

FUNDING REQUEST

Tailored to Material Change

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| SUMMARY INFORMATION | | | |
| Applicant | Lao PDR Country Coordinating Mechanism | | |
| Component(s) | HIV | | |
| Principal Recipient(s) | Ministry of Health of Lao PDR | | |
| Envisioned grant(s) start date | 01/01/2018 | Envisioned grant(s) end date | 31/12/2020 |
| Allocation funding request | USD$6,931,650 | Prioritized above allocation request | USD$2,515,711 |

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| SECTION 1: CONTEXT |
| This section should capture in a concise way relevant information on the country context and highlight the need for material change to programming. It should refer to the existing and latest sources of information available, particularly (but not limited to) national health plans and other national strategy documents. This information is critical for justifying the choice of interventions under the funding request. To respond, refer to additional guidance provided in the *Instructions.* |

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| 1.1 Background:Material Change triggers | |
| Indicate below the area(s) of change that most accurately describes the need for revising the programming of certain areas. | |
| 1. Epidemiological contextual updates | |
| Are there any relevant changes in the country’s epidemiological context as compared to the previous funding request (e.g. important changes in trends in incidence/notification rates or prevalence, key drivers of the epidemics, emerging high risk behaviors, drug/insecticide resistance, or coverage of interventions in the general population or specific key populations based on the latest surveys or other data sources)? | ☐Yes  ☒ No |
| 1. National policies and strategies revisions and updates | |
| Are there new approaches adopted within the national policy or strategy for the disease program (e.g. Test and Treat guidelines for HIV, short-term regimens for MDR-TB, shift in interventions from Malaria control to pre-elimination, expanded role of the private sector)? | ☒ Yes  ☐ No |
| 1. Investing to maximize impact towards ending the epidemics | |
| Referring to available evidence and inputs from technical partners and key stakeholders, does the current program continue to be relevant, and is it progressing and generally on track to achieve results and impact? | ☒ Yes  ☐ No |
| 1. Alignment with 2017 – 2022 Global Fund Strategy Objectives 2 and 3 | |
| Objective 2 to Build Resilient and Sustainable Systems for Health | |
| Are changes in Resilient and Sustainable Systems for Health (RSSH) investments needed in order to maximize Reproductive Maternal Neonatal and Child Health impact, (RMNCH) or other RSSH areas? | ☒ Yes  ☐ No |
| Objective 3 to Promote and Protect Human Rights and Gender Equality | |
| Is there a need for intensifying efforts to address human rights and gender-related barriers to services and to ensure appropriate focus on interventions that respond to key and vulnerable populations? | ☒ Yes  ☐ No |
| 1. Effectiveness of implementation approaches | |
| Are the current implementation arrangements effective to deliver on the program objectives and anticipated impact (including the Principal Recipient and the main sub-recipients)? | ☒Yes  ☐ No |
| 1. Sustainability, transition and co-financing | |
| Are there changes in domestic or international financing (e.g. due to withdrawal of a major donor or significant increase in domestic allocation/funding), resulting in material impact on funding availability for programmatic interventions and sustainability? | ☒ Yes  ☐ No |
| Is your country’s 2017-2019 Global Fund allocation for the disease component is significantly lower as compared to the current grants’ spending levels[[1]](#footnote-1)?? | ☒ Yes  ☐ No |
| 1. Others: | |
| HIV disease allocation is US$7,374,096 including 6% RSSH US$442,446 for the period 2018-20, average US$2,310,550 per year, significantly lower than the average US$4,159,327 for the period 2016-2017 (with 95% budget utilization in 2016), and leaving a gap of US$5,560,759 per year compared to the National HIV and AIDS Strategic Action Plan (NSAP) costing of US$29,784,225 (2018-20) (Annex 9). The lowered resource availability through both government financing mechanisms and through Global Fund, the request for investment is focused on essential programming, in this case, treatment care and support of people living with HIV as well as package of prevention intervention. |  |

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| 1.2. |
| Given the above,   1. Describe the reasons for programmatic changes which form the basis of your funding request, as applicable (e.g. refocusing to high impact interventions, epidemiological changes, alignment with the latest normative guidelines, changes to funding landscape, etc.) 2. As applicable, specify how these changes relate to key and vulnerable populations and human-rights and gender considerations; 3. Describe how the request builds on lessons-learned from existing and other donors’ programs. |

1.2 a) Programmatic changes are related to: (i) clear targets (ii) changed normative guidelines (iii) the new ‘joint programmatic approach’ for the key RSSH interventions and (iv) lowered Global Fund (GF) allocation to HIV component. During the submission of the last concept note, National Strategic Action Plan for HIV 2016-2020 (NSAP) was not yet finalized. This new funding request is aligned to the targets set out in the NSAP which are measurable and the progress can be assessed. The programtargetsare set accordingly; i.e 80% of key population (KP) access HIV Testing and Counselling (HTC), 90% treated, 85% female sex workers will be reached with interventions and 80% of men who have sex with men (MSM)/transgenders (TG) will be reached with interventions. This funding request builds on the progress made during the current grant and the efficiencies gained through collaboration with other departments within MoH including the National Tuberculosis Center (NTC).

