakeholders, at least annually, through national HIV progress reports
- Develop a national HIV research agenda, complemented by annual HIV research plans.

8.3.3 Health systems strengthening and community involvement

Expected outcome by 2015

- HIV/AIDS is included in the training curriculum for all health workers
- National guidelines and standard operating procedures exist for key HIV services, including testing & counselling, medical management of HIV, PMTCT, targeted prevention interventions and home/community-based care
- Supportive supervision and quality assurance system for HIV services institutionalised
- NGOs report increased organisational, financial and technical support from the government as well as development partners.

Key issues and challenges

- Most prevention and treatment interventions rely on the health system (condom programming, VCT, STI management, PMTCT, blood safety, management of HIV and opportunistic infections, etc.) For a sustainable response, HIV needs to be integrated into health systems
- Priority HIV services, including prevention for marginalised populations and home care, rely on community-based organisations and strong community systems
- Capacity shortfalls exist among many partners in the HIV response, amongst programme planners and policy makers as well as service providers
- Training needs have not been assessed or documented systematically
- There is not a clear national capacity building strategy, identifying priorities, resources and methodologies for capacity building.

Strategies

- Undertake a national AIDS programme capacity and training needs assessment in line with the NSAP 2011-2015, develop a prioritised capacity building strategy and agree annual capacity building plan with development and technical partners
- For all HIV service areas, develop national guidelines, standard operating procedures and training materials, for use in capacity building
- Roll out training programmes in coordination with line ministries in order to reinforce their operational capacity
- Ensure that line ministries integrate HIV-related issues and services in the sectoral supervision
- Encourage financial, organisational and technical support to national NGOs and CBOs from international development partners and international NGOs

8.3.4 Coordination of the multisectoral and decentralized response

Expected outcome by 2015

- Annual multisectoral operational plans developed jointly with implementing partners
- Joint reviews of NSAP undertaken at mid-term (2013), and end of project (2015)
- Coordination structures at provincial and district level reviewed and strengthened where appropriate
- Partnerships between public/private/civil society strengthened.

Key issues and challenges

- HIV requires a multisectoral response, with contributions of several sectors, such as health, education, social welfare, transport, private sector and civil society. Not all sectors have sufficient capacity and resources to provide sector response
- Decentralisation allows local responses to be more relevant, but local capacity is limited

Strategies

- Relevant line ministries will develop sectoral HIV/AIDS strategies, operational plans, and mobilise the necessary resources and technical assistance for implementation
- Promote and advocate that all provincial and priority district authorities integrate HIV in local development planning, and have access to resources and technical assistance for implementation
- Organise regular national partnership forums, with all implementing partners, to review progress towards the national objectives, and the relevance of the response and services
- Undertake joint implementation reviews of the NSAP at mid-term and end of programme.

8.3.5 Resource mobilisation and financial management

Expected outcome by 2015

- Annual AIDS budget and expenditure increased based on budget needs to be mobilised externally
- Proportion of annual plan supported by domestic resources increased
- Costed operational plans developed each year.

Key issues and challenges

- Given the global economic crisis, maintaining current levels of external assistance for the national programme is doubtful
- National budget for the national AIDS response is limited
- The major share of HIV funding comes from Global Fund grants, which is conditional on results, prompt reporting and strict financial management.

Strategies

- Develop annual, costed operational plans according to the NSAP
- Develop a resource mobilisation strategy, including national and international resources
- Advocate with the Ministry of Planning and Investment for increased allocation of resources to the HIV response
- Advocate with line ministries and private companies to include relevant components of the national operational plan into their own work plan and budget.

8.4 Cost projections and resource gap analysis

Annex 3A and 3B provide an overview of the estimated unit costs, total costs and resource needs for implementation of the NASP 2011-2015. The total estimated resource needs are US$ 54.2 million for 5 years, increasing from US$ 7.3 million in 2011 to over US$ 14.6 million in 2015. The resource estimates are based on the budgets for the current NSAP, Global Fund work plans, actual expenditures, coverage targets and population size estimates, as well as regional cost averages for unit costs. These estimates will be updated annually at the time of annual work plan development.

Cost projections for the national programme 2011-2015

No	Activity set/Activities	2011	2015	Total	%
		(Cost in US$)			
1	**Increase coverage and quality of HIV prevention services**	**4,314,712**	**7,943,913**	**30,499,931**	56.25%
1.1	Sex workers	972,300	1,303,900	5,791,050	10.68%
1.2	Men who have sex with men	507,600	1,504,800	4,973,200	9.17%
1.3	Drug users/Injecting drug users	343,600	1,160,400	3,638,900	6.71%
1.4	Men with multiple sex partners (clients)	304,650	790,160	2,710,360	5.00%
1.5	STI services in public sector	145,287	376,478	1,291,871	2.38%
1.6	Condoms	480,000	480,000	2,400,000	4.43%
1.7	PMTCT	306,000	850,000	2,805,000	5.17%
1.8	Blood safety	702,000	864,000	3,969,000	7.32%
1.9	General population	553,275	614,175	2,920,550	5.39%
2	**Increase coverage and quality of HIV treatment, care and support services**	**1,899,002**	**4,665,736**	**15,842,482**	29.22%
2.1	Voluntary counselling & testing (VCT)	425,000	622,243	2,594,668	4.78%
2.2	ARV and OI treatment	1,171,350	3,159,225	10,413,900	19.20%
2.3	Home and community based care	218,652	758,268	2,287,914	4.22%
2.4	Positive health	84,000	126,000	546,000	1.01%
3	**Improve national programme management to support service delivery**	**1,171,371**	**2,060,965**	**7,884,241**	14.54%
3.1	Policy, Legal Reform & Advocacy	50,000	50,000	250,000	0.46%
3.2	Strategic Information	280,000	530,000	1,900,000	3.50%
3.3	Strengthening health system & community involvement	621,371	1,260,965	4,634,241	8.55%
3.4	Coordination of the multisectoral and decentralized response	200,000	200,000	1,000,000	1.84%
3.5	Resource mobilisation & financial management	20,000	20,000	100,000	0.18%
	Grand Total	**7,385,085**	**14,670,613**	**54,226,653**	100.00%

The cost for scaling up prevention services will increase, from US$ 4.3 million to US$ 7.9 million in 2015, which will then be over 50 % of the total programme costs. As the prevention component is focused on most-at-risk populations and aims to increase coverage to 60%-85% by 2015, these comprehensive prevention services will make up nearly half of the prevention resource needs. Of the remaining prevention costs, the most costly programmes are prevention services for the general population (including school programmes and mass media), blood safety, PMCT, men with multiple sex partners, and condom social marketing.

Around 75 % of the total resource needs are for scaling up treatment, care and support services. The overall budget is increased by more than 50% in 2015. Of the total costs, the costs for antiretroviral treatment and management of opportunistic infections comprise roughly 19%.

The cost for programme management is estimated to increase from nearly US$ 1.2 to 2 million. The most costly activities are health systems and community involvement strengthening, and strategic information (including surveillance, monitoring and coordination). The cost of strengthening health systems and community involvement is estimated on the basis of a proportion of service delivery costs (10%).

The cost projection constitutes an increase compared to current spending, which is between 5 and 6 million US dollars. The successful implementation of the proposed action plan will therefore depend on a combination of resource mobilisation, cost-cutting, efficiency gains and mainstreaming vertical HIV services into sectoral workplans and budgets.

