**Response to GF Comments and Feedback on Lao PDR HIV “Applicant Response Form” submitted on 25 August 2017**

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What processes will be used to ensure that this shift happens in a seamless and timely manner?*   **Response:**   * There has been a series of provincial planning development workshops and meetings of HIV programmes which include two regional planning at the end of 2016, one workshop planning conducted for the line ministries in late 2016, and the remaining planning workshops for each province is scheduled by the end of 2017 to be funded by MOH. All these planning workshops and meetings include developing its own budget and possible sources through local fundraising and advocacy activities.  1. *No specific timelines have been included for this to take place*   **Response:**   * Need clear transition plan to convince national and local government. This may take time, as we need to have the complete provincial plan and national transition plan and advocacy brief for fundraising campaign. This would be done at central and local levels. The NCCA, PCCA, DCCA, line ministries and mass organizations are responsible to conduct fundraising campaigns and activities under their geographical areas. The budget should fill the gaps of external support and not fully rely on central or external assistance.  1. *There are many suggested/planned fundraising approaches but these do not seem to be coordinated and feeding into one central point.*   **Response:**   * A good transition plan which includes a planning team for fund raising activities at central and local levels. This includes for line ministries, mass organizations and the private sector.   ***GF: GF will support the country to facilitate a transition readiness assessment to inform country discussions in order for Lao PDR to decide its national transition strategy (to take place in Q2 2018)***   1. *It was the intention of the TRP to derive sufficient certainty about future Government commitments – to allow the budgets to accommodate PAAR activities.  This does not seem to be yet there.*   **Response:**   * There has been initiatives to allow the budgets to accommodate PAAR activities to include the following: * HSS: Mapping, studies- the co-financing for ARV will help moving IBBS from PAAR to Allocation Budget, other studies under negotiation with potential partners (French 5%) or by co-funding for study on prisoners (2019-2020). * The amount for government co-financing for ARV drugs in 2019 and 2020 is US$ 244,055. With this contribution, it would be able to bring the budget for IBBS for FSW and MSM under PAAR to “Allocation Budget” in 2020. This translates into government’s treatment, care and support to ARV in 2019 (10%) and 2020 (15%).   Comment from GF on 18 August:  It will be important that data on population size estimated/mapping and behaviours result from the various studies  Response: Agree and we will consolidate data on population size estimated/mapping and behaviours  How representative of the KPs will this be? This IBBS will cover which regions? / and only FSW/MSM? This is an opportunity to include other KPS.  Response: The 2017 IBBS that will be conducted in Q4 2017 would be the 7th round conducted only for FSW and MSM. However, for the planned round 8 2020 IBBS for FSW and MSM, we could incorporate questions related to drug use. For prisoners, it should be a separate study in collaboration with TB center. IBBS for FSW will cover 6 representative provinces namely ( northern :LNT, BK, LPB) , (Central: VTC and SVK ) and (southern: CPS, and for MSM 4 provinces : LPB, VTC, SVK and CPS. The IBBS for PWID will be conducted in 2018 with support from French 5% if approved. It was earlier conducted in two northern provinces : Phongsaly and Houaphanh in 2010. However, we need to identify the provinces in consultancy with the TA (French 5%) on potential provinces/areas for next PWID IBBS.  **Issue 2: Lack of accurate program data**   1. *We flag that it is the strong intention of the TRP that epi data is derived as soon as possible in 2018 – given the requested actions were raised some years ago (last request).  So we ask whether some of the timelines can be advanced.