Table 1: Progress made under the current grant up to December 2016

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| INDICATOR | TARGET | | | RESULT | | |
| N# | D# | % | N# | D# | % |
| FSW |  |  |  |  |  |  |
| KP-1c: Percentage of sex workers reached with HIV prevention programs - defined package of services | 8,462 | 9,955 | 85% | 10,008 | 9,955 | 101% |
| KP-3c: Percentage of sex workers that have received an HIV test during the reporting period and know their results | 5,923 | 9,955 | 59% | 7,750 | 9,955 | 78% |
| MSM |  |  |  |  |  |  |
| KP-1a: Percentage of MSM reached with HIV prevention programs - defined package of services | 4,740 | 5,576 | 85% | 4,592 | 5,576 | 82% |
| KP-3a: Percentage of MSM that have received an HIV test during the reporting period and know their results | 3,318 | 5,576 | 59.50% | 1,801 | 5,576 | 32% |
| PMTCT |  |  |  |  |  |  |
| PMTCT-1: Percentage of pregnant women who know their HIV status | 52,184 | 199,262 | 26.20% | 51,899 | 199,262 | 26% |
| PMTCT-2: Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission | 157 | 416 | 38% | 234 | 416 | 56% |
| PMTCT-3: Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth | 157 | 416 | 38% | 23 | 416 | 6% |
| HIV/TB |  |  |  |  |  |  |
| TB/HIV-1: Percentage of TB patients who had an HIV test result recorded in the TB register | 3,397 | 3,397 | 100% | 2,375 | 2,514 | 94% |
| TB/HIV-2: Percentage of HIV-positive registered TB patients given anti-retroviral therapy during TB treatment | 272 | 272 | 100% | 115 | 156 | 74% |
| TB/HIV-3: Percentage of HIV-positive patients who were screened for TB in HIV care or treatment settings | 2,789 | 2,789 | 100% | 4,751 | 4,751 | 100% |
| TB/HIV-4: Percentage of new HIV-positive patients starting IPT during the reporting period | 368 | 819 | 45% | 142 | 540 | 26% |
| ART |  |  |  |  |  |  |
| TCS-1: Percentage of adults and children currently receiving antiretroviral therapy among all adults and children living with HIV | 5,578 | 11,796 | 47% | 4,646 | 11,796 | 39% |
| TCS-3: Percentage of adults and children that initiated ART, with an undetectable viral load at 12 months (<1000 copies/ml) | 5,020 | 5,578 | 90% | 3,605 | 4,646 | 78% |
| TCS-4: Percentage of health facilities dispensing antiretroviral therapy that experienced a stock-out of at least one required antiretroviral drug in the last 12 month | 0 | 11 | 0% | 0 | 11 | 0% |

There are no epidemiological changes from the current grant to the funding request, however the country has recently adopted two ambitious protocols based on World Health Organization’s (WHO) recommendation: (a) testing guidelines to adopt the 3-test algorithm (b) adoption of “Treat All” policy, where every newly diagnosed people living with HIV (PLHIV) will be initiated on treatment. This changes the implications for program targets, gaps and funds required, as reflected in this request (Annex 40). In order to strengthen the health information system, and bring about systemic and structural efficiency, the District Health Information System (DHIS) and the Logistic Management Information System (LMIS) will integrate across the three diseases. This is a significant departure from earlier concept notes where each disease component was working independently on reporting. 6% of the HIV allocation has been allocated to the RSSH component and will be managed under TB grant (Annex 12). Lao PDR CCM wants to acknowledge that Global Fund is the largest investor in Lao’s HIV program. The total estimated resource needs for implementing the NSAP is US $50 million for 5 years, increasing from US$ 8.3 million in 2016 to US$ 11.7 million in 2020[[2]](#footnote-2) (Annex 9). The allocation for this funding request is almost half of the current grant, which covered 41% compared to 25% of the country need for respective periods. (Annex 3)