9. Implementation Arrangements

9.1 Governance: National Committee for the Control of AIDS

The National Committee for the Control of AIDS (NCCA) has multisectoral membership from line ministries and national organisations, and is responsible for governance of the response. The NCCA meets twice yearly, approves national strategic and operational plans, and oversees progress towards overall objectives. The current membership of the NCCA is comprised of fourteen members with representation from seven line ministries including Ministry of Health, Education, Information and Culture, Labour and Social Welfare, Defence, Public Security and Ministry of Public Work and Transportation. There is also representation of mass organizations and civil society, including Lao Youth Organization, Lao Women's Union, Lao Trade Union, Lao Front for National Construction and Lao Red Cross,. A new NCCA structure has recently been submitted to the Prime Minister's office for consideration and approval, with the addition of more members such as focal points of the National Assembly, National Chamber of Commerce and Industry, Lao National Commission of Drug Control and Supervision, Buddhist Association and LNP+. The Center of HIV/AIDS/STD (CHAS) acts as the secretariat for the NCCA. (See annex 1 for an organogram of the national response)

The Country Coordinating Mechanism (CCM) is the governance body for the Global Fund to Fight AIDS, TB and Malaria. The CCM is chaired by the vice minister for Education, and membership includes several ministries, development partners and civil society organisations.

Other specific mechanisms exist with bilateral and multilateral (UN) systems and NGOS to coordinate and implement the specific interventions.

9.2 Coordination and programme management

The Center for HIV/AIDS/STI within the Department of Hygiene and Prevention, Ministry of Health, is responsible for the management and coordination of the national response. CHAS coordinates the development of the NSAP and annual operational plans. The CHAS Strategic Information unit (Surveillance and M&E) is responsible for monitoring and reporting on impacts and outcomes and service outputs. Technical units in CHAS are responsible for developing national technical strategies, guidelines, and training.

The Department of Hygiene and Prevention, Ministry of Health, acts as the principle recipient (PR) for Global Fund (GFATM) grants for the national response, which is the largest contribution. The PR disburses funding to sub-recipients including CHAS and NGOs, and reports to the CCM and GFATM on progress

At provincial and district level, multisectoral PCCAs and DCCAs combine coordination and implementation responsibilities.

9.3 Service delivery and programme implementation

Several government and NGO partners are responsible for the implementation of the response, including service delivery, training, research and advocacy.

The health sector is the key actor in implementing the national response. Service delivery for prevention and care is the responsibility of health workers in health centres, hospitals, plus specialised ART, antenatal and TB clinics, amongst others. Technical support, training, supervision and surveillance are the responsibility of CHAS. Other key partners in the health sector are the Laboratory & Epidemiology Center, Medical Product and Supply Center and HMIS Unit. Other sectors, e.g. National Blood Center and private health providers have a role too, especially for STI management and HIV testing.

Other important government partners for service delivery are the Ministry of National Defence, Ministry of Public security; the Ministry of Education, Ministry of Labour and Social Welfare (to ensure access for HIV affected families and children); and the Ministries of Public Works and Transport (to encourage workplace interventions for mobile and migrant workers)

Mass organisations and Lao Red Cross currently support implementation of HIV services. Civil society partners, including NGOs and CBOs are important for service delivery for marginalised groups with little access to public services, such as sex workers, MSM, drug users, adolescents and migrants. Community-based organisations and NGOs also have a big role in providing home and community-based care, including support for orphans and widows. The National network of people living with HIV (LNP+) and self-help group networks are crucial for peer support and promoting greater involvement of people with HIV in policies and programmes.

9.4 Capacity building and technical assistance

Capacity building is a cross-cutting issue throughout the national response and the NSAP 2011-2015, as is reflected in many of the specific strategies: developing service standards, guidelines, and training of service providers, supportive supervision and quality assurance. The section on 'health systems strengthening and community systems strengthening' further specifies the broad target audiences for capacity building: implementing partners within MoH departments (general health workers, blood banks, antenatal service, etc.), versus mass organizations, and civil society partners, etc.).

Implementation arrangements for capacity building will be spelled out in a capacity building strategy. Development partners such as WHO, the UN system and the French Development Agency (AFD) and international NGOs will support Lao PDR with international technical assistance for the development of national technical guidelines, standard operating procedures, training programmes and quality assurance systems.

9.5 Financial management and resource mobilisation

Funds for the NSAP will be mobilised from various sources: national budget, private and locally organisational contributions, international donors, and funding generation through specific events. The NCCA will develop a resource mobilisation strategy to finance the NSAP and annual operational plan, including coordinating the application to the GFATM and other donors.

10. Monitoring and Evaluation

10.1 National programme core indicators

Annex 2 provides an overview of the core indicators for impact, outcomes, and outputs. Most indicators are based on internationally agreed indicators for national HIV/AIDS programmes, and agreed as part of the UNGASS declaration of commitment in 2001.

10.2 Roles and responsibilities

The Centre for HIV/AIDS/STI is responsible for the monitoring and evaluation of the response through the M&E strategy and annual work plans. The CHAS Strategic Information Unit is responsible for implementing the Integrated Behavioural and Biological Surveys, with technical assistance, to monitor the most important impact and outcome indicators. The unit is responsible for collecting, analysing and reporting on key output indicators: service statistics. CHAS collaborates closely with the HMIS department in the Ministry of Health and other relevant sectors.

