**Applicant Response Form – For Grant Making**

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| **SECTION 1: Overview** |
| **Applicant Information** |

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| **Country** | |  | | --- | | Lao (Peoples Democratic Republic) | | **Currency** | USD |
| **Applicant type** | CCM | **Component(s)** | HIV |
| **Envisioned grant(s) start date** | 1 January 2018 | **Envisioned grant(s) end date** | 31 December 2020 |
| **Principal Recipient 1** | Ministry of Health | **Principal Recipient 2** | N/A |

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| **SECTION 2: Issues to be addressed during grant-making and/or grant implementation** | |
| **Issue 1: Limited Government commitment to financing of the HIV program** | **Cleared by:** Secretariat |
| **TRP Input and Requested Actions**  **Issue:** Increasing domestic financing for HIV has been challenging, given the low burden of HIV, the low overall proportion of total government expenditure on health, and prevailing stigma towards the disease and legal/policy barriers to access services given the nature of its transmission in key affected populations. The program requires sustained advocacy and sensitization efforts that have not always been possible in a resource constrained setting.  The Global Fund is the largest donor of the national HIV and AIDS response to date. There is limited current or future support identified from other donors and the current government’s contribution is primarily through salaries for health workers, infrastructure, workshops and maintenance of health facilities and other running costs.  While Lao PDR is foreseen to transition out of Global Fund support to fully sustain the HIV response with its own resources, it is very unlikely this will be possible for some time to come. There is a need to address a road map for transition preparedness during the current funding request program period.  **Action:** The applicant is requested to officially inform the Global Fund how it will increase its domestic financing, beyond the current government contribution, that will support the longer-term implementation and sustainability of the national HIV program.  Secondly, the applicant is requested to work closely with the Global Fund, and local and international partners to develop a gradual and realistic transition plan, identifying key milestones, and resource and technical assistance requirements, to prepare for a full transition from Global Fund support. In terms of milestones, the TRP suggests that a sizeable percentage (e.g. between 30-50%) of key ARV supply be covered by the government by the end of the grant, and that government contribution also include funding for prevention among key populations.  The transition plan will form the cornerstone of the country's request for the next allocation period and thus will have to be developed during the proposed grant implementation period, prior to the next Global Fund call for funding requests  **Timeline: During grant making** and no later than 12 months into grant implementation | |
| *Please provide an executive summary on the actions taken:*  **Country Response**  **Action 1: The applicant is requested to officially inform the Global Fund how it will increase its domestic financing, beyond the current government contribution, that will support the longer-term implementation and sustainability of the national HIV program**  The Government of the Lao PDR has established strong leadership, implementation and oversight mechanisms for its national HIV response which works to engage a diverse range of stakeholders.  As shown in the Concept Note, Government figures show in-kind contributions from Government sources of:   * US$1,847,083.00 in 2015 * US$2,054,526 US$ in 2016, and * US$2,122,097 US$ in 2017   For the Global Fund new grant period of 2018-2020, the Lao government has committed to contribute the amount of US$ 6,366,291.00 (in-kind) and US$ 1,482,942.00 (cash) during the three year period. This represents a total Government cash and in-kind contribution of US$7,849,233.00, representing approximately 107% of the GF grant allocation for the 2018-2020 timeframe. See attached table on government funding.  CHAS and the PR note, however, that despite this significant and increased government co-financing, the combined support from Government, the Global Fund and other donor partners is still not enough to meet the estimated costs of fully implementing the national response as laid out in the NSAP 2016-2020 implementation plan and budget. CHAS regularly consults its partners and donors on budget and financial matters, and in the most recent discussions conducted on 2 August 2017, the following action strategies were agree to explore options to increase and sustain domestic financing for the national HIV response including and in addition to the current and projected government contributions. 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. Below are key activities and planning and resource mobilization process:   * Provide more and continuing technical support to the National Committee for the Control of AIDS (NCCA), Provincial Committees for the Control of AIDS (PCCA), and District Committees for the Control of AIDS (DCCA) to strengthen their skills in advocating for and mobilizing additional (and continuing) local resources at central, provincial, and district levels; * Develop a plan, targets and timeframe for negotiations with line ministries, mass organisations, and the private sector to further mobilize domestic funds beyond the health sector; * Provide technical assistance to all provinces, line ministries, and mass organizations at central and local level to develop their own strategic and action plans on HIV and AIDS which include their own budgets and financing plans; * Develop a strategy and action plan by the end of 2017 to advocate for and mobilize new / additional financial resources from the local private sector and companies, working closely and in partnership with the Ministry of Planning and Investment, the Ministry of Public Works and Transportation, the Ministry of Industry and Commerce, the Ministry of Natural Sciences and Environment, the Ministry of Energy and Mines, using information on infrastructure development projects and workers as the entry point for such discussions; * Develop a joint policy with related ministries on financial contribution of construction companies for HIV interventions in collaboration with ADB and targeting ADB-funded infrastructure and development initiatives by the end of 2017; * Continue and maintain ongoing discussions with key external donors and stakeholders to mobilize additional technical and financial assistance, including with– through 2017 and ongoing: * PEPFAR (USAID, USCDC) , RTI, local societies and companies * UN Agencies, WHO, UNICEF, UNODC, UNFPA, French 5% Initiative * AIDS Care China, AIDS Healthcare Foundation * Private construction companies, local societies, companies, factories * Strengthen the M&E system for CHAS and the national HIV response , working closely with the RSSH component under the Global Fund new grant to collect more accurate and evidence-based information which will help better tailor the national response and financial need– through 2017 and ongoing; * Expand the current work undertaken by CHAS to improve relations and cooperative agreements with the MOH and relevant centers (such as Department of Healthcare, Department of Food and Drugs, MCH Center) to explore existing, new and potential supply systems for pharmaceutical products and commodities that could provide efficiencies and cost-savings– through 2017 and ongoing; * The main intention of this proposed strategy is the shifting on responsibility on ART management from CHAS to Healthcare Department, MOH in collaboration with the new PR, which oversee policy, management, procurement of all drugs for all diseases, including the Global Fund project. This transition may take some time and will start in the transition period of the PR at the end of 2017 and ongoing. * Work with the MOH Bureau for National Health Insurance to develop a policy that would enable PLHIV to have access to HIV treatment, care and support under the UHC and to also include HIV program into MOH Universal Health Coverage (UHC) plan as part of the health sector reform, with the aim to provide good health services effectively delivered to the population through increased social protection which reflects the people’s health risks – through 2017 and ongoing; and * Conduct Advocacy Meetings with NCCA and partners in collaboration with the UNAIDS Country office - before the end of 2017.   ***Action 2: Secondly, the applicant is requested to work closely with the Global Fund, and local and international partners to develop a gradual and realistic transition plan, identifying key milestones, and resource and technical assistance requirements, to prepare for a full transition from Global Fund support. In terms of milestones, the TRP suggests that a sizeable percentage (e.g. between 30-50%) of key ARV supply be covered by the government by the end of the grant, and that government contribution also include funding for prevention among key populations.***   * The Global Fund will provide separate funding for technical support to Lao PDR to facilitate a transition readiness assessment to inform country discussions in order for Lao PDR to decide its national transition strategy (in Q2 2018)CHAS will seek additional funding from other domestic and external sources.. UNAIDS has expressed support to Lao PDR. CHAS will try to complete the relevant data by early 2018 to be used for the transition plan development. * CHAS has undertaken initial consultations with PEPFAR (USCDC and USAID) on possible technical and financial assistance to Lao PDR to develop the country transition plan. The next technical consultation is planned to take place at the end August 2017; * Assistance from other partners such as the French 5% Initiative are currently under discussion; * CHAS and the PR note that there are opportunities to learn from the experiences of other countries which may have already started developing their transition plans, such as Thailand, Malaysia, and Viet Nam and notes that there is are already initiatives such as the AFAO-managed SHIFT programme underway which could be a source of learning / capacity development for the Lao country team which is beginning work on the country transition thinking and plans; * CHAS has begun the process to develop a way forward on transition planning, which includes what main activities would need to be supported (consultations, meetings, workshops), what the technical assistance and financial needs would be, and timeline and responsibility identification; and   CHAS will initiate discussions with Government, with support from UNAIDS, WHO and other locally based partners and the GFATM Portfolio Team. These discussions will be conducted with the involvement of the Ministry of Finance and the Ministry of Planning with Investment through the CCM mechanism.  The amount of US$ 244,055 has already placed for government co-financing for ARV drugs in 2019 and 2020. With this government co-financing , it would be able to bring the budget for IBBS for FSW and MSM under PAAR to “Allocation budget” in 2020.  ***Action 3: The transition plan will form the cornerstone of the country's request for the next allocation period and thus will have to be developed during the proposed grant implementation period, prior to the next Global Fund call for funding requests***  We agree. | |

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| **Issue 2: Lack of accurate program data** | **Cleared by:** Secretariat |
| **TRP Requested Actions**  **Issue:** The applicant acknowledges that current program planning relies heavily on modelling based on few data and many assumptions. There are no accurate size estimates of key populations, while an integrated HIV bio-behavioral survey (IBBS) is said to be underway. The lack of accurate data is compounded by lack of staff with capacities in M&E, and the absence of a proper HMIS.  **Action:** The TRP recommends the applicant starts to collect accurate and comprehensive data about its HIV epidemic. This includes data disaggregated by sex and age, and mapping potential key and vulnerable populations including sex workers, men who have sex with men (MSM), transgender women, people who inject drugs (PWID), prisoners, migrant workers, mobile populations and other potentially vulnerable groups, and include these groups in integrated HIV bio-behavioral surveys (IBBS) and size estimation exercises.  The TRP notes with concern that lack of size estimates and the need of an integrated HIV bio-behavioral surveys (IBBS) have already been flagged in the previous funding request, and therefore the TRP recommends the actions above be given the utmost priority. The TRP further recommends that that the proposed IBBS and other studies under the resilient and sustainable systems for health (RSSH) activities in the prioritized above allocation request(PAAR), in the amount of USD 536,494 be moved to the allocation.  **Timeline:** During grant implementation | |
| *Please provide an executive summary on the actions taken:*  **Country Response**  *•*As the one of the member states of the United Nations, Lao PDR has already committed to 2016 Political Declaration on Ending AIDS: On the Fast-Track to accelerate the fight against HIV and to end the AIDS epidemic by 2030.  •Lao HIV country team and CHAS fully agree with TRP recommendation on the need for robust data that reflects the HIV epidemic, behaviour and response needs of key and vulnerable populations.  •CHAS and country team also recognize the country’s potential on the collection and use of key strategic information that could help prioritization of effective HIV response tailored to the needs of key and vulnerable populations.  **Current situation**  The availability of epidemiological, behavioral and response data: the country has conducted the HIV bio-behavioral surveys starting from 2001 among female sex workers and long distance truck drivers, attempting to fill the strategic information need to the response, followed by a series of behavioral and bio-behavioral surveys among female sex workers in 2004, 2008, 2011 and 2014 respectively. The first bio-behavioral survey among MSM was conducted in 2007 Vientiane Capital followed by the next rounds of survey in 2009 and 2014. The tracking surveys among transgender people were conducted in 2010 and 2012 respectively. An ad-hoc PWID HIV study was carried out in 2 provinces (Phonsaly and Houaphanh) in 2010. Mapping exercise was first time conducted among female sex workers (in Vientiane Capital, Savannakhet, Luang Prabang, Luang Namtha, Champasak and Bokeo provinces) along with IBBS in 2014 and pilot mapping exercise for men who have sex with men was conducted in Vientiane Capital and Vientiane Province with support from USCDC and WHO in 2015.HIV estimation exercise including AEM, EPP-spectrum and AEM-spectrum has been conducted on annual basis since 2012 using data inputs from bio-behavioral surveys and programmatic data to some extent of program planning and response.  The HIV cases reported data from 2013 to 2016 is 679 in 2013, 834 in 2014, 1,096 in 2015 and 1,243 in 2016 based on HIV Registry. The 2014 IBBS revealed that the HIV prevalence was found in key affected population, men who have sex with men (MSM), 1.6% and female sex workers (FSW) 1.4%.The 2017 HIV modeling and estimations showed that estimated new HIV infections has declined from 1,000 in 2010 to 650 in 2016. It is estimated that there were 11,400 people living with HIV and <500 AIDS-related deaths in 2016.  **Challenges, weakness and limitation**   1. Although the series of bio-behavioral surveys were conducted among certain key and vulnerable populations such as FSW and MSM, there has been a major strategic information gap among people who inject drugs, mobile and migrant populations and prisoners; 2. The regularity and consistency of surveys sites and limited coverage of surveyed areas (sometime due to the project based demand from donors – even though NSP 2006-2010 recognized the need of strategic information for MSM) in earlier rounds (for instance, only one site VTC in 2007 and 2009 rounds of surveys among MSM) cause the major weakness in understanding of nation’s HIV epidemic (in terms of patterns, trends and geographical hotspots, etc.) as well as data analysis and use for evidence informed HIV responses; 3. Even though the mapping exercise was done for female sex workers in 2014, the results were not used to come up with provincial and national size estimates for female sex workers. Similarly the limited or no information available on the mapping population size for other key populations such as MSM, PWID and transgender people leave a major gap in programme planning and effective HIV response; 4. Timeliness in comprehensive survey data analysis and report preparation (due to time and human resource limitation) and use of survey data for programme response; 5. Lack or insufficient data analysis and triangulation for preparation of data inputs for HIV estimation exercise; 6. IBBS survey methodology (RDS) that wouldn’t allow to collect/map KP population; and 7. Limited capacity in terms of human resource and staff time and budget limitation are also seen as overarching constraints.   **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 | 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 | March 2017 to Dec 201 7 | French 5% Initiative | | 5. | Prisoners | HIV study on prisoners in collaboration with TB center | PAAR: 2018  French5% : 2018  Gov: : 2019 | The timeline of the implementation depends on funding availability |  1. IBBS among female sex workers and men who have sex with men are planned to conduct in quarter 4 of 2017 with technical support from USCDC and WHO, and the results on HIV serology, behavioral and response needs are expected to come out in 2018; 2. Before mapping data from IBBS 2017 are available, there is an opportunity to use mapping data from IBBS 2014 (FSW) and MSM mapping exercise 2015 as an interim solution for better data inputs for the upcoming AEM HIV estimation exercise (Q1 2018); 3. MSM IBBS 2017 will not do mapping exercise separately but there are specific questions in survey questionnaire that can be used as proxy for population size estimation; and 4. The review and analysis of data available from new bio-behavioral surveys and previous rounds of survey a) to understand the epidemic dynamics, behavioral patterns, trends and geographical hotspots of HIV epidemic among key and vulnerable populations for effective HIV programming and response, and b) to triangulate and use of better data inputs for HIV estimation exercise.   Fully agreed TRP recommendation on the need of robust HMIS and filling the capacity gap of M&E team at national, provincial and district levels.  **Current situation**   1. Availability of programme data through existing HIV reporting system   The HIV case reporting system that was initiated since 1990 has been establishing from hospital/health facility-based case recording to regular and routine data collection from VCT sites in 2005 and to computerized and web-based data collection and monitoring in recent years.  M&E unit was formed in 2012, and the guidelines and tools to support and strengthen the data collection, analysis and assessment of immediate and intermediate results of the response programmes are produced and updated on regular basis.  Currently National HIV and AIDS strategy and action plan 2016-2020, National HIV/AIDS and STI monitoring and evaluation plan 2016-2017, standard recording and reporting format for HIV prevention, treatment, care & support services and M&E supervision checklist have been applied as the guiding tools and standard operating procedures to support and strengthen M&E system.  Since quarter 1 of 2017, data quality review and monitoring are conducted through regular M&E review meeting led by CHAS along with all implementing partners, and quality assessment and supervision visits were initiated.  Technical meetings with CDC Bangkok have been organized regularly to discuss on update, progress and challenges of the HIV care data collection tool, outcome and analysis of data  Regular DHIS2 Implementation Progress Reviews are conducted in collaboration with HMIS team started since late 2016.   |  | | --- | | **Monitoring and evaluation reporting structure of national AIDS programme\*** | |  |   **Blue arrow/line** – hierarchical organizational structure (line of management) from central, provincial to district  **Red arrow/line** – data flow and feedback  \* the data flow will be updated in line with the progress of use DHIS2 and will be added in the next M&E plan 2018-2020  Currently available data tools and software for data collection and reporting in National AIDS Programme   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | *Software* | *Backend platform* | *Currently used for* | *Started* | *Supported by* | | *1* | *HIVCAM*  *(HIV Care and ART Monitoring)* | *MS ACCESS* | *HIV care and monitoring in all ART sites* | *2009* | *First TA by GF until 2012 and continued by TA from US CDC Bangkok, Thailand* | | *2* | *MERS*  *(Monitoring and Evaluation Reporting System)* | *MS ACCESS* | *Prevention services including HIV testing and STI testing, condoms* | *2014 piloted for MSM and 2015 PMTCT in four provinces* | *TA US CDC Bangkok, Thailand* | | *3* | *COMMCARE* | *MS ACCESS* | *HIV testing and HIV care* | *2015 still under piloting* | *FHI360 and USAID* | | *4* | *DHIS2* | *Web-based interactive data platform* | *Aggregated and individual data on HTC and STI*  *TB/HIV screening, TB/HIV co-infection, PMTCT and treatment cases (on process)* | *2017* | *The Global Fund and TA WHO* |   ***Challenges, weakness and limitation***   1. Currently key programme data such as prevention, HIV testing and counseling and treatment and care data are collected using four parallel data collecting tools (mentioned above) and that cause challenges in streamlining and use of data for monitoring and programming of effective and timely HIV response tailored to need of key and vulnerable populations; 2. The major gap in terms of staff time and capacity to adapt computerized and web-based data platforms especially at the district level; 3. Limitation of IT resources including unreliable internet connectivity and limited number of computers for online data reporting at the HIV service provision sites ; 4. Lack of experience and capacity to conduct data analyses to inform and improve programme response and policy decision making; and 5. Currently HIVCAM in 11 treatment sites use identification code (UIC) (12 digits) for tracking the patients enrolled into the treatment centers. However, to address the leakages between HIV testing to care, there is an urgent need for a robust unique identifier system that should be applicable to both HTC and treatment programmes.   ***Planned activities (immediate and intermediate) and opportunities***   1. CHAS recognizes the need of real time integrated data repository that could capture all the routine data from HIV registry, HTC sites, STI programmes, PMTCT centers prevention programmes and cohort data on HIV treatment and care, and see DHIS 2 as an opportunity to streamline the parallel data systems currently implementing along with mainstream HIV response.   DHIS 2 integration roadmap and implementation plan 2017 has been planned and set out with major steps as below:   1. HIV testing and counselling and STI screening data from all HTC and STI sites nationwide captured in DHIS2 (Initiation phase including training for HMIS staff at provinces and districts nationwide completed and regular data collection continued); 2. Integration of results summary data for key HIV treatment indicators to create dashboard (data showcase) on DHIS2; 3. Agreed data set of prevention, treatment and care indicators with the information of disaggregation by age, sex, denominators and numerators to be integrated into DHIS2 – This has been already initiated in Q3 2017 and will be completed by mid-2018. 4. All comprehensive data set imported to DHIS2 (expected to complete by the end of 2017).   