1.2b) At the beginning of 2018, the current grant with Global Fund will have closed. Only one project will remain which is United States Agency for International Development (USAID) supported Family Health International (FHI) 360 implementing an MSM/TG Community Testing Program in 3 provinces up to end of 2019. See Annex3. Besides the technical support on strategic information, quality improvement and legal protections, almost all service delivery will be not be funded. A series of country dialogues were held (Annex 13) which consisted of civil society partners, key affected people, technical partners, and other line department and agencies. In these platforms, priorities were discussed and the implications for the country. Given that government co-financing timelines were not forthcoming, it was decided that the first priority would be to use the available allocation to test all those at risk and treat all those diagnosed positive. The second and third priorities were on prevention package for FSWs and MSM/TG. The country has made valiant effort in trying to mobilize funds for the HIV program particularly through the United States President’s Emergency Plan for AIDS Relief (PEPFAR) key population investment fund (KPIF) request in October 2016.

The civil society organizations impressed upon the fact that prevention particularly among FSW and MSM/TG could not be ignored and the country must intensify efforts to find efficiency gains in order to set aside allocation for prevention actions. The fact that heterosexual contact accounted for the majority of HIV transmission at 88% from 1990 to2013 followed by homosexual contact at 8% and mother to child at 4% makes a clear case[[3]](#footnote-3). Key populations only represent 4% of the population, yet accounts for 40% of the new cases in 2017, presents a strong case for targeted intervention for female sex workers (FSW) and MSM/ TG. With 0.76%[[4]](#footnote-4) (Annex 19a), prevalence rate, the FSW alone contributes to 21% of new infections through heterosexual contacts and MSM to 18% of the total new infections[[5]](#footnote-5). Though there is an increased recognition of HIV risk among people who inject drugs (PWID) and prisoners, concrete evidence is absent.

The civil society including key affected population strongly influenced the selection of the priority districts and provinces based on their knowledge and experience on where efforts must be concentrated in order to achieve maximum impact. CHAS with UNAIDS/UNDP partners undertook an Assessment of the Policy and Protections Framework during 2016. This resulted in a range of recommendations which CHAS used to advocate for a change to the Penal Code (under review in 2016). It is noteworthy to mention that they have been successful in reducing penalties associated with sex work as well as intentional transmission of HIV, and they continue to advocate on increasing the drug threshold possession for personal use. The new penal code is now being reviewed by National Assembly in May 2017 (not part of funding request).

1.2 c) Key lessons learned through experience in service delivery and considered in this funding request include effectiveness of peer led strategies both for FSW and MSM/TG strategies. (1) Specific salaried peer educators reach out to a fixed target of peers with prevention Behavior Change Communication (BCC) and condoms has limitations of reach and coverage. This model will be replaced by the “Enhanced Peer Mobilizer- EPM” Model where every peer mobilizer reaches 10 of their known and trusted peers which snowballs further, detailed in the next section. This strategy was reflected in the “Expressions of Interest- EOI” submitted by two civil society organizations both of whom being existing sub-recipients and endorsed in a country dialogue. (2) Success in collaboration and leveraging between CHAS and the National Tuberculosis Center (NTC) in ensuring HIV positive patients get treated for tuberculosis (TB) and TB patients get tested and treated for HIV has been felt, hence joint reviews and coordination will be enhanced, which will be government funded and coordinated by Department of Communicable Disease Control (DCDC).

The existing targets and scope of prevention program is based on the Asian Epidemic Modelling (AEM) and not on population size estimates through geographic mapping exercise. Size estimates available for FSW, are based on outdated mapping of female sex workers at drink bars [[6]](#footnote-6)(Annex 14). For men who have sex with men, the size estimates are based on a percentage of adult population multiplied by an arbitrary figure[[7]](#endnote-1). The country acknowledges that there is need for realistic and updated estimates however due to constrained resources has been unable to update this information.

Drop-In Centers (DICs) though useful have reached a fairly small proportion of female sex workers and few MSM and some transgenders (Annex 15) hence, the DICs have been dropped from the package of intervention for FSW and MSM/TG as discussed in the third country dialogue. However, they are indeed useful to key populations (provides safe haven, place to meet, psycho-social support) and hence included in PAAR. In addition, the peer outreach model is ineffective in areas of high mobility and international migrants like Luang Prabang and Bokeo due to variance in language, culture and high nature of mobility, hence a different condom strategy has been proposed. Moreover we know from program experience that the decision of condom use and purchase is less often the choice of the sex worker, but rather the client who most often prefers to purchase condoms from pharmacies and markets. Thus, given the constrained resources limited numbers of free condoms will not impact the epidemic, hence while looking for efficiencies in the allocation the decision to exclude the condoms from the health product list, and to use the government funded free condoms and socially marketed condoms was made.