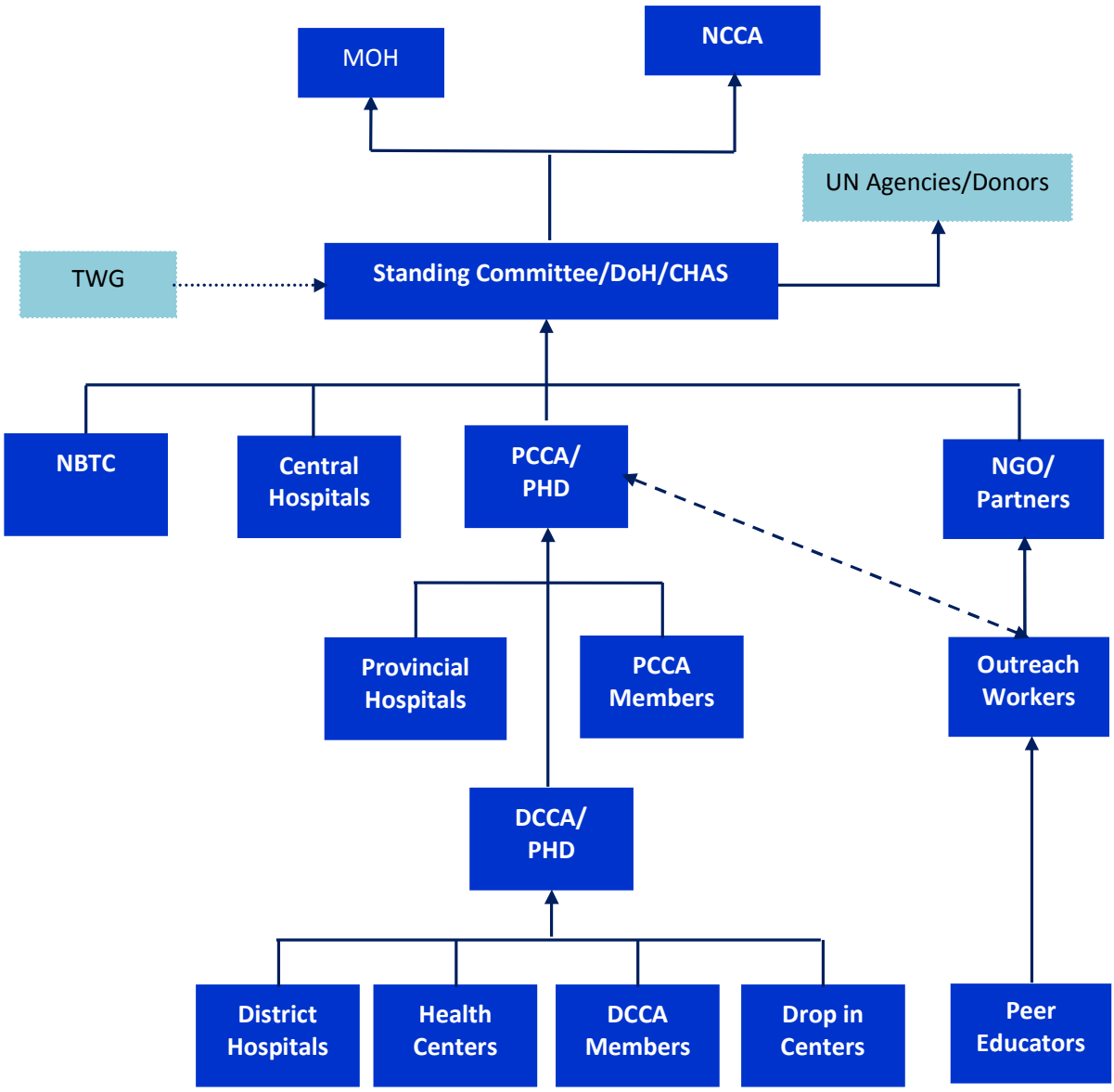
Development partners will support specific studies for some of the national core indicators, including the UN system and bilateral donors. These studies include UNGASS reporting, national AIDS spending assessment (NASA), AIDS questionnaire for the Lao Social Indicator Survey (LSIS)[22], health facility and school surveys.

CHAS will organise annual joint reviews of the national response to inform annual work planning. Special joint reviews are planned for 2013 (mid-term review) and 2015 (end-of-project review) to inform the next NSAP.

[22] UNFPA and UNICEF will jointly support the 2010/2011 LSIS as a nationally representative survey on demographic and reproductive health issues, combining the Lao Reproductive Health Survey, and Multiple Indicator Cluster Survey (MICS), both last conducted in 2005.

Annexes

Annex 1: Reporting Structure for the National AIDS Programme



Annex 2: National Core Indicators

Indicators	Data source	Baseline	Reporting schedule
Input indicators			
Domestic and international AIDS spending	National AIDS Spending Assessment	US$ 5,9 m (2009) Source: UGASS Report 2009	2 yearly
Impact indicators			
HIV prevalence among general population (Estimated adult prevalence)	CHAS	0.2%	5 yearly
Percentage of sex workers who are HIV infected.	IBBS	1,2% [23]	2 yearly
Percentage MSM who are HIV infected.	IBBS	2.8%[24]	2 yearly
Percentage DU who are HIV infected	RAR 2010	1.5% [25]	2 yearly
Percentage adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy.	ART MIS	Adults: 95% Children: 100% (2009)	Annually
Percentage infants born to HIV-infected mothers who are infected	ART MIS	15% (2009)	Annually
Outcome indicators			
Percentage sex workers who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.	IBBS	49% (2008)	2 yearly
Percentage sex workers who consistently use condom with their client the past 3 months.	IBBS	70% (2008)	2 yearly
Percentage MSM who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.	IBBS	38%[6]	2 yearly
Percentage MSM reporting the use of a condom the last time they had anal sex with a male partner	IBBS	45%[6]	2 yearly
Percentage drug users who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.	IBBS	NA	2 yearly
Percentage drug users who reported the use of a condom at last sexual intercourse	IBBS	9.5%, [26]	2 yearly
Percentage injecting drug users who reported using sterile injecting equipment the last time they injected	IBBS	NA	2 yearly
Percentage young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.	LSIS	NA	5 yearly
Percentage of young women and men who have sexual intercourse before the age of 15	LSIS	NA	5 yearly

[23] Means between 2 rounds of IBBS conducted in 2004 and 2008
[24] Means between 2 surveys among MSM groups conducted in Vientiane Capital 2007 and Luangprabang 2009
[25] Percentage of HIV infected among DU, RAR survey conducted in 2 northern provinces, 2010
[26] survey conducted in 2 northern provinces, 2010

Indicators	Data source	Baseline	Reporting schedule
Percentage adults (15-49) who have had sexual intercourse with more than one partner in the last 12 months	LSIS	NA	5 yearly
Percentage adults (15-49) who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse	LSIS	NA	5 yearly
Output indicators prevention			
Number of sex workers reached by prevention programmes.	CHAS M&E report	6,598 (2009)	Quarterly
Number of MSM reached by prevention programmes	CHAS M&E report	1,362 (2009)	Quarterly
Number of drug users reached by prevention programmes	CHAS M&E report	1,030	Quarterly
Number of migrant/mobile populations exposed to outreach programmes	CHAS M&E report	R4Q17: 35,041	Quarterly
Number of condoms distributed for free in both private and public sector	CHAS M&E report	5.3 Millions	Quarterly
Percentage HIV+ pregnant women who receive antiretroviral medicines to reduce the risk of mother-to-child transmission in the last year	ART clinic report	14% (2009)	Annually
Percentage schools that provided life skills-based HIV education within the last academic year.	School survey (UNICEF)	74%	Annually
Output indicators care and treatment			
Percentage adults and children with advanced HIV infection receiving antiretroviral therapy	ART clinic reports	92% (2009)	Annually
Percentage estimated HIV/TB cases that received treatment for TB and HIV	NTBC report	NA	Annually
Percentage orphans and vulnerable children whose households received free basic external support in caring for the child.	CHAS M&E report	NA	Annually

Annex 3: Summary Intervention Packages for Prevention

Interventions	Means of delivery	Expected output
Essential interventions		
Enabling environment	• Reaching out to local decision-makers, law and other personnel, and communities to strengthen and support community-based interventions • Mobilize local support and cooperation in local communities regarding HIV/AIDS interventions	• Supportive and understanding local environment
Awareness	• IEC • Mass media • Non-traditional media shows, theatre, sport events, campaign, etc. • Pre-departure package (migrants) • Mass orientation sessions (lectures)	• Correct knowledge
Condoms	• Condom provision: through outreach, DIC • Social marketing including non-traditional outlets (mamasans, bars, drink shops, guest houses, etc.) • 100% condom use promotion	• Condoms are accessible and affordable
Comprehensive intervention (Essential interventions + below interventions)		
Behaviour change communication	The mode of delivery of BCI varies according to the type of population - the more marginalised, the more limited mass education and group education becomes. To compensate for this, the frequency of peer education increases. • Peer Education; • Outreach with peer-education; • Drop-in centres with outreach activity	• Increase knowledge and awareness • Promote safe sexual and occupational behaviour as “group norm” or “value” • Reinforce the messages through peer-examples, frequent face-to-face intervention, IEC material • Reference to other services
Harm reduction	• Tailored interventions where IDU exist based on harm reduction principle,	• Increase numbers of IDU reach HR interventions • IDU report safe use of injecting equipment • IDU report consistent condom use
STI services	• Mainstream clinics (referral) • Tailored STI services • Self-run clinics, Private sector	• Easily accessible, affordable, friendly, confidential and non-stigmatising STI treatment
VCT	• Mainstream centres • Tailored services, i.e. DIC	• Non-discriminatory, confidential access to VCT