After preparation of DHIS2 to capture all programme data including HIV prevention, care and treatment data, there are still options to decide 1) if district/health facility data entry level continue to use HIVCAM as offline collection tool and transfer data to DHIS2 at central level (or) 2) moving away from multiple database system to one data system using DHIS2 at all levels starting from data entry at district/health facility level to management and analysis at provincial and central level and endorse real time data management, analysis and use for timely and effective HIV programming and response. However, the team agrees that we could go ahead with the phasing approach by starting with option 1 first until 2019, and the transition will start in 2020.  Time line and key activities for DHIS 2 implementation plan 2017     1. CHAS recognizes the importance of addressing the leakages in “first 90” in overall achievement 90-90-90 targets, and see the opportunity of using more specific identifier, such as “national ID” as a unique identifier for linking the clients at VCT centers to the treatment centers. The options could be explored in 2018 in collaboration with key partners, such as USCDC; 2. Regular M&E review meeting, DHIS2 implementation progress review and M&E supervision visit for data quality assurance are planned to continue to strengthen the HIV data system at all district, provincial and central levels; and 3. Possibility of contracting full-time M&E international TA at central level to oversee the HIV data system for a certain period of time, and to enhance as well as perform data analysis and synthesis for evidence informed HIV programming and response at national and subnational levels starting probably by mid-2018. Financial support for this TA will be sought from French 5% Initiative. | |
| **Issue 3: Insufficient detail about strategies to address HIV care cascade gaps and insufficiently ambitious cascade targets** | **Cleared by: TRP** |
| **TRP Requested Actions**  **Issue:** The funding request presents a detailed HIV care cascade analysis which showing significant leakages. For example, in 2016 only 65% of estimated people living with HIV (PLHIV) were diagnosed, 62% were on antiretroviral therapy (ART) and of those accessing viral load testing, 87% were virally suppressed. The TRP is concerned that the leakages in the HIV care cascade are not adequately addressed and the proposed targets towards 90-90-90 lack ambition.  **Action:** The TRP requests the applicant to develop a detailed 2-page plan for key populations funded under this grant, on the basis of key activities outlined in the National HIV and AIDS Strategy and Action Plan2016-2020, clearly describing specific interventions to find and diagnose people living with HIV (PLHIV), provide them with antiretroviral therapy (ART) and retain them on antiretroviral therapy (ART) including viral load monitoring. This plan should also explain in detail how the proposed new approaches to HIV testing such as snowball peer  outreach model would be implemented including plans for training and monitoring..  **Timeline: During grant making** | |
| *Please provide an executive summary on the actions taken:*  **Country Response**  The PR and CHAS accept the recommendation of the TRP and would like to submit the following action plan:  **HIV and AIDS Action Plan for Key Populations in Lao PDR**  **Supported by the Global Fund New Funding Cycle (2018-2020)**  **1. Background**  The HIV national response supports the Fast-Tack Initiative which increased the target of HIV coverage of 90-90-90 in the cascade of services to create significant impact in ending the HIV epidemic as a global health threat by 2030. The strategy is to quicken the pace for essential HIV prevention and treatment approaches to limit the epidemic to more manageable levels and enable countries to move towards the elimination phase.  With assistance from UNAIDS RST from Bangkok, CHAS updated in August 2017 the HIV care cascade for Lao PDR. Based on this new calculation, 2016 data shows that only 65% of PLHIV know their status, 41% of the PLHIV who know their status are on treatment (ART) and only 32% of those PLHIV are virally suppressed. According to these data the gap for first 90 is 2,800 PLHIV, for second 90 is 4,600 and for third 90 is 4,700 PLHIV respectively out of the total estimated 11,413 PLHIV in the country. Data also showed that care cascade for male is 60 - 60 – 77 and for female 71- 65 - 79. However, the progress toward UNAIDS 90-90-90 treatment target is now 65-63-78. The biggest challenge is in initiating HCT and starting with ART. This scenario will eventually change as the new treatment protocol on starting ART (Rapid Advise 2016) will make all PLHIV eligible to start with the treatment, and the option B+ which allows all HIV infected women to take lifelong ARV drugs. Reducing lost to follow-up will greatly impact in managing the epidemic. For details see Annex 1.  This plan focuses on key interventions, services and programs for female sex workers, men who have sex with men and transgender women under the support of Global Fund New Funding Cycle (GFNFM) 2018-2020 for Lao PDR. The plan will be expanded later on for other key populations, such as people who inject drugs (PWID), migrant workers and mobile populations, and prisoners in early 2018 once the information will be available from the ongoing or planned research and studies. According to the earlier plan, CHAS will request government funding to conduct a study on prisoners in 2019-2020 as it is too late now to request funding for 2018. However, further to the recent discussion with Embassy of France, it is possible to submit a request for French 5% Initiative financial support. If approved, the study could be conducted earlier in 2018. We also included this study in PAAR for 2018. Whatever source of funding is available earlier in 2018 we will conduct the study earlier. If not we need to wait until 2019 for government funding if approved .  ADD answers on 90-90-90  **2. Goal and Objective**  **Goal:** The goal of the HIV national program is to end the transmission of HIV and alleviate the impact of AIDS in Lao PDR.  **Objective:** To contribute to the effective implementation of services and programs for key populations in order to reach a target of the maximum plausible level of coverage of core interventions outlined in the National HIV and AIDS Strategy and Action Plan 2016-2020 and WHO Consolidated guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations.  **3. Strategies and intervention approaches**  The main strategies and interventions approaches of this plan are to continue and expand targeted interventions to reach key populations, such as those engage in sex work, men who have sex with men, transgender women in order to reduce risk behaviours and increase demand for prevention, sexually transmitted infections, HIV Testing and Counselling Services, treatment care and support by creating linkages between prevention interventions and health services, and ensuring that healthcare facilities are sensitized and becoming welcoming and service-minded towards key populations.  **Strategy 1: Expansion of Prevention Coverage to Increase Access to female sex workers (FSW) and men who have sex with men (MSM) and transgender women (TG) for Continuum of Prevention to Care and Treatment using snow ball peer-led interventions model**   This strategy is an innovative model piloted and implemented already for more than a year by LaoPHA supported by FHI360 and CHAS called “Enhanced Peer Mobilizer Model” or snow ball peer-led intervention. Under this model, the teams of qualified, experienced and well trained Community Based- Supporters (CBS) will identify “Peer Mobilizers” (PM) who are members of high-risk networks in their communities (FSW, MSM/TG ). These PM will reach and refer members of their social and/or sexual networks (FSW, MSM/TG) to the CBS in exchange for a small incentive in kinds. The CBS in turn will provide prevention counseling for all referred FSW or MSM/TG and screen them to be potential new PM to expand the project’s reach into new community and social networks. The CBS will conduct community-based HIV testing using national testing algorithm and approved HIV test kits or work with healthcare providers for HIV testing and refer the clients to confirmatory testing at the provincial ART sites under the PCCA before starting the treatment. The CBS will also serve as “clinic navigators” to help ensure that clients receive timely, appropriate and friendly services at the HIV Testing and Counselling (HTC) and ART sites and follow-up them through the continuum of care services. For details see annex 2.   