The prioritization has hence been guided by these material changes and strong contributions from civil society including key affected populations.

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| SECTION 2: FUNDING REQUEST (Within Allocation) |
| This section should describe and provide a rationale for the program elements proposed for this funding request. Attach and refer to completed Programmatic Gap Table(s), Funding Landscape Table(s), Performance Framework and Budget.  To respond, refer to additional guidance provided in the *Instructions.* |

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| 2.1 Funding request |
| Describe the funding request for the disease program(s) by specifying the changes to the current funded program, taking into account the existing programmatic and financial gaps that now need to be addressed, and how the changes in certain program areas affect the scope/scale of the Global Fund investments.  Additionally, outline in particular:   1. The changes to the (i) Performance Framework such as impact on targets, geographic coverage, or the diversity/quality of the service packages, (ii) budget 2. How the proposed revisions will ensure:    1. continued scale up where feasible;    2. effective and efficient use of Global Fund investments;    3. maximum impact for ending epidemics HIV/AIDS, TB and malaria; 3. How the proposed investment ensures appropriate focus on building resilient and sustainable systems for health, and key and vulnerable population programs as applicable |

The goal of this funding request is: “Leverage and sustain the gains made in the HIV response by focusing investments to highest impact interventions.” This is aligned with the goal of NSAP which is to end the transmission of HIV and alleviate the impact of AIDS in Lao PDR.

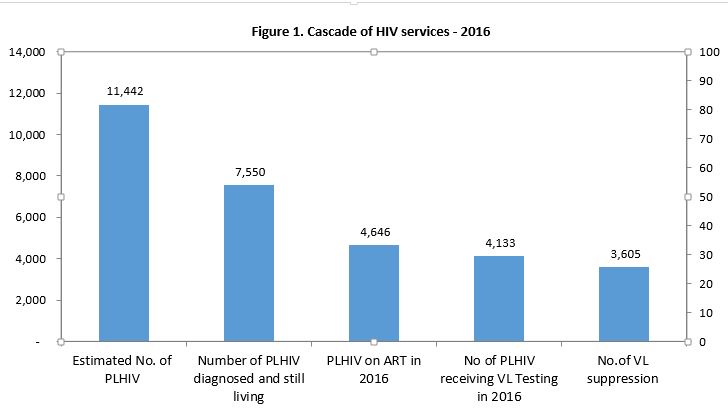
Given the funding constraints, the epidemic scenario and strong inputs from civil society and technical partners, the priorities to use the available allocation is to test all those at risk and treat all those diagnosed positive, second and third priorities are prevention for FSWs and MSM/TG respectively.

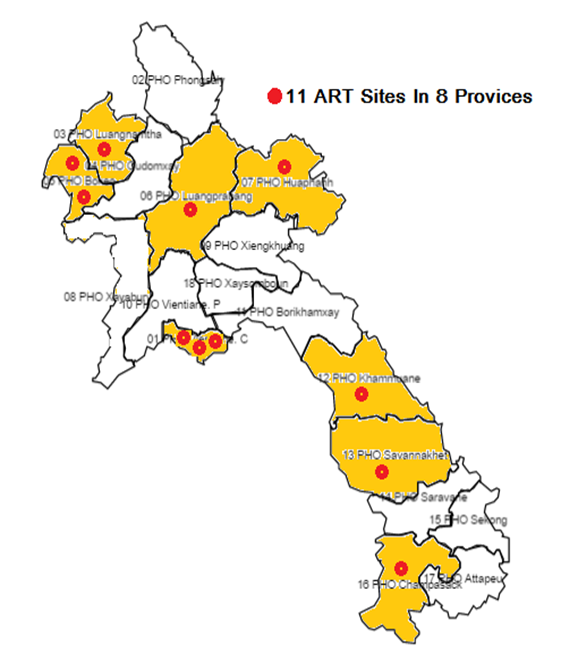
2.1 a) There are significant reductions to the performance framework, targets and geographies. In addition, there are service package differences. While the targets and scope for treatment care and support are maintained, TB/HIV and PMTCT services are being leveraged through the TB grant from Global Fund as well as efficiencies under MoH. The prevention package for FSW (10,005 in 2016 to 10,505 in 2018) and MSM (903 in 2018 to 932 in 2020) has altered in approach and in scope.