Annex 4: Framework of the National Strategy and Action Plan on HIV/AIDS/STI, 2011-2015

Goal: 1. Maintain the present low level of HIV prevalence in the general population (15-49) below 1%

2. Ensure HIV seroprevalence among most-at-risk population is lower than 5%.

Objectives: 1. Scale up the national response in order to minimize the impact of HIV/AIDS on the social and economic development in the Lao PDR

2. Improve the quality of life of people infected and affected by HIV

Increase coverage and quality of HIV prevention services
1. Sex workers
2. MSM
3. Drug users/IDU
4. Men with multiple concurrent Partners (clients)
5. STI services
6. Condom programming
7. PMTCT
8. Blood safety
9. General population

Increase coverage and quality of HIV treatment, care and support services
1. VCT
2. ARV and OI management
3. Home and community based care
4. Positive health

Improve national programme management
1. Policy, legal reform and advocacy
2. Strategic information
3. Strengthening health systems and community involvement
4. Coordination of a multisectoral and decentralized response
5. Resource mobilization and financial management

Annex 5A: Summary Estimated Costs for National Action Plan on HIV/AIDS/STI, 2011-2015

No	Activity set/Activities	2011	2012	2013	2014	2015	Total	%
1	**Increase coverage and quality of HIV prevention services**	**4,314,712**	**5,206,864**	**6,074,230**	**6,960,212**	**7,943,913**	**30,499,931**	56.25%
1.1	Sex workers	972,300	1,069,500	1,171,200	1,274,150	1,303,900	5,791,050	10.68%
1.2	Men who have sex with men	507,600	783,450	983,950	1,193,400	1,504,800	4,973,200	9.17%
1.3	Drug users/Injecting drug users	343,600	515,400	708,000	911,500	1,160,400	3,638,900	6.71%
1.4	Men with multiple sex partners (clients)	304,650	417,840	536,750	660,960	790,160	2,710,360	5.00%
1.5	STI services	145,287	199,224	255,855	315,027	376,478	1,291,871	2.38%
1.6	Condom programming	480,000	480,000	480,000	480,000	480,000	2,400,000	4.43%
1.7	PMTCT	306,000	416,500	544,000	688,500	850,000	2,805,000	5.17%
1.8	Blood safety	702,000	756,000	810,000	837,000	864,000	3,969,000	7.32%
1.9	General population	553,275	568,950	584,475	599,675	614,175	2,920,550	5.39%
2	**Increase coverage and quality of HIV treatment, care and support services**	**1,899,002**	**2,422,560**	**3,053,766**	**3,801,418**	**4,665,736**	**15,842,482**	29.22%
2.1	Voluntary counseling & testing (VCT)	425,000	467,500	514,250	565,675	622,243	2,594,668	4.78%
2.2	ARV and OI management	1,171,350	1,547,550	2,000,700	2,535,075	3,159,225	10,413,900	19.20%
2.3	Community based care and support	218,652	309,510	426,816	574,668	758,268	2,287,914	4.22%
2.4	Positive health	84,000	98,000	112,000	126,000	126,000	546,000	1.01%
3	**Improve national programme Management to support service delivery**	**1,171,371**	**1,562,942**	**1,462,800**	**1,626,163**	**2,060,965**	**7,884,241**	14.54%
3.1	Policy, Legal Reform & Advocacy	50,000	50,000	50,000	50,000	50,000	250,000	0.46%
3.2	Strategic Information	280,000	530,000	280,000	280,000	530,000	1,900,000	3.50%
3.3	Strengthening Health system & Community involvement	621,371	762,942	912,800	1,076,163	1,260,965	4,634,241	8.55%
3.4	Coordination	200,000	200,000	200,000	200,000	200,000	1,000,000	1.84%
3.5	Resource mobilisation & financial management	20,000	20,000	20,000	20,000	20,000	100,000	0.18%
	Grand Total	**7,385,085**	**9,192,366**	**10,590,796**	**12,387,793**	**14,670,613**	**54,226,653**	100.00%

Annex 5B: Detail Estimated Costs for National Action Plan on HIV/AIDS/STI, 2011-2015

No	Activity set/ Activities	Coverage				Estimated cost for 5 years		Remarks
		Year	Population size	Coverage Rate	Value	Unit cost USD	Total cost USD	
1	**Increase coverage and quality of HIV prevention services**						**30,499,931**	
1.1	**Sex workers**						**5,791,050**	
	Comprehensive intervention	2011	13,890	70%	9,723	100	972,300	High and low frequency sex workers targeted
	. Peer education	2012	14,260	75%	10,695	100	1,069,500	Unit cost as per costing guideline for HIV/AIDS intervention strategy (UNAIDS-ADB, 2004)
	. Condoms	2013	14,640	80%	11,712	100	1,171,200	
	. STI management/VCT	2014	14,990	85%	12,742	100	1,274,150	
	. Enabling environment	2015	15,340	85%	13,039	100	1,303,900	
1.2	**Men who have sex with men**						**4,973,200**	
	Comprehensive intervention	2011	16,920	30%	5,076	100	507,600	Only high risk MSM/TG targeted
	. Peer education	2012	17,410	45%	7,835	100	783,450	Unit cost as per costing guideline for HIV/AIDS intervention strategy (UNAIDS-ADB, 2004)
	. Condoms	2013	17,890	55%	9,840	100	983,950	
	. STI management/VCT	2014	18,360	65%	11,934	100	1,193,400	
	. Enabling environment	2015	18,810	80%	15,048	100	1,504,800	
1.3	**Drug users/Injecting drug users**						**3,638,900**	
	Comprehensive intervention	2011	17,180	20%	3,436	100	343,600	Targets include drug users and injecting drug users
	. Peer education	2012	17,700	30%	5,154	100	515,400	Unit cost as per costing guideline for HIV/AIDS intervention strategy (UNAIDS-ADB, 2004)
	. Condoms	2013	18,230	40%	7,080	100	708,000	
	. STI management/VCT	2014	18,770	50%	9,115	100	911,500	
	. Enabling environment	2015	19,340	60%	11,604	100	1,160,400	
	. Harm reduction for IDU							
1.4	**Men with multiple sex partners (clients)**						**2,710,360**	
	Essential intervention	2011	101,550	30%	30,465	10	304,650	Targets include civil servants, uniformed men, migrants, transport workers, business men, others
	. Outreach and IEC	2012	104,460	40%	41,784	10	417,840	
	. Condoms	2013	107,350	50%	53,675	10	536,750	
	. STI/VCT referral	2014	110,160	60%	66,096	10	660,960	
		2015	112,880	70%	79,016	10	790,160	