1. This will be now the only standard comprehensive package of services which will be used by all projects and implementing partners (LaoPHA, PEDA, PSI) in Lao PDR, including the project supported by the Global Fund, USAID through FHI360. Except for LPB and XYB are under PAAR, which will implement only condom programming for FSW. The prevention programs and the active referral programs of treatment, care and support of FSW, MSM and TG communities will be implemented by civil society organizations who actively engage with these key populations. The review and oversight mechanisms also include active participation of key affected people as well as those living with HIV.   **Strategy 2: Provide community-based case management and adherence support services to improve treatment initiation and retention**    The CBS will also work closely with ART sites, including peer counselors who are PLHIV based at all ART sites to follow-up the clients who are HIV tested positive and help them access to ARV treatment services, including facilitating CD4 and viral load (VL) testing, provide treatment literacy education and potentially home-based care services, follow-up clients who become lost to follow-up, and conduct adherence counselling, through mobile phone, home visit, and regular gathering for self- help groups. The peers are assigned to cover a certain number of patients by district. The training of health care providers to alleviate stigma and discrimination of key populations and PLHIV in healthcare settings has been conducted in June 2017 in four ART sites and will be expanded to all ART sites. This would help address the leakages in the HIV care towards 90-90-90 treatment targets in additional to the adoption and implementation of “Treat All” policy, viral load monitoring for all people on treatment , and the expansion of ART sites in all provinces in the country by 2020.  **Strategy 3: Strengthen (behavioural change communication) BCC quality to improve service uptake and retention in care and treatment**   CHAS, UNAIDS, WHO, CDC and FHI360 will assist CSOs to develop a standard operating procedure (SOP) to ensure high-quality and targeted prevention counselling using appropriate messages to encourage consistent use of condoms and lubricants, STI screening and regular HIV counselling and testing. They will also provide additionally training in the motivated interpersonal communications model that uses skills and techniques of motivational interviewing to strengthen client’s motivation for change. Finally, they will work with CSOs/NGO to strengthen their skills and strategic planning around the use network of hidden FSW and MSM and social media network to reach new members of the target populations, disseminate HIV prevention messages and promote access to services.  This is a standard package of services which will be implemented in all provinces supported by the Global Fund for both FSW and MSM/TG. For FSW there are the following provinces for full package of services (Allocation: VTP, VTC, KM, SVK and CPS ) and 3 provinces under PAAR: BK, LPB and BLX. For MSM/TG ( Allocation: VTP and KM, and PAAR: LPB and XYB). However, there are also two provinces namely BK and LPB which will implement condom programming for FSW also under “Allocation”. Please see the main reasons described in the concept note. Condoms and lubricants will be procured under government funding totalling 4.5 million for three years ( 2018, 2019, 2020).    **4. Main activities and implementation areas**  **Prevention program for female sex workers:** Given the severely constrained resources, provinces with higher estimates and better performances were selected for the current funding request. The prevention programme consists of peer-led interventions using snow ball peer-led intervention model, condom distribution, active referrals to HIV and STI testing and counseling as well as referral to antiretroviral therapy (ART), and follow-up on ART adherence and those who become lost to follow up. There will be a dual track strategy for the prevention programme for female sex workers at the provinces. While Vientiane Capital, Vientiane province, Savannakhet, Champasak and Khammouane the full package including peer led outreach (under Allocation) and 8 drop-in centers (PAAR). However, these 8 DIC will be opened only if PAAR is received, but the number of DIC will be reduced with VTC to open only 1 instead of currently 5 existing but add 1 province BLX because of the increase number of FSW and the transit city forf northern and southern province with the link to Thailand and Viet Nam,. The provinces with DIC are as follows under PAAR ( BK, LPB, VTP, VTC, BLX, KM, SVK and CPS) Luang Prabang, the world Heritage City with a lot of tourists and population mobility, and Bokeo, due to its profile of experiencing much cross-border movement being an economic zone , part of the golden triangle, with shared borders with Thailand, China, Myanmar, migration and an existence of casinos, makes it difficult to have an efficient peer outreach model. The condom social marketing will continue to be implemented with the contracted private company, who will manage to distribute and sell to whole sellers and retailers (drug stores and mini-markets) and collect the money Condom promotion, monitoring, recording and reporting system will be managed by the contracted company in close collaboration with CHAS and PR.  The peer-led intervention sees a seismic shift in the model. Based on lessons learnt from other settings, severely constrained resources and the urgent need to reach key populations, an “Enhanced Peer Educator Model” described above under section 3 has been proposed by the civil society partners for 2018-2020. However, they will also perform other duties as described above in strategy 1 and in the section of the concept note..  The first year, all the CSOs and PCCA will undergo one week training on program management, outreach study, Government/Non-Government Organisation (GO/NGO) relationships, supportive supervision and reporting for Global Fund. There will be at least one joint review meeting every year. These will be supported and financed through CHAS/government.   1. While the PCCA provides guidance, supportive supervision, training and reporting, they will manage the local CSOs in implementing the FSW outreach models. The local CSOs will be promoting behaviour change through community mobilisation and peer outreach. At the same time they will also implement the prevention programs and the active referral programs of treatment, care and support of FSW, MSM and TG communities because they are actively engage with these key populations. The review and oversight mechanisms also include active participation of key affected people as well as those living with HIV.   **Comprehensive prevention programs for MSM:** It is estimated that there will be about 51,900 MSM in Lao PDR in 2018 with 15,600 reachable, based on AEM data last updated on March 10, 2017. Mapping will be included as part of the new IBBS planned in 2017 using the respondent driven sampling (RDS) technique as part of the NFM grant. Given the severely constrained resources, only two provinces with higher estimates (Vientiane Province and Khammouane) were selected for the current funding request (2018-2020) whereas the three other provinces namely Vientiane Capital, Savannakhet and Champasak currently covered by FHI360 through USG funding will continue for this period. The prevention programme consists of peer-led interventions, condom distribution, active referrals to HIV and STI testing and counselling as well as referral to antiretroviral therapy (ART) using EPM or snow ball peer-led intervention model described above. They will also perform the same activities as described above for FSW.  The detailed activity tables are in Annex 3,4 and 5.  **5. Implementation arrangements**  **Implementers**  The activities for FSW will be implemented by local CSO and INGO namely Promotion of Education Development Association (PEDA) and Population Service International (PSI) in Vientiane province, Vientiane Capital, Khammouane, Savannakhet and Champasak provinces under allocation and Bokeo, Luang Prabang (under PAAR) while activities for MSM/TG by local CSO Lao Positive Health association ( LaoPHA) will be implemented in Vientiane province and Khammouane (under allocation) and Sayabouly and Luang Prabang provinces (under PAAR) ,with support from CHAS, PCCA and other partners. The standard package of interventions and services is the same for both FSW and MSM and implemented by all CSO and INGOin all provinces supported by the Global Fund except Bokeo and Luang Prabang which will focus on condom programming only..  **Capacity building**  CHAS in collaboration with UNAIDS, WHO, PEPFAR and other partners will provide technical support to CSOs (SR) and INGO to develop necessary guidelines, SOP, manuals and tools to implement an Enhanced Peer Mobilizer (EPM) model or snow ball peer-led intervention model implemented by all provinces and all partners. They will also build capacity for CSOs and NGOs in program management, M&E and training for peer educators and key populations.  **Monitoring and Evaluation system**  CHAS will work with other partners to strengthen M&E system by improving recording and reporting tools for key populations. Training and coordination with CSOs, NGOs, health care providers will be conducted to provide timely and complete data and reports on key populations. This will include introduction of SIMS, Data Quality Assessment, Quality Assessment, and Quality improvement system, which have been supported by PEPFAR (USAID and USCDC) regular field supervision and coaching for local M&E teams will be conducted on regular basis. Training on data analysis and use and size estimation and projection exercise will also be conducted for central and provincial level. | |
| **Issue 4: Address needs of key and vulnerable populations** | **Cleared by: TRP** |
| **TRP Requested Actions**  **Issue:** People who inject drugs (PWID), prisoners, migrant workers and mobile populations are absent from the funding request programming. Prevention programs care and support programs do not provide a tailored approach to each key or vulnerable population. Not adequately addressing/programming the needs of key and vulnerable populations resulted in limited use of Drop In Centers (DICs). Removal from the funding request of DICs for key populations and condoms from the health product list will have negative impact on coverage and quality of the program.  **Action:** Once data from operational research (e.g. IBBS) become available as per Issue 2 (estimated by Q1 2018) about key populations that are not covered by this grant, the TRP recommends to expand the two-page plan (as listed in Issue 3)with activities to reach key populations for whom data are lacking at the time of review. The TRP recommends that these key populations should include people who inject drugs (PWID), prisoners, migrant workers and mobile populations. Based upon epidemiological data, interventions would include tailored prevention, care and support interventions for each of these populations; strengthened, expanded and redesigned drop in centers to address key population needs; and maintaining condoms on the list of the health products and expanding distribution to key and vulnerable populations.  **Timeline:** During grant implementation, within 6 months of completion of the IBBS. | |
| *Please provide an executive summary on the actions taken:*  **Country Response**  TRP Issues Noted:   1. People who inject drugs (PWID), prisoners, migrant workers and mobile populations are absent from the funding request programming; 2. Prevention programs, care and support programs do not provide a tailored approach to each key or vulnerable population;and 3. Proposal does not adequately address or program for the needs of key and vulnerable populations which has resulted in limited use of Drop In Centres (DICs) and the TRP notes that removal from the funding request of DICs for key populations and removal of condoms from the health product list will have negative impact on coverage and quality of the program.   **TRP Suggested Action:**  Once data from operational research (e.g. the IBBS) becomes available as noted in Issue 2 of the TRP Response in reference to key populations that are not covered by the proposed grant (IBBS estimated to be completed with data available by the end of Q1 of 2018), the TRP recommends to expand the two-page plan (requested under TRP comments listed under Issue 3) with activities to reach key populations for whom data are lacking at the time of review. The TRP recommends that these key populations should include people who inject drugs (PWID), prisoners, migrant workers, and mobile populations. Based upon epidemiological data, interventions would include tailored prevention, care and support interventions for each of these populations; strengthened, expanded and redesigned DICs to address key population needs; and maintaining condoms on the list of the health products, and expansion of distribution of condoms to key and vulnerable populations – (timeline: during grant implementation, within six months of completion of the IBBS).   1. **Country Response to TRP Issues and Suggested Actions- PWID and Prisoners:**   **PWID, Addiction, Incarceration, and HIV: The PR and CHAS recognize and accept the comments of the TRP and provide the following additional background information and specific responses to the issues raised**:   1. The overall number of drug users in the Lao PDR has not been estimated using formal methodologies as noted in the TRP comments. However, in 2017 the Southeast Asia HIV addiction Technology and Transfer Center (SEA-HATTCT) in collaboration with the Government of Lao PDR estimates that there are currently about 28,000 opium users and small sample size studies involving school-based youth indicate that lifetime prevalence of drug use ranged from around 17% in the capital, to around 5% in other parts of the country. The same study found that 7% of youth involved in the study in Vientiane had used an illegal drug at least monthly. Use of amphetamine-type stimulants (ATS) is thought to exceed use of opium and other drugs. The health system reports an increase in the number of drug-related mental health hospital admissions in Vientiane during 2016-17, and although there is as yet no specific data, it is thought that this increased evidence of use will result in increases in HIV infections especially as there is growing anecdotal evidence from health facilities in Vientiane that injecting is becoming the most common route of drug administration.   This marks a sharp upward estimation from earlier Government estimates from 2012 that indicated approximately 10,000 opium users, and 44,000 people addicted to ATS drugs. The 2012 study estimated that an additional 55,000 people were at-risk of becoming addicted to opium or ATS drugs.  The Lao *National Drug Control Master Plan for 2016-20* was completed in November 2015 and provides a long-term vision and strategy for combating drug production, trafficking, and use and the associated risks and health implications.   