Table 2: Change in the targets and scope

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Module | Provinces under GF NFM 2016-2017 | Provinces under proposed GF FR  2018-2020 | PAAR | Government and other sources of funding |
| Prevention Program for FSW | BK, LPB, VTC, VTP, KM, SVK, CPS | VTC, KM, SVK, CPS,VTP | BK, LPB | BK, LPB (govt condoms only) |
| Prevention Program for MSM | LPB, XYB, VTC, VTP, KM, SVK, CPS | VTP, KM | 0 | VCT,CPS and SVK (USAID/FHI360) |
| Treatment, Care and Support | 11 ART sites | 11 ART sites | Expansion to 10 more provinces |  |

Objective 1: To increase coverage and improve quality of treatment, care and support services for people living with HIV

Treatment, care and support: Testing and treatment of PLHIV is key to the Joint United Nations Programme on HIV/AIDS (UNAIDS) strategy to eliminate HIV. PLHIV on diagnosis initiate and sustained on antiretroviral therapy (ART) See Annex 16 for National guidelines. GF is the financier of majority of HIV health products co-financed by the government, so the gap in treatment is reduced , hence this funding request will be used to treat all 9,472 PLHIV that should be reached to comply with the country target for 2020 (target calculated by the ARV forecasting tool). However, this number is derived from AEM\_Spectrum and does not reflect the reality[[8]](#footnote-7). (Annex 17) This will continue to be implemented in all 11 ART sites in 8 provinces. PAAR includes expansion of ART sites in the remaining 10 provinces. In Figure 1 this cascade is shown for PLHIV in Lao PDR, there is a large gap from the estimated number of PLHIV 11,442 in 2016 to the number of PLHIV with actual viral load suppression (3,605). To increase the number of PLHIV identified it is best to scale up screening in the subgroups with the highest prevalence such as FSW or MSM. Identifying PLHIV and starting them on treatment is essential to turn around the epidemic[[9]](#footnote-8). HIV testing and counselling (HTC) services have been scaled up to 170 sites in 17 provinces (from 165 in 2013) and ART services are now available in 11 sites in eight provinces.(Annex 20a)



[[10]](#footnote-9)PLHIV with a reduced viral load are unlikely to infect their sexual partners; hence this testing and treatment cascade is important to end the epidemic. The targets below are reflective of the number of people already diagnosed HIV positive and on treatment is 4646 on 2016.

Table 3: People living with HIV in need of ARV

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Percentage of people living with HIV currently receiving antiretroviral therapy | | | | |
| Adults and Children |  | 2018 | 2019 | 2020 |
| (Population size estimates) PSE in need/at risk | # | 11,705 | 11,766 | 11,803 |
| Targets | # | 6,114 | 6,805 | 7,526 |
| Funding request | # | 6,114 | 6,805 | 7,526 |
| (% of need) | % | 52% | 58% | 64% |

PMTCT and pregnant HIV women: The program will continue to prevent HIV among newborns. All positive women will be advised about the dangers of pregnancy and continually supported by the peer mobilizers. Provider initiated counselling and testing (PICT) is given to all pregnant women at ANC and delivery rooms in health facilities which are the PMTCT pilot centers (provincial and district hospitals in Vientiane Capital, Luang Prabang, Savannakhet and Champasak) and in the TB units. When a screened pregnant woman is found positive, she will be eligible for lifelong treatment and support (Option B+). All positive pregnant women and their infants will be referred to receive ART. This is being implemented in the country through MOH and GF TB fund and the treatment through ARVs under the Treatment, Care and Support Module. To understand the health service delivery better, read Annex 26 on health sector response to HIV.

TB/HIV: The TB allocation supports TB-HIV collaboration activities as demonstrated by the TB-HIV indicators. In the TB funding request it is already mentioned that there is 100% HIV testing among TB patients, 100% testing for active TB among persons living with HIV, 90% early start of ART among TB/HIV patients and 80% implementation of Isoniazid preventive therapy (IPT). Centre against HIV/AIDS and sexually transmitted illnesses (CHAS) will collaborate with TB Units and the 11 anti-retroviral treatment (ART) centers in provinces, and with DCCA in districts to jointly provide the full package of patient centered TB/HIV diagnosis and care services. In addition, outreach by civil society SRs include HIV/TB outreach messaging both in the current HIV allocation as well as the TB funding request. TB-HIV collaborative activities (TB-HIV Manual 2011, Annex 18) will be updated together with the National TB technical guidelines in 2017. These activities are funded through the TB Funding request and hence not included in the current HIV funding request.