No	Activity set/ Activities	Coverage				Estimated cost for 5 years		Remarks
		Year	Population size	Coverage Rate	Value	Unit cost USD	Total cost USD	
1.5	**STI services**						**1,291,871**	
	Strengthening STI services	2011	32,286	30%	9,686	15	145,287	STI services for MARP included in 1.1, 1.2, 1.3
	. Training	2012	33,204	40%	13,282	15	199,224	Estimate 10% prevalence of target clients and general pop
	. Drug procurement	2013	34,114	50%	17,057	15	255,855	
	. Equipment	2014	35,003	60%	21,002	15	315,027	Unit cost based on GF country proposals
	. STI management	2015	35,855	70%	25,099	15	376,478	
1.6	**Condom programming**						**2,400,000**	
	Social marketing	2011			6,000,000	0.08	480,000	Condoms for MARP included
	Free distribution	2012			6,000,000	0.08	480,000	Condoms MCH not included
		2013			6,000,000	0.08	480,000	Unit cost includes condom and lubricants
		2014			6,000,000	0.08	480,000	
		2015			6,000,000	0.08	480,000	
1.7	**PMTCT**						**2,805,000**	
	Providing PICT in ANC clinics	2011	60,000	30%	18,000	17	306,000	ANC attendants (25% of total estimated
	Referral ART Prophylaxis mother/child	2012	70,000	35%	24,500	17	416,500	pregnant women and increase 5% per year)
		2013	80,000	40%	32,000	17	544,000	ART cost under care
		2014	90,000	45%	40,500	17	688,500	Unit cost as per costing guideline for HIV/AIDS
		2015	100,000	50%	50,000	17	850,000	intervention strategy (UNAIDS-ADB, 2004)
1.8	**Blood safety**						**3,969,000**	
	Safe blood supply	2011			26,000	27	702,000	Target as blood units
	· Screening of blood and its products	2012			28,000	27	756,000	
	. Promote voluntary donation	2013			30,000	27	810,000	
	· Quality assurance & control	2014			31,000	27	837,000	
	. Training	2015			32,000	27	864,000	
1.9	**General population**						**2,920,550**	
	Mass media campaigns	2011	221,310	50%	110,655	5	553,275	Targeted people who may engage in casual sex
	Life skills education in schools	2012	227,580	50%	113,790	5	568,950	School programme integrated in MoE
	Condom promotion	2013	233,790	50%	116,895	5	584,475	MARY/MARA included under MARP
		2014	239,870	50%	119,935	5	599,675	
		2015	245,670	50%	122,835	5	614,175	

No	Activity set/ Activities	Coverage				Estimated cost for 5 years		Remarks
		Year	Population size	Coverage Rate	Value	Unit cost USD	Total cost USD	
2	**Scaling up treatment, care and support**						**15,842,482**	
2.1	**Voluntary counseling & testing (VCT)**						**2,594,668**	
	Strengthening and expanding VCT	2011			25,000	17	425,000	Targets as number of people tested per year
	incl. HIV/TB co-infection testing	2012			27,500	17	467,500	Increase 10% per year
		2013			30,250	17	514,250	Unit cost as per costing guideline for HIV/AIDS intervention strategy (UNAIDS-ADB, 2004)
		2014			33,275	17	565,675	
		2015			36,603	17	622,243	
2.2	**ARV and OI management**						**10,413,900**	
	Providing ARV and OI treatment	2011	2,740	95%	2,603	450	1,171,350	Unit cost as per costing guideline for HIV/AIDS intervention strategy (UNAIDS-ADB, 2004)
	Monitoring	2012	3,620	95%	3,439	450	1,547,550	
	Nutritional support	2013	4,680	95%	4,446	450	2,000,700	
		2014	5,930	95%	5,634	450	2,535,075	
		2015	7,390	95%	7,021	450	3,159,225	
2.3	**Home and community based care**						**2,287,914**	
	Community mobilization	2011	2,603	70%	1,822	120	218,652	Based on implementation of GF country proposals
	Home based Care activities	2012	3,439	75%	2,579	120	309,510	
	Social support to PLHIV	2013	4,446	80%	3,557	120	426,816	
	Involvement of religious leaders	2014	5,634	85%	4,789	120	574,668	
	Monitoring	2015	7,021	90%	6,319	120	758,268	
2.4	**Positive health**						**546,000**	
	National PLHIV network	2011			12	7,000	84,000	Unit cost (includes overhead for national network)
	Provincial chapters	2012			14	7,000	98,000	
		2013			16	7,000	112,000	
		2014			18	7,000	126,000	
		2015			18	7,000	126,000	
3	**Programme Management**						**7,884,241**	
3.1	**Policy, Legal Reform & Advocacy**						**250,000**	
	Sectoral policy development	2011					50,000	
	Training law makers, law enforcers, etc	2012					50,000	
		2013					50,000	
		2014					50,000	
		2015					50,000	

No	Activity set/ Activities	Years	Coverage			Estimated cost for 5 years		Remarks
			Population size	Coverage Rate	Value	Unit cost USD	Total cost USD	
3.2	**Strategic Information**						**1,900,000**	
	Second generation surveillance	2011		200,000	80,000		280,000	Cost based on implementation of current NSAP
	Programme M&E	2012		200,000	80,000	250,000	530,000	. US$ 200, 000 for programme M&E
	AIDS research agenda development	2013		200,000	80,000		280,000	. US$ 80,000 for research
		2014		200,000	80,000		280,000	. IBBS rounds 2012 & 2015 * US$ 250,000
		2015		200,000	80,000	250,000	530,000	
3.3	**Strengthening Health system and Community involvement**						**4,634,241**	
	Capacity building and QA	2011					621,371	Calculated as 10% of annual programme activity costs
	Develop guidelines, SOP, etc	2012					762,942	
	Technical & organisational support	2013					912,800	
	Sectoral supervision	2014					1,076,163	
	Community involvement	2015					1,260,965	
3.4	**Coordination**						**1,000,000**	
	Coordination	2011					200,000	Total cost estimates based on budget 2010
	Develop sectoral strategies and plans	2012					200,000	. US$ 150, 000 for national coordination systems
	Advocacy for HIV integration	2013					200,000	. US$ 50, 000 for sectoral/decentralised planning
	International & national AIDS Forum/conferences and meetings	2014					200,000	
	Annual and mid term review	2015					200,000	
3.5	**Resource mobilisation & financial management**						**100,000**	
	Proposal development	2011					20,000	Most costs included in coordination
	Resource mobilisation meetings	2012					20,000	
		2013					20,000	
		2014					20,000	
		2015					20,000	
	Grand Total						**54,226,653**	