*   **Response:**   * The IBBS will be completed and paid for prior to 31 December 2017. It is understood that based on the Global Fund’s new allocation process (described earlier) services must be completed prior to grant end date in order to utilize funds under the grant. * All the implementations of IBBS/Mapping (Female sex workers and Men who have sex with men) will be completed before the end of this year, 2017. The funding will be properly utilized within the grant timeline and will be included in the expenditure report as of 31 Dec 2017. * CHAS would like to clarify that the preliminary results and findings of IBBS/Mapping will be finalized by late Dec 2017 and the key study results will be reported in 2017 PUDR. * The final draft report of IBBS/Mapping would be completed in Q1 2018.   Please see the Annex, Timeline for IBBS study 2017 for detailed information.  Comments on 18 Aug 2017: Presumably services will only be paid on completion. If this is being completed in Q1 2018 – it will not be able to use 2016-17 grant funds.  Response: Data collection and field work will be completed by end 2017 and cost paid. For the report we will request the consultant to submit the preliminary report also by end of 2017 so we could disburse the TA fee before the end 0f 2017. We may request the GF to acknowledge the timeline limitations on the final report.  ***GF: The Issue that the TRP/GF raises is in relation to all other data studies for KPs (PWID, prisoners, migrants, mobile populations). The response above and Applicant response incorrectly addresses MSM/FSW***  2.      *There is no detail/response on how individual-based monitoring for KP interventions is going to be developed/strengthened and assured.*    **Response:**   * Please see the above   ***GF: The Issue that the TRP GF raises is in relation to all other data studies for KPs PWID, prisoners, migrants, mobile populations)***  **Please see below additional responses to question 1 issue 2**  *Bio-behavioral rapid assessment (including mapping) for People who inject drugs (supported by French 5%): Can this be brought forward? Planning could start now in the remaining months of 2017; with assessment to*  **Response:**  CHAS discussed with French 5% and requested to conduct this study earlier (expected to be conducted from Q1 2018 to mid- 2018) however, this dependent on the duration of TA selection process, budget approval and availability of TA.  *Migration, mobility and HIV/STI vulnerabilities: an interdisciplinary and community based participatory research (supported by French 5%): Was this already commenced in February?*  **Response:**  That study has been initiated in March 2017 and estimated to be completed in Oct 2017. The draft report of findings, interpretation and analysis is expected to be finalized in Dec 2017.  ***GF: Please advise what the TORs are – we would need to understand what sets of data will result***  *Study on prisoners in collaboration with TB Center (2019-2020) with the support of Government of Lao PDR: The TRP wishes the data to be available prior to the next grant. The current proposed timelines will only deliver data during the next grant.**As prisoners are a defined population and easily accessed, we request that this is advanced into 2018*  **Response:**  Previously, CHAS put this activity budget under the PAAR of GF grant in 2018 as there were other priority interventions under the allocation grant.  Further, CHAS will submit the Government funding request in early 2018 for the study on prisoners. It is expected that the approval will be in October 2018 for implementation in 2019.  CHAS fully agrees with the comment of TRP and CHAS will include this activity budget (study on Prisoners) in the Government funding request of the Year 2019 and it is expected to be conducted in early 2019. On the other hand, CHAS will seek the additional funding support of French 5% to conduct this study earlier.  ***GF - Kindly note that the NTC plans to undertake screening for TB of Prisoners during this coming grant – why cannot CHAS undertake the study at the same time for incremental costs?***  ***we would need to understand what sets of data will result from the proposed study***  *Cannot this information (Mapping data from IBBS 2017) be available earlier?*  **Response:**  CHAS would like to confirm that the preliminary mapping data from IBBS 2017 would be available in Q1 2018 as this will be conducted before the AEM HIV estimation exercise.  ***GF – Please refer to my comments in the Response form If this is being completed and paid for in 2017 using current grant funds – why will the report only be available in 2018? Payment should be made on completion of the service.***  Before mapping data from IBBS 2017 are available  *We understood that it is unlikely for the HIV program to be reporting through DHIS2 even by the end of 2017 – and mid- 2018 is more realistic.