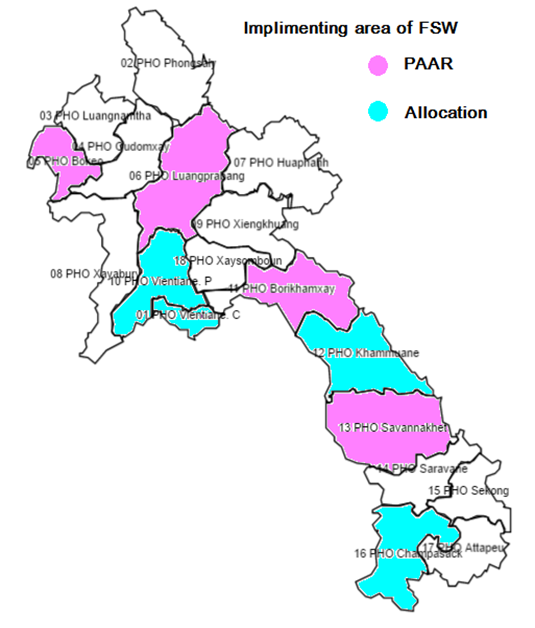
Objective 2: To provide HIV prevention program among FSW and MSM/TG

The prevention program for both FSW and MSM/TG consists of peer-led interventions, Drop in Centers (DIC), HIV and Sexually Transmitted Infections (STI) testing and counselling as well as referral to antiretroviral treatment (ART) through civil society SRs. The package of services under this funding request has a varied outreach strategy (Annex 37) and the DICs are not included. Hence the prevention package includes consists of peer outreach providing BCC, screening of STI and for one year STI treatment, referral to HIV Counselling and testing as well as active referral to ART. The current outreach approach is that the select CSO SRs will recruit the key population (FSW, MSM or TG) as peer mobilizers to encourage BCC counselling and tested and to ensure that the clients know their results. HIV positive cases get referred to case management teams from the CSO for active referral and linkage to ART clinics. The case management team continues to monitor the clients for six months up to one year to provide psychosocial support, and to ensure they adhered to treatment until they are virally suppressed. (Annex 37)

Female Sex Workers: Five provinces out of the current 7 will continue the prevention program and will cover all 100% of the need in these provinces and 64% percent of the national need.

Table 4: FSW Prevention program and targets

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | 2018 | 2019 | 2020 |
| FSW reached with prevention programs- defined package of services | | | | |
| PSE in need/at risk | # | 13,900 | 14,100 | 14,300 |
| Targets | # | 11,815 | 11,985 | 12,155 |
| Funding request | # | 10,005 | 10,309 | 10,505 |
| (% of need) | % | 72% | 73% | 73% |

The program gap for the percentage of the FSW that have received an HIV test during the reporting period and who know their results is 100%, the number of FSWs in need for testing are 13,900 in 2018 to 14,300 in 2020. The target is to reach 80% of the FSW with HIV testing. For efficient prioritization, provinces with the highest prevalence and population size estimates were selected for interventions under this request for funding.

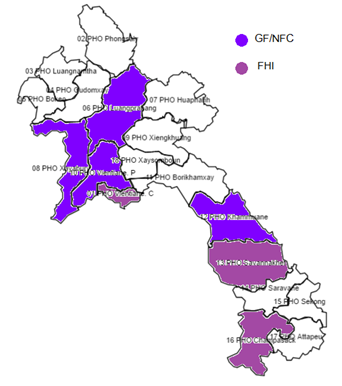
Every prioritized province, has select districts for intervention (Annex 20a) based on estimates, and other markers like socio-economic zones. CSO SRs will be selected as before however each district will have a district facilitator who recruit 10 known/familiar peers who will in turn recruit 10 of their known peers as mobilizers in a cascade with the intention that many new contacts/KP will be reached, and the outreach will be more effective due to trust between the mobilizer and peer. DICs were removed from the package as they did not cover sufficient KP.[[11]](#footnote-10)(See Annex 15). While the prevention program extends to select districts in five provinces—Vientiane Capital, Vientiane province, Savannakhet, Champasak and Khammouane (See Annex 20 for detailed targets), priority hot spots/entertainment establishments within Luang Prabang, location of 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, Myanmar, will have condom boxes provided by the government, which enable staff for free distribution under the guidance of the District Committee for the Control of AIDS (DCCA)s.