Annex 6A: Priority districts per province

No	Provinces	Priority Areas	
		Comprehensive Interventions	Essential Interventions
1	Vientiane C.	7	2
		Chanthabuly, Sikhottabong, Xaysetha, Sisattanak, Naxaithong, Xaithany, Hadxaifong	Sangthong, Mayparkngum
2	Phongsaly	3	4
		Phongsaly, May, Boon neua, Khua, Boon tai	Samphanh, Nhot ou
3	Luangnamtha	3	2
		Namtha, Sing, Viengphoukha	Long, Nalae
4	Oudomxay	4	3
		Xay, Namor, Hoon, Pakbeng	La, Nga, Beng
5	Bokeo	2	3
		Houixai, Tongpheung	Meung, Pha oudom, Paktha
6	Luangprabang	6	6
		Luangprabang, Xieng ngeun, Nan, Phoukhoune, Nambak Ngoi	Pak ou, Pakxeng, Phonxay, Chomphet, Viengkham Phonthong
7	Houphan	3	5
		Xamneua, Viengxay, Xiengkhor	Viengthong, Huameuang, Xamtay, Sopbao, Add
8	Xayabury	8	3
		Xayabury, Hongsa, Ngeun, Xienghone, Phiang, Paklai, Kenethao, Botene	Khop, Thongmyxay, Xaysathane
9	Xiengkhuang	2	6
		Pek, Kham	Nonghed, Khoune, Phaxay, Morkmay, Phookood, Thathom
10	Vientiane P.	9	4
		Phonhong, Thoulakhom, Keo Oudom, Kasy, Vangvieng, Feuang, Xanakham, Vienkham, Hom	Hinherb, Mad, Lonsan, Xaysomboon
11	Borikhamxay	7	
		Paksane, Thaphabath, Pakkading, Bolikhanh, Khamkeuth, Viengthong, Xaychamphone	
12	Khammuane	9	
		Thakhek, Mahaxay, Nongbok, Hinboon, Nhommalath, Bualapha, Nakai, Xebangfay, Xaybuathong	

No	Provinces	Priority Areas	
		Comprehensive Interventions	Essential Interventions
13	**Savannakhet**	**9**	**6**
		Kaysone, Outhoomphone, Sepone, Songkhone, Champhone, Phine, Atsaphone, Xaybuly, Phalanxay	Atsaphangthong, Nong, Thapangthong, Xonbuly, Vilabuly, Xayphouthong
14	**Saravane**	**6**	**2**
		Saravane, Ta oi, Lakhonepheng, Vapy, Khongxedone, Lao ngam	Toomlarn, Samuoi
15	**Sekong**	**3**	**1**
		Lamam, Dakcheung, Thateng	Kaleum
16	**Champasack**	**10**	
		Pakse, Sanasomboon, Bachiang chaleunsook, Pakxong, Pathoomphone, Phonthong, Champasack, Sukhuma, Moonlapamok, Khong	
17	**Attapeu**	**3**	**2**
		Xaysetha, Sanxay, Phouvong	Samakkhixay, Sanamxay
Total		94	49

Annex 6B: Vulnerability per district and province

Province/ District	Priority Criteria Selection					
	Urbanization	Entertainment Sites	Main transport routes	Big infrastructure projects	Highly mobile populations	Vulnerability score (C#E)
Vientiane C.	7	8	9	5	9	7#2
Chanthabuly	X	X	X	X	X	5
Sikhottabong	X	X	X	X	X	5
Xaysetha	X	X	X	X	X	5
Sisattanak	X	X	X	X	X	5
Naxaithong	X	X	X		X	4
Xaithany	X	X	X		X	4
Hadxaifong	X	X	X	X	X	5
Sangthong			X		X	2
Mayparkngum		X	X		X	3
Phongsaly	2	5	7	2	7	3#4
Phongsaly	X	X	X		X	4
May		X	X	X	X	4
Khua		X	X		X	3
Samphanh			X		X	2
Boon neua	X	X	X	X	X	5
Nhot ou			X		X	2
Boontai		X	X		X	3
Luangnamtha	2	4	5	4	5	3#2
Namtha	X	X	X	X	X	5
Sing	X	X	X	X	X	5
Long		X	X		X	3
Viengphoukha		X	X	X	X	4
Nalae			X	X	X	3
Oudomxay	4	6	7	4	7	4#3
Xay	X	X	X	X	X	5
La		X	X		X	3
Namor	X	X	X	X	X	5
Nga			X		X	2
Beng		X	X		X	3
Hoon	X	X	X	X	X	5
Pakbeng	X	X	X	X	X	5
Bokeo	2	3	5	2	5	2#3
Houixai	X	X	X	X	X	5
Tongpheung	X	X	X	X	X	5
Meung		X	X		X	3
Pha oudom			X		X	2
Paktha			X		X	2
Luangprabang	6	5	12	5	12	6#6
Luangprabang	X	X	X	X	X	5
Xieng ngeun	X	X	X	X	X	5
Nan	X		X	X	X	4
Pak ou			X		X	2
Nambak	X	X	X		X	4
Ngoi	X		X	X	X	4
Pakxeng			X		X	2

Province/ District	Priority Criteria Selection					
	Urbanization	Entertainment Sites	Main transport routes	Big infrastructure projects	Highly mobile populations	Vulnerability score (C#E)
Phonxay			X		X	2
Chomphet			X		X	2
Viengkham			X		X	2
Phoukhoune	X	X	X	X	X	5
Phonthong		X	X		X	3
Houphan	2	5	7	2	7	3#5
Xamneua	X	X	X	X	X	5
Xiengkhor	X	X	X		X	4
Viengthong			X		X	2
Viengxay	X	X	X	X	X	5
Huameuang			X		X	2
Xamtay			X		X	2
Sopbao		X	X		X	3
Add		X	X		X	3
Xayabury	7	10	11	9	11	8#3
Xaybury	X	X	X	X	X	5
Khop		X	X		X	3
Hongsa	X	X	X	X	X	5
Ngeun	X	X	X	X	X	5
Xienghone	X	X	X	X	X	5
Phiang		X	X	X	X	4
Paklai	X	X	X	X	X	5
Kenethao	X	X	X	X	X	5
Botene	X	X	X	X	X	5
Thongmyxay		X	X		X	3
Xaysathane			X	X	X	3
Xiengkhuang	2	2	7	2	7	2#6
Pek	X	X	X	X	X	5
Kham	X	X	X	X	X	5
Nonghed			X		X	2
Khoune			X		X	2
Morkmay			X		X	2
Phookood			X		X	2
Phaxay			X		X	2
Thathom					X	1
Vientiane	9	12	13	6	13	9#4
Phonhong	X	X	X	X	X	5
Thoulakhom	X	X	X		X	4
Keo Oudom	X	X	X		X	4
Kasy	X	X	X		X	4
Vangvieng	X	X	X	X	X	5
Feuang	X	X	X	X	X	5
Xanakham	X	X	X		X	4
Mad		X	X		X	3
Vienkham	X	X	X	X	X	5
Hinherb		X	X		X	3
Hom	X	X	X	X	X	5
Lonsan			X		X	2
Xaysomboon		X	X	X	X	4