*  **Response:**  CHAS fully agrees with the comment of TRP that mid-2018 would be more realistic timeline for the DHIS2 integrated reporting.  *We suggest that the transition of DHIS2 reporting starts earlier – from start of 2019.*    **Response:**  Starting from Q4 2017, with the support of US CDC and WHO, HIV CAM data reporting will be integrated to the DHIS2. However, it needs times to monitor and review the progress and functioning of this integrated DHIS2 reporting at the implementation level. This will be undertaken the whole year 2018 then, fully integrated DHIS2 reporting will be carried out in 2019.  ***GF – We can envisage that funding next allocation will decrease. It will therefore be unlikely that there are sufficient funds to continue a dedicated DHIS2 TA. It is more advisable for this process to be managed when there are greater staff/technical resources. We recommend that full integration takes place through out 2018 and CHAS commence using DHIS2 from the start of January 2019***  **The following are additional responses to question 2 issue 2**  *There is no detail/response on how individual-based monitoring for KP interventions is going to be developed/strengthened and assured.*  **Response :**  With the technical support of US CDC, WHO, FHI360, UNAIDS and other UN agencies, CHAS will improve the robust unique identifier coding system for both HTC and treatment centers to enhance the linkage between HIV testing and Care & ART treatment services. Through MERS and HIVCAM databases, CHAS will strengthen the tracking system of individual- based data monitoring for KP interventions to improve the continuum of prevention, care and treatment services.  In addition, CHAS central M&E team will conduct regular teleconferences and mentoring field visits to monitor progress and find out operational bottlenecks of individual-based data monitoring and tracking system, and will provide the required technical assistance to improve the skills and capacity of field staff.  Both MERS and HIV CAM systems will be streamlined in DHIS2 in 2019 and it will make easier for all HIV implementing partners to perform the individual-based monitoring for KP interventions.  ***Comment on 18 Aug 2017: GF This is unclear as MERS and HIVCAM were to be streamlined for incorporation into DHIS2 by end 2017. We request that you map out exactly the plan detailing steps/milestones and timelines to achieve this by January 2019.***  ***Response:*** Discussion has been made with TA from USCDC Bangkok on the streamlining plan, which will need to be in phases with the expectation that there is a lead time for implementation when the DHIS2 system will be stable. We expect that the full integration of MERS and HIVCAM into DHIS2 will be completed in early 2019.  **Issue 3:** Insufficient detail about strategies to address HIV care cascade gaps and insufficiently ambitious cascade targets  3.      *The response to this issue is largely a replication of the funding request submission. It is a challenge to deduce what additional information is shared to articulate the proposed activities for identifying the PLHIV and retaining them in care for immune suppression*  **Response:**   * It is well noted.   4*.      The gaps to the 90-90-90 targets have been clearly identified as 2800, 4600 and 4700 respectively. What has not been done is the identification of where these numbers lie within the KP groups as this would then influence the prioritised activities to bring them into care and retain them.*  **Response as of 18 Aug 2017 :**  The numbers are high because it is a projected number using AEM modelling and the formula to calculate this is recommended by UNAIDS for the GARP report that you have to use the total number estimated PLHIV for all three 90 which may not be quite logical.  The planned mapping of KP may help determine the size of KP. We will consult with EWC and USCDC who will assist in the estimation exercise at the end of 2017 on the matter.  ***GF Please note this remains insufficiently addressed and cannot be submitted to the TRP for their review in this current form.***  ***The response would benefit from detail about how the identified gaps link back to the different gaps in each target KP category and therefore how specific strategies will be laid to reach these pockets of KPs to achieve the 90-90-90 targets.***  ***We currently have the details of the proposed approaches but they don’t link back to the intended impact. We for instance don’t know how each model proposed will achieve specific targets.