Savannaket

Men who have sex with men and transgenders: For MSM, total of 15,600 higher risk MSM in 2018 to 16,200 in 2018 require HIV testing. The target is to reach 722 MSM in 2018, 734 in 2019, and 745 in 2020 in priority districts within two provinces Vientiane Province and Khammouane with full prevention package of BCC, STI testing (referral), HIV testing referral and ART referral and follow up support including referral to condom purchase. The USAID/FHI360 Linkages program with community HIV testing pilot will continue till 2019 in three provinces of Vientiane Capital,Savannakhet, and Champasak.

Table 5: MSM/TG prevention program in relation to national targets

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | 2018 | 2019 | 2020 |
| Percentage of the key population reached with prevention programs- defined package of services | | | | |
| MSM |  |  |  |  |
| Population size estimates (PSE) in need/at risk | # | 15,600 | 15,800 | 16,200 |
| Targets | # | 12,480 | 12,640 | 12,960 |
| Funding request | # | 903 | 918 | 932 |
| (% of need) | % | 6% | 6% | 6% |

Since the activity will be implemented in only 2 priority provinces (VTP, KM). Therefore, the country target is below the 80% of the denominator as planned in NSAP 2016-2020. United States Agency for International Development (USAID) through FHI 360 provided support in implementing the “Linkages” Project for MSM and TG populations in three provinces namely, Vientiane Capital (VTC), Savannakhet (SVK) and Champasak (CPS) The other provinces (VTP and KM) are covered by FHI and 2 under this funding request). (Annex 20a)

People Who Inject Drugs: A study conducted in 2010 in only 2 provinces shows an HIV prevalence of people who inject drugs (PWID) 17%. According to the 2017 AEM projection, the new infection among PWID is small, about 17 to 19 new cases annually, that is 3% of the total new infections. Data on PWID is limited driven by the nature of drug use having criminal liability. Injecting drug use and drug possession are criminal offenses based on the Law on Drugs (No. 10/NA) and the Penal code (Articles 55 and 146). Penalties include imprisonment up to five years or compulsory drug treatment, and families are fined if they do not report individuals who use drugs in the family or if they relapse after treatment[[12]](#footnote-11). A pilot program in two provinces of Houaphanh and Phonsaly on a Harm reduction program till 2018. CHAS along with UNAIDS, WHO and MOH worked with the National Task Force on Penal Code to change laws on drug possession, which will be considered in the national assembly in May 2017. See Annex 21 for details. A proposal to study the epidemiology among PWID is under preparation to the French 5% initiative. This funding request has no available allocation for work with PWID.

Prisoners: There are currently no specific programs for prisoners for prevention. However, if the prisoner is admitted to the hospital with illness, HIV testing and subsequent treatment is provided in Police Hospital in Vientiane Capital. There is a plan to study HIV prevalence and risky behaviors along with a TB study that is planned, in 2019 through government financing.

Condom Programming: The requirement for condoms used in the general population is estimated to be 6 million annually until 2020. Specifically for MSM the need is 2,808,000 in 2018 to 2,916,000 in 2020[[13]](#footnote-12) the country targets are set on 2,527,200 in 2018 to 2,624,400 in 2020, given that 2 million condoms per year are provided through social marketing, the remaining gap ranges from 527,200 in 2018 to 624,400 in 2020. For FSW and clients, the need is 2,001,600 in 2018 to 2,059,200 in 2020[[14]](#footnote-13). The country target is set on 1,601,280 condoms in 2018 to 1,647,360 in 2020. The country plans to distribute for free 1 million condoms from domestic resources annually until 2020, therefore the remaining gap to the target for FSW ranges from 601,280 in 2018 to 647,360 in 2020.

National Condom Committee is negotiating with PSI to: (1) reduce the price of NUMBER ONE condom brand, (2) have a new company manage the condom brand but with IPR to remain with PSI. It is also planned that the unmet need would be met through social marketing of “Huk Der” (government SM condoms) through the staff of DCCA, PCCA and civil society. The commercial condoms sold in mini markets, private pharmacies, and in all the provinces where the purchases of the condoms are largely led by client choice and not often by the sex workers themselves. The goal for 2018–2020 is to build a sustainable and sufficient supply of quality assured, Food and Drug Department registered condoms. Steps are being taken towards a segmented market strategy that will maintain focus on most at risk populations, and a tiered pricing strategy will ensure that all portions of each income segment are being reached so that distribution becomes sustainable. For details on the country’s plans on condom programming see Annex 22. There is no allocation for condoms in this funding request.