Province/ District	Priority Criteria Selection					
	Urbanization	Entertainment Sites	Main transport routes	Big infrastructure projects	Highly mobile populations	Vulnerability score (C#E)
Borikhamxay	5	7	7	7	7	7
Paksane	X	X	X	X	X	5
Thaphabath	X	X	X	X	X	5
Pakkading	X	X	X	X	X	5
Bolikhanh	X	X	X	X	X	5
Khamkeuth	X	X	X	X	X	4
Viengthong		X	X	X	X	4
Xaychamphone		X	X	X	X	4
Khammuane	5	9	9	8	9	9
Thakhek	X	X	X	X	X	5
Mahaxay	X	X	X	X	X	5
Nongbok	X	X	X	X	X	5
Hinboon		X	X	X	X	4
Nhommalath	X	X	X	X	X	5
Bualapha		X	X	X	X	4
Nakai		X	X	X	X	4
Xebangfay	X	X	X		X	4
Xaybuathong		X	X	X	X	4
Savannakhet	9	9	15	1	15	9#6
Kaysone	X	X	X	X	X	5
Outhoomphone	X	X	X		X	4
Atsaphangthong	X	X	X		X	4
Phine	X	X	X		X	4
Sepone	X	X	X		X	4
Nong			X		X	2
Thapangthong			X		X	2
Songkhone	X	X	X		X	4
Champhone	X	X	X		X	4
Xonbuly			X		X	2
Xaybuly	X	X	X		X	4
Vilabuly			X		X	2
Atsaphone			X		X	2
Xayphouthong			X		X	2
Phalanxay	X	X	X		X	4
Saravane	5	6	7	5	8	6#2
Saravane	X	X	X	X	X	5
Ta oi		X	X	X	X	4
Toomlarn			X		X	2
Lakhonepheng	X	X	X		X	4
Vapy	X	X	X		X	4
Khongxedone	X	X	X	X	X	5
Lao ngam	X	X	X	X	X	5
Samuoi				X	X	2
Sekong	2	3	4	3	3	3#1
Lamam	X	X	X	X	X	5
Kaleum			X			1
Dakcheung		X	X	X	X	4
Thateng	X	X	X	X	X	5

Province/ District	Priority Criteria Selection					
	Urbanization	Entertainment Sites	Main transport routes	Big infrastructure projects	Highly mobile populations	Vulnerability score (C#E)
Champasack	7	9	10	10	10	10
Pakse	X	X	X	X	X	5
Sanasomboon		X	X	X	X	4
Bachiang chaleunsook	X	X	X	X	X	5
Pakxong	X	X	X	X	X	5
Pathoomphone	X	X	X	X	X	5
Phonthong	X	X	X	X	X	5
Champasack	X	X	X	X	X	5
Sukhuma		X	X	X	X	4
Moonlapamok		X	X	X	X	4
Khong	X		X	X	X	4
Attapeu	3	4	5	2	5	3#2
Xaysetha	X	X	X	X	X	5
Samakkhixay		X	X		X	3
Sanamxay			X		X	2
Sanxay	X	X	X		X	4
Phouvong	X	X	X	X	X	5
Total	79	107	140	77	140	94#49

Annex 6C: Current interventions per district and province

Province/ District	Target Prevention for MARPs														VCT Sites		
	Sex Workers						MSM					DU			Provincial level	District level	Health Center
	PCCA/ DCCA	FHI	PSI	NCA	PEDA	Other	PCCA/ DCCA	PSI	LYAP	BI	Other	PCCA/ DCCA	LCDC	Other			
Vientiane C.	9	9	5				9	9		8					7	9	
Chanthabuly	X	X	X				X	X		X						1	
Sikhottabong	X	X	X				X	X		X						1	
Xaysetha	X	X	X				X	X		X						1	
Sisattanak	X	X	X				X	X		X						1	
Naxaithong	X	X					X			X						1	
Xaithany	X	X	X				X			X						1	
Hadxaifong	X	X					X	X								1	
Sangthong	X	X					X			X						1	
Mayparkngum	X	X					X			X						1	
Phongsaly												3	3		4	2	
Phongsaly																	
May												X	X				
Khua												X	X			1	
Samphanh																	
Boon neua																1	
Nhot ou												X	X				
Boontai																	
Luangnamtha	4			4											1	5	
Namtha	X			X												1	
Sing	X			X												1	
Long	X			X												1	
Viengphoukha	X			X												1	
Nalae																1	

Province/ District	Target Prevention for MARPs														VCT Sites		
	Sex Workers						MSM					DU			Provincial level	District level	Health Center
	PCCA/ DCCA	FHI	PSI	NCA	PEDA	Other	PCCA/ DCCA	PSI	LYAP	BI	Other	PCCA/ DCCA	LCDC	Other			
Oudomxay	7		7					3							1		
Xay	X		X					X									
La	X		X														
Namor	X		X														
Nga	X		X														
Beng	X		X														
Hoon	X		X					X									
Pakbeng	X		X					X									
Bokeo	2			2											3	3	
Houixai	X			X													
Tongpheung	X			X												1	
Meung																	
Pha oudom																1	
Paktha																1	
Luangprabang	10	2	9					1							3	3	
Luangprabang	X	X	X					X									
Xieng ngeun																	
Nan	X		X													1	
Pak ou	X		X														
Nambak	X		X													1	
Ngoi	X		X													1	
Pakxeng	X	X															
Phonxay	X		X														
Chomphet	X		X														
Viengkham	X		X														
Phoukhoune	X		X														
Phonthong																	
Houphan	6		6									5	5		1	3	
Xamneua	X		X														

Province/ District	Target Prevention for MARPs														VCT Sites		
	Sex Workers						MSM					DU			Provincial level	District level	Health Center
	PCCA/ DCCA	FHI	PSI	NCA	PEDA	Other	PCCA/ DCCA	PSI	LYAP	BI	Other	PCCA/ DCCA	LCDC	Other			
Xiengkhor	X		X									X	X				
Viengthong																1	
Viengxay	X		X									X	X				
Huameuang	X		X													1	
Xamtay	X		X									X	X			1	
Sopbao	X		X									X	X				
Add												X	X				
Xayabury	6		6			4	4			4					3	4	
Xaybury	X		X			BI	X			X							
Khop																1	
Hongsa	X		X			BI	X			X							
Ngeun																	
Xienghone	X		X														
Phiang	X		X			BI	X			X						1	
Paklai	X		X													1	
Kenethao	X		X			BI	X			X						1	
Botene																	
Thongmyxay																	
Xaysathane																	
Xiengkhuang	2				2		4			4					2	2	
Pek	X				X		X			X							
Kham	X				X		X			X						1	
Nonghed																	
Khoune							X			X						1	
Morkmay																	
Phookood							X			X							
Phaxay																	
Thathom																	

Province/ District	Target Prevention for MARPs														VCT Sites		
	Sex Workers						MSM					DU			Provincial level	District level	Health Center
	PCCA/ DCCA	FHI	PSI	NCA	PEDA	Other	PCCA/ DCCA	PSI	LYAP	BI	Other	PCCA/ DCCA	LCDC	Other			
Vientiane	7		5		2	3	4		4						1	6	
Phonhong	X		X			BI	X		X							1	
Thoulakhom	X				X		X		X							1	
Keo Oudom	X		X				X		X								
Kasy																	
Vangvieng	X				X		X		X							1	
Feuang	X		X			BI										1	
Xanakham																1	
Mad																	
Vienkham	X		X														
Hinherb	X		X			BI											
Hom																1	
Lonsan																	
Xaysomboon																	
Borikhamxay	3				3		4			4					3	3	
Paksane	X				X		X			X							
Thaphabath							X			X						1	
Pakkading	X				X		X			X							
Bolikhanh																1	
Khamkeuth	X				X		X			X						1	
Viengthong																	
Xaychamphone																	
Khammuane	6		5		2		3		3						1	3	
Thakhek	X		X		X		X		X								
Mahaxay																	
Nongbok	X		X				X		X							1	
Hinboon	X				X		X		X								
Nhommalath																1	
Bualapha	X		X														