1. Since 2009, harm reduction activities have been implemented by UNODC through the AusAID-funded HAARP Laos Country Program, in partnership with the Lao Commission for Drug Control and Supervision (LCDC), and the Center of HIV/AIDS and STI Control (CHAS) under the Ministry of Health (MOH). Since 2010, the program has focused on Houaphanh and Phongsaly, two provinces bordering Viet Nam. The project supported by the project involves community and peer outreach workers and operates through local health centers and the district hospitals. Unfortunately, the project was close in mid- 2014. The capacity building project supported by ADB continues to implement the activities with smaller scale at the beginning of 2016 also in the above provinces in 5 districts. The main activities include peer-led interventions where the peers work with the village authorities in 13 villages to provide education on harm reduction for PWID and the community, distribution of clean syringes, needles and condoms. to 30 PWID. 2. CHAS understands that it is crucial to improve the country’s understanding of the drug use situation and the behaviours associated with HIV risk, but note that one of the main impediments to producing better PWID population size estimates or undertaking an IBBS is that the country’s official policy is based on the implementation of three strategies: prevention and rehabilitation of drug users; alternative options for crop farmers; and enforcement of punitive laws against drug traffickers. The official policy in the country is geared towards total abstinence and does not provide for use of substitution therapy, needle exchange, or other bio-medical approaches, and favors detoxification, primary education and harsh penalties for drug use. The conditions of individuals in closed settings in general is extremely harsh, and there is a silo-ing of health services for the corrections service from main Government health services. Despite many attempts over many years to gain access to correctional facilities and associated health services by CHAS and other HIV responders, to date limited access has been possible and so the national HIV response is dependent on Government estimates of drug use, drug administration (eg needle use vs smoking), and HIV and health implications. 3. There are or have been six internationally supported initiatives in Lao PDR related to addiction, harm reduction, HIV and health implications, and supply / use issues, including:  * A Rockefeller Foundation health risk study in 2005-2007 amongst ethnic minorities along the Lao-Thai border focused on social and economic consequences of the National Road 3 construction programme; * A UNODC initiative to build drug control capacity focused on establishing national drug control regulations and data collection systems; * A UNODC initiative on reducing opium production and consumption amongst ethnic minorities in highlands communities of Lung Namtha Province border ares in north-western Lao PDR; * A UNODC initiative focused on reduction of opium consumption through alternative development and treatment schemes; * A Lao-American project focused on rural development, drug treatment and law enforcement; and * A UNODC study focused on assessing the extent of ATS use and HIV implications in three provinces Conducted in November 2013- December 2014.   **Actions and Timelines – PWID and Prisoners**   * The PR and CHAS will explore the development of a Memorandum of Understanding (MOU) with the line department responsible for correctional services, addiction and drug-use issues to try to build greater cooperation and data sharing systems, and for joint development of behavioural and size estimation studies by mid- 2018 of the GFATM grant; and for improvement in provision of treatment and related health services in closed settings. These are not new activities which need to be included in the GFATM grant application, but are on-going domestic initiatives; * CHAS is currently negotiating with the French 5% Initiative to secure support for the design and implementation of a study on PWID and HIV risk, and the design and protocol for the study can be shared with the Global Fund following completion of negotiations; * There are already plans underway to undertake a study on prisoners and HIV risk with Government support and funding, although there is as yet no agreement on when or if this can proceed; and * As more and better data is generated from operational research (e.g. IBBSs for FSW and MSM with data available by end of March 2018), the action plan (i.e. the two page plan recommended by the TRP for development under the TRP comments related to Issue 3) will be expanded to include more and better targeted activities to reach key populations for whom data is currently inadequate or lacking. In addition, and prior to securing improved / enhanced data, the national response will continue to work to expand peer-led or Government outreach services designed to reach more key population individuals in more locations through tailored prevention, care, treatment and support interventions. This will be completed within six months of completion of any new operations research.  1. **Country Response to TRP Issues and Suggested Actions- Migrants and Mobile Populations:**   **Migrant and Mobile Populations:**  The PR and CHAS recognize and accept the comments of the TRP and provide the following additional background information and specific responses to the issues raised:   1. Lao PDR is both a source and destination country for migrant workers mainly employed in infrastructure projects, domestic and agricultural work, and the fishing industry. Malaysia and Thailand are the primary destination countries for Lao migrant workers. At the time of the UN study cited, migrants from Lao PDR in Thailand accounted for 12% of the estimated 1,284,920 migrants and dependents registered for the general ID card, and the 849,552 migrants registered for a work permit. These figures did not include the reportedly large numbers of undocumented migrants from Lao PDR in Thailand. Long, porous borders and Thailand’s demand for low-skilled labour make for possible various migration networks for economic opportunities abroad.   Lao PDR is also a destination country for migrant workers, especially from Viet Nam and China. In 2006, 5,731 Vietnamese migrant workers worked in Lao PDR, while in 2008 an estimated 300,000 Chinese workers were in the country as well. The Lao population is vulnerable to trafficking due to high poverty levels and porous borders.  Lao PDR is a source country for trafficked men, women and children to Thailand and a destination country for trafficked Vietnamese, Chinese and Burmese women and girls.  The National Strategic and Action Plan on HIV/AIDS and STIs shows commitment to address HIV and mobility issues with provisions on HIV prevention, testing and counseling for mobile populations and their families.  B Migrant workers and mobile populations have been included in the Technical Framework of Collaboration with Thailand. Referral systems have been developed and implemented since 2015 between hospital networks in Thailand and Lao PDR. This also includes access to HIV prevention and ARVs for Lao migrant workers working in Thailand.   1. The Lao PDR CHAS recognizes that pre-departure HIV information and linguistically and culturally appropriate prevention programmes for prospective migrants need to be expanded, as do comprehensive HIV prevention, care, treatment, VCT and support services for returning migrants. To successfully address HIV and mobility issues, CHAS recognizes that it is important to develop a more comprehensive surveillance system including gender-based data to target HIV interventions among migrant and immigrant groups. 2. There are currently a number of on-going and planned initiatives to address migrant / immigrant issues related to HIV, and to generate better strategic information on mobility and HIV issues (which are not mentioned or included in the GFATM grant application) including:    * An initiative supported by ADB namely “Block Grant” approach, which channels the fund directly to be local implementers has already been implemented since early 2017, including the project to collect data in selected sites of the Attapeu Province Rubber Plantation , which would lead to the development of policies for the comprehensive prevention package for company migrant workers; the development of an advocacy / information programme for workers; the launch of a mobile VCT service; and the completion of an MOU with the company for provision of ARV treatment for PLHIV migrant workers. The provincial key implementer is the Provincial Department of Information, Culture and Tourism.   