***  **Response as of 25 Aug 2017 :**  To support the achievement of the 90-90-90, the following strategies are being implemented or can be improved:  *We have well described in the narrative document and Applicant Response Form on individual-based tracking and monitoring as follows:*   * *Reach KP by peers (EPM),* Increase HTC uptake among KPs by providing a package of quality and standard of services, starting in accessing the facilities for HTC, by accompanying the peer to the HTC sites where pre and post-test counselling are conducted and rapid HIV test is done initially, following testing algorithm approved by WHO. When positive results are confirmed, the peer tested will be accompanied by a team member of EPM to be brought to the ART site for provision of ART. * *Referral to HTC if positive then referral to ART sites, w*hen positive results are confirmed, the peer tested will be accompanied by a team member of EPM to be brought to the ART site for provision of ART.      * *Follow-up through continuum of care , community visit and mobile phone, EPM team member and or self-help-groups will closely monitor the new PLHIV to adhere to ART regimen.* * *CBS, ART sites, peer PLHIV will track and monitor the new PLHIV to get necessary laboratory examination including the viral load according to the scheduled testing period.* * *Currently the PEPFAR Project is on the way of conducting HTC review followed by the development of Standard Operating Procedures for HTC sites to provide a package standard and quality of services, which will improve access to HTC thereby improving the HIV prevention and treatment cascades. The SOP for treatment, care and support will be developed in the early 2018, as a result of the of assessment of the ART treatment services conducted by WHO TA in the beginning of 2017.* * Further, CHAS together with MCHC, will provide the HTC services to the pregnant women and their partners. * Regarding the Second 90 and Third 90: The technical support of CDC WHO, CHAS will improve the individual-based monitoring system by unique identification coding system to monitor to improve the linkage of ARV treatment services to the HIV positive people including KP and PMTCT and other HIV infected patients. All these monitoring and treatment adherence services will be assisted by the peer counsellors and peers from the NGOs and CSOs.   5. *As explained above, the critical element of individual-based tracking and monitoring is not detailed and is critical for patient care and support as well as evidence of impact.*  ***GF Please note this remains insufficiently addressed and cannot be submitted to the TRP for their review in this current form.***  ***What we specifically mean in addition to the programmatic description is the data collection and monitoring system that ensures and guarantees reliable “individual and not episodes of contacts” information. This has been a major challenge with the program even during funding request writing and submission.***  ***The availability and implementation of standard stakeholders agreed data collection tools***  ***A shared understanding of unit of measure/when an individual is counted as reached by a service by all implementers and managers at all levels***  ***Processes and methods of avoiding and eliminating duplication in the context of the moving population either within localities or across boarders in high***  ***The handling and processing the data including cleaning and data quality assurance processes for all core people reached indicators***  ***Information use and sharing***  ***Results assessment and impact measurement building on and collating quality assured programmatic data with the overall need per KP group. This is why the estimates and the remaining identified gap under the 90-90-90 targets is important and needs to be defined in terms of where the individual are (population groups) and how they will be reached, tested and linked and kept in care until immunosuppression***  With the technical support of US CDC, CHAS applied the Unique Identification Coding (UIC) system for the KPs (MSM/TG and FSW) in 2 pilot sites (VTC and VTP) in 2015. Since mid-2016,  in order to avoid the data duplication , all HIV implementers including CSOs/NGOs/PCCAs/DCCAs are agreed to follow the Unique Identification Coding (UIC)   to monitor the KPs (MSM/TG and FSW) reached by HIV prevention services.  In term of data collection and reporting, the new client of KPs (MSM/TG and FSW) who receive the full prevention package of services (health education on HIV,STI & BCC, condom distribution, referral for STI diagnosis and treatment and HIV Testing and counselling) is counted and reported as once a year during the annual period of implementation.  