Province/ District	Target Prevention for MARPs														VCT Sites		
	Sex Workers						MSM					DU			Provincial level	District level	Health Center
	PCCA/ DCCA	FHI	PSI	NCA	PEDA	Other	PCCA/ DCCA	PSI	LYAP	BI	Other	PCCA/ DCCA	LCDC	Other			
Nakai																	
Xebangfay	X		X													1	
Xaybuathong	X		X														
Savannakhet	9	1	8				4	4							6	15	30
Kaysone	X	X					X	X									2
Outhoomphone	X		X				X	X								2	2
Atsaphangthong	X		X													1	2
Phine	X		X													1	2
Sepone	X		X													1	2
Nong																1	2
Thapangthong																1	2
Songkhone	X		X				X	X								1	2
Champhone	X		X				X	X								1	2
Xonbuly																1	2
Xaybuly	X		X													1	2
Vilabuly																1	2
Atsaphone																1	2
Xayphouthong																1	2
Phalanxay	X		X													1	2
Saravane	5		5				3		3						4	5	
Saravane	X		X				X		X								
Ta oi																1	
Toomlarn																	
Lakhonepheng	X															1	
Vapy	X								X							1	
Khongxedone	X						X		X							1	
Lao ngam	X						X		X							1	
Samuoi																	

Province/ District	Target Prevention for MARPs														VCT Sites		
	Sex Workers						MSM					DU			Provincial level	District level	Health Center
	PCCA/ DCCA	FHI	PSI	NCA	PEDA	Other	PCCA/ DCCA	PSI	LYAP	BI	Other	PCCA/ DCCA	LCDC	Other			
Sekong	2			2											2	1	
Lamam	X			X													
Kaleum																	
Dakcheung																	
Thateng	X			X												1	
Champasack	7	2	5			1	6		6						8	9	
Pakse	X	X				BI	X		X								
Sanasomboon	X		X				X		X							1	
Bachiang chaleunsook	X		X				X		X							1	
Pakxong	X		X				X		X							1	
Pathoomphone	X		X													1	
Phonthong	X	X					X		X							1	
Champasack	X		X				X		X							1	
Sukhuma																1	
Moonlapamok																1	
Khong																1	
Attapeu	2			2											3	4	
Xaysetha	X			X												1	
Samakkhixay	X			X													
Sanamxay																1	
Sanxay																1	
Phouvong																1	
Total															53	77	30

Annex 7: NSAP Targets and Achievements, 2006-2009

Activities	2006			2007			2008			2009			2010		
	T	A	%	T	A	%	T	A	%	T	A	%	T	A	%
1. SW & Clients															
- SW (registered)	5,000	5,945	119	7,000	6,570	94	9,000	4,061	45	11,000	6,598	60	12,000	NA	
- Clients	50,000	20,270	41	70,000	35,470	51	75,000	41,368	55	80,000	NA		85,000	NA	
2. MSM (registered)	500	70	14	1,000	271	27	1,700	2,041	120	2,000	1,362	66	2,300	NA	
3. DU	500	2,146	429	800	2,071	259	1,000	610	61	1,000	1,030	103	1,000	NA	
4. Mobile groups	70,000	10,834	15	90,000	21,245	24	110,000	30,165	27	130,000	3,212	2	150,000	NA	
5. Uniformed personnel	20,000	6,647	33	25,000	9,978	40	30,000	11,145	37	35,000	NA		40,000	NA	
6. Youth															
- Number of school	150	764	509	250	788	315	300	822	274	400	778	194	500	NA	
- Students reached										NA	294,000		NA	NA	
- Out of school	150,000	32,005	21	200,000	83,475	42	250,000	164,554	66	300,000	188,184	63	350,000	NA	
7. Ethnic Groups	46,800	24,449	52	49,000	40,527	83	51,400	38,788	76	53,900	NA		56,500	NA	
8. PMTCT															
- Counselled	5,000	NA		6,000	NA		7,000	NA		8,000	3,094	39	9,000	NA	
- PMTCT			15			14			12			14		NA	
9. Blood safety															
- Safe blood sites	10	8	80	12	12	100	14	12	86	16	17	106	18	NA	
- Units screened				NA	31,279		NA	18,333		NA	19,277		NA	NA	
10. VCT															
- Sites	45	34	76	55	37	86	60	91	152	65	110	169	70	NA	
- Tests	NA	19,324		NA	21,696		NA	28,878		NA	37,900		NA		
11. STI service sites	NA	32		NA	164		NA	164	78	NA	211		NA		
12. Condoms	7 m	8.16m	117	8 m	7.78m	97	8 m	4.23m	53	8m	5.27m	66	8 m		
13. Mass campaigns											2,500				
14. Treatment/care															
- ART	400	470	118	500	813	163	1,700[27]	894	53	2,000	1,345	67	2300	NA	
- Care and support	500			600	360	60	700	420	60	800	1,400	175	1,000		
- ARV sites	1	1	100%				2	2	100	3	5+2	167			

[27] Revised targets was done in 2008

Annex 8:

HIV and Health System Strengthening (HSS)

The number of people reached by the HIV activities in the near future will increase; in particular the number of patients who would require access to specialized medical care including OI and ARV. In response to this, the new HIV/AIDS strategy is ambitious in its objectives. And in order to adequately and sustainably achieve the objectives of the strategy a strong link between the HIV/AIDS programme and the health system needs to be fostered.

Health Systems Bottlenecks and Synergistic Interventions related to HIV/AIDS in Lao PDR were previously analyzed by the representatives of the Lao PDR MOH in a workshop organized by WHO in Philippines in November 2009.

Following the WHO six building blocks framework, we have identified the following bottlenecks and priority actions for HIV:

	Weakness	Priority action
Leadership and governance	- Un-sustainable incentive system up to grassroots level;	- Apply the National incentive scheme when available;
Medical products & technology	- Fragmented logistics and supply/distribution systems; - Separate laboratories.	- Continue the integration of drug chain management with malaria, TB and HIV; - Integrate HIV laboratory activities.
Information	- No HIV data in the National HIMS	- Integrate disease specific HMIS data in annual report
Health workforce	- Limited staff capacity, in particular at provincial level	- Integrate HIV training in nursing and medical schools; - Strengthen in-job training including management.
Financing	- Lack of health insurance protection for HIV patients; - No clear list of free services	- Include HIV/AIDS as part of the benefit package of the different health insurance schemes; - Free minimum package for HIV patients.
Service delivery	- Un-safe workplace; - Poor quality assurance system	- Implementation of standard precautions; - Implementation of quality assurance guidelines;

Our analysis of the health system's bottlenecks to the achievement of the HIV/AIDS targets suggested that the main weaknesses lie on three key areas: 1)the incentive system; 2) the procurement, supply and distribution system and 3) the human resource capacity. The existing incentive system is *ad hoc* and based on projects with a disease specific focus leading to potential distortions at service delivery level. As for the procurement, supply and distribution system it is based on the requirements of specific projects, and mostly carried out by the

national programme in parallel to the national system for other diseases/conditions. As scaling up of the HIV/AIDS programme will increase substantially over the next 5 years, health workforce requirement to support this scaling-up is much of a concern.

Unless these health system bottlenecks are properly addressed, the objectives of the HIV/AIDS programme will not be able to be reached. A therefore greater effort towards strengthening the health system by addressing the root causes of its weaknesses and not only responding to its constraints through a disease specific and fragmented approach is urgently needed.