There are ongoing additional studies on migrant workers conducted by French Red Cross in collaboration with Lao Red Cross with financial support from French 5% Initiative conducted from march 2017 to December 2017. **Actions and Timelines – Migrant and Mobile Populations**   * The PR and CHAS will work with the French 5% Initiative and other partners to continue to improve the country’s knowledge base on HIV-related issues associated with the country’s mobile and migrant / immigrant populations, and to ensure that this information is used to develop more and better outreach and community-based / public-private partnerships around prevention, testing, treatment, care and support service provision where services are most needed; * As more and better data is generated from operational research (see list and timeline in issue 2 response) , the action plan (ie the two page plan recommended by the TRP for development under the TRP comments related to Issue 3) will be expanded to include more and better targeted activities to reach key populations for whom data is currently inadequate or lacking. In addition, and prior to securing improved / enhanced data, the national response will continue to work to expand peer-led or Government outreach services designed to reach more key population individuals in more locations through tailored prevention, care, treatment and support interventions. This will be completed within six months of completion of any new operations research.  1. **Country Response to TRP Issues and Suggested Actions- Drop-in Centres:**   HIV Drop-in Centres: The PR and CHAS recognize and accept the comments of the TRP and provide the following additional background information and specific responses to the issues raised:   1. Jamie Uhrig’s 2016 (Global Fund supported) study on service delivery for peer prevention outreach and HIV testing and counselling for key populations (female sex workers, men who have sex with men, and transgender women), sought to evaluate the extent to which interventions were reaching target recipients with the type and quality of services required to improve the country’s HIV response and made specific recommendations for programme improvement. The study team visited seven peer education programme sites in Vientiane (three sites), Vientiane Province (two sites), and in Khammouane Province (two sites).   The study recommended a number of specific changes to existing programmes and enhancements or changes to peer outreach and drop-in centre structures and processes to improve effectiveness.  CHAS and the PR recognize this important study and recognize the need to expand and improve non-government (or quasi government) services outside of formal health facilities which target various key population communities, and further recognize the importance of working towards changing policies which prevent community-based testing or treatment management in the country.  CHAS and the PR further recognize the prohibitive costs of providing peer-led services, and the difficulties of engaging “peers” for communities of people whose behaviours are criminalized in Lao PDR.  **Actions and Timelines – Drop-In Centres**   * The PR and CHAS will work with partners to continue to improve the country’s knowledge base on HIV-related issues associated with the country’s provision of outreach and mobile services particularly targeting key populations, and to ensure that this information is used to develop more and better outreach and community-based / public-private partnerships around prevention, testing, treatment, care and support service provision where services are most needed; * As more and better data is generated from operational research, the action plan (i.e. the two page plan recommended by the TRP for development under the TRP comments related to Issue 3) will be expanded to include more and better targeted activities to reach key populations for whom data is currently inadequate or lacking. In addition, and prior to securing improved / enhanced data, the national response will continue to work to expand peer-led or Government outreach services designed to reach more key population individuals in more locations through tailored prevention, care, treatment and support interventions. This will be completed within six months of completion of any new operations research.  1. **Country Response to TRP Issues and Suggested Actions- Condoms and lubricants and Social Marketing:**   The PR and CHAS recognize and accept the comments of the TRP and provide the following additional background information and specific responses to the issues raised:  The first shipment of more than two million new brand “*Huk Der*” condoms and lubricants is being supplied to the country in August 2017 and the cost of US$130,000 has already been paid from the current NFM grant. These 2.2 million pieces are intended for a soft launch of the “*Huk Der*” brand and distribution to key population individuals during the remainder of 2017 via NGO/PCCA outreach initiatives. All procurement of condoms planned in 2017 will arrive no later than 31 December 2017. Plan is now made to procure *“Huk Der”* condoms using current available revenue from selling of NUMBER ONE condoms. According to earlier coordination with UNFPA, if we place the order by 1 September 2017, the condoms will arrive no later than end of December 2017. These condoms will be for the buffer period (until end of June 2018).   1. The first shipment of more than two million new brand *“Huk Der”* condoms is being supplied to the country in August 2017 and the cost of US$130,000 has already been paid from the current NFM grant . These 2.2 million pieces are intended for a soft launch of the *“Huk Der”* brand and distribution to key population individuals during the remainder of 2017 via NGO/PCCA outreach initiatives. 2. In addition CHAS has mobilized domestic funding from the Government of the Lao PDR for financing the purchase of one million more “*Huk Der*” condoms per year for the period 2018-2020.  CHAS and the PR understand that this leaves a gap of approximately 0.5 million free distribution condoms per year. CHAS is currently exploring financing options to ensure that a full and sustained supply of condoms remains available but to date has not identified ways to fund the remaining condom requirements. The following options have been identified to address the shortfall of condoms: 3. Use of current program income from CSM (under NFM 2016-2017) that could be used to procure an additional amount of 1 million “*Huk Der*” *condoms* that would cover the program needs to June 2018 (buffer period). If this is the preferred option, orders would need to be placed during the third quarter of 2017 to ensure delivery to the country in the first half of 2018; or 4. Request has been submitted to MOH for co-funding to to procure 4.5 million of condoms for three years (2018-2020 for free distribution to key populations to ensure that there will be sufficient quantity of “ *Huk Der* “ condoms in 2018, 2019 and 2020; or 5. The PR and CHAS note and accept the comments of the TRP on the IPR issues related to the “Number ONE” condom package (currently used for social marketing). Bearing in mind that there is still a need for a social marketed condom in Lao PDR before the country can rely fully on the private market (quality as well as price), the PR and CHAS further agree to explore the possibility to develop a new condom brand in a branded packaging with a fixed retail price and work with partners in order to develop and implement a marketing and sales strategy for condoms during grant implementation. It should be further noted that all male latex condoms procured under the grant now and in next grant cycle are and will strictly comply with WHO2010 specifications for manufacturing by pre-qualified sources. It is only the packaging, width, color, scent/taste that will vary among different proposed brands.   **Actions and Timelines – Condoms and Social Marketing**   * As more and better data is generated from operational research, the action plan (i.e. the two page plan recommended by the TRP for development under the TRP comments related to Issue 3) the two-page action plan will be expanded to include more and better targeted activities to reach key populations for whom data is currently inadequate or lacking. * In addition, and prior to securing improved / enhanced data, the national response will continue to work to expand peer-led or Government outreach services designed to reach more key population individuals in more locations through tailored prevention, care, treatment and support interventions including both supplies of free and social marketed condoms. This will be completed within six months of completion of any new operations research. | |

Your replies to the clarifications requested must be provided to the Fund Portfolio Manager.