In addition, if the client of KP referred by CSOs/NGOs is accepted for the HIV testing, it is recognized and monitored by the HTC coding.  Since Q2 2017, at the end of each month, DCCAs/PCCAs and Peers of CSOs/NGOs at each implementing project site of KP is conducting the joint data review monthly meeting to ensure the data quality and data assurance of KP reached and tested & known their HIV result and it is counter checked by the UIC and HTC coding and log book.   At the end of each quarter, CHAS central M&E team and CSOs/NGOs (central level) with assistance from PR M&E TA and WHO staff is undertaking the M&E review meeting to monitor and evaluate the reported data of KP reached and HIV tested. This regular review and M&E coordination meeting is facilitated by CHAS since April 2017 with the aims to avoid the data duplication and under reporting issues of programmatic reporting and to monitor the results attained and to assess the progress of quarterly implementation.  All data reported for the PUDR are cross-checked and verified by LFA for data quality assurance.  *6. While some figures have been proposed in the different annexes as targets, it is challenging to see how these are linked and feed into the identified gaps above.*  **Response:**   * Please let us know which are challenging parts, so we can fix and explain further.   ***GF See above***  7.      *Further related to the above, the specific targets to be reached under the different implementation models: Enhanced Peer Mobilizer Model and the expanded Condom Use program need to be seen to link back into the overall need and national targets with clear highlight of limitations and risks for the programme.*  Agreed and well noted. Clarifications are given in the revised “ Applicant Response Form”.  **Issue: 4 Address needs of key and vulnerable populations**  8.      The proposed actions will be further reviewed and contextualised once data is derived as per timelines.   However we note that there are inconsistencies within the document regarding the timelines to obtain the data.  **Response:**   * *The timeline has been revised to be consistent.*   **Planned activities (immediate and intermediate) and opportunities**   |  |  |  |  |  | | --- | --- | --- | --- | --- | |  | Target population | Study type | Timeline | Supported by | | 1 | Female sex workers | Mapping and IBBS | *Q4 2017 – Q1 2018* | The Global Fund and TA US CDC | | 2 | Men who have sex with men | IBBS | *Q4 2017 – Q1 2018* | The Global Fund and TA US CDC | | 3 | People who inject drugs | Bio-behavioral rapid assessment  (including mapping) | *Q1 2018 – mid 2018* | French 5% Initiative | | 4 | Mobile and migrant populations | Migration, mobility and HIV/STI vulnerabilities: an interdisciplinary and community based participatory research | *March2017 to Dec 2017* | French 5% Initiative | | 5 | Prisoners | Study on prisoners in collaboration with TB Center | *2019* | Government of Lao PDR |     Comment on 18 August: Kindly note that the NTC plans to undertake screening for TB of Prisoners during this coming grant – why cannot CHAS undertake the study at the same time for incremental costs?  Response: We included the HIV study on prisoners (not screening) during this coming grant under PAAR (US$ 49,000). Discussion is still 0ngoing on submission on proposal for funding support from French 5% that may allow the study in 2018. The last option is by the Lao PDR government co-funding, which may be possible only in 2019 at the earliest.  ***Please see below tables on additional information on key populations proposed interventions and plan***  Table 1: Standard package of services for key populations sites   |  |  |  |  |  | | --- | --- | --- | --- | --- | | Agencies | Key populations | Provinces | Type of funding | | | Allocation | PAAR | | LaoPHA | MSM & TG | VTP, KM | Yes | No | | LaoPHA | MSM &TG | XYB, LPB | No | Yes | | PEDA | FSW | KM, SVK, CPS | Yes | No | | PEDA | FSW | BLX | No | Yes | | PSI | FSW | VTP, VTC | Yes | No | | PSI | FSW | BK, LPB | For condom programming only | No |   Table 2: Sites with only condom programming interventions   |  |  |  |  |  | | --- | --- | --- | --- | --- | | Agencies | Key populations | Provinces | Type of funding | | | Allocation | PAAR | | PSI | FSW | BK, LPB | No | Yes |   Table 3: Drop-in Centers for FSW sites   |  |  |  |  |  | | --- | --- | --- | --- | --- | | Agencies | Key populations | Provinces | Type of funding | | | Allocation | PAAR | | PEDA | FSW | BLX, KM, SVK, CPS | No | Yes | | PSI | FSW | BK, LPB,VTP, TVC | No | Yes | | |