2.1b) i. The prevention program included in the Request reflect the reduction in reach and coverage due to decreased available resources. This is likely to lead to an increase in HIV in those provinces that do not have the full prevention package of intervention. The Request aims to maintain the current coverage for five provinces for FSW prevention services: two provinces for MSM prevention services, and the 11 ART sites in 8 provinces for HIV treatment care and support remain the same. However the removal of incentives for the staff to undertake HIV specific activities is likely to create delays in service delivery, since the staff of Provincial Committee for the Control of AIDS (PCCA), District Committee for the Control of AIDS (DCCA), ART centers, HTC centers have multiple roles to play. Prioritized above allocation request (PAAR) includes the scaling up the ART sites to at least one per province, and covering the unmet need for condoms.

ii. Since 68% of the total funding request is on health products, there is limited scope for efficiency gains. Efficiency gains have been made through:(1) Collaboration with TB division both at the district level as well as the provincial levels (2) enhanced peer model works at the same cost but expected to reach hidden key population more effectively (3)The removal of the DICs that cater to a very small population.

iii. The funding request is unlikely to end HIV, however it is very likely to halt the epidemic from further impact through sustaining the lives of those who are affected, by preventing those who are at highest risk and through strengthening capacities in programming and monitoring and evaluation. Furthermore, in order to end the epidemic, there needs to be robust information. Currently the data with which the program is planned is a modelling estimate derived from some real data but many assumptions. Accurate size estimates, IBBS and strong capacity of data analysis and utilization is required to sharpen the focus of the Lao HIV epidemic. It is planned to include size estimation as part of the role of CSOs. Technical assistance for Data analysis is part of a request to WHO and PAAR. The Program has made available US$442,446 for RSSH interventions (to be managed as part of the integrated RSSH approach under the TB grant (submitted in the TB Request Wave 1) Investments will be focused on further rollout of the District Health Information System (DHIS) 2 and a Logistics Management Information System (LMIS), commenced under the Current Global Fund HSS grant. It is anticipated that a robust DHIS2 would improve the quality and speed of reporting. The strengthening of an integrated LMIS “mSupply” is anticipated to assist in inventory management address proper forecasting and prevent stock outs of life saving drugs such as anti-retroviral (ARVs). Given that the most crucial aspect of HIV program is having adequate health products to treat those with HIV and test those at risk, this funding request does focus on achieving the maximum impact possible for ending HIV, particularly for the most at risk and vulnerable populations. Regarding the budget allocation towards key populations, summary breakup of the request is as follows:

1. Comprehensive Prevention Programs for SW/MSM and their clients and HIV testing services:

648,245$ + 972,210$= 1,620,455$ = 22%

2. Treatment (ARV drugs and care and support) (almost all are key population): 3,711, 655 US$= 50.3%

Total: 5,332,110 US$= 72.3%. Hence a more than 72% of the budget goes to key population.

Issues and Suggested Actions- Condoms 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 regarding condom social marketing:

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. Negotiations with the Government of Lao PDR to purchase an additional 1 million pieces over 3 years (in total 4 million pcs instead of 3 million) to ensure that there will be sufficient quantity of *Huk Der* condoms in 2019 and 2020; or
5. If options 1 and 2 fail, CHAS will prioritize grant savings in Y1 and Y2 to finance the purchase of an additional quantity for Y2 and Y3.
6. 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 (such as Marie Stopes Viet Nam, as suggested by the GF) 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.

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| SECTION 3: OPERATIONALIZATION AND RISK MITIGATION |
| This section describes the planned implementation arrangements and foreseen risks for the proposed program(s).  To respond, refer to additional guidance provided in the *Instructions*. |

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| 3.1 Implementation arrangements summary | |
| Do you propose major changes from past implementation arrangements, e.g. in key implementers or flow of funds or commodities? | ☒Yes ☐ No |
| If yes,   1. Outline the reasons and the key changes from past implementation arrangements to give an understanding of grant operationalization. You can provide an updated Implementation Arrangements Map; 2. Detail how representatives of women's organizations, key populations and people living with the disease(s) as applicable will actively participate in the implementation of this funding request; 3. Include a description of procurement mechanisms for the grant(s).   (maximum ½ page) | |

1. The Ministry of Health (MoH) has always been the sole Principal Recipient (PR) in the country. A Principal Recipient Office was established in the (DCDC) DCDC is the institution directly involved in directing, managing, and supervising communicable disease prevention and control programs at national, provincial, district and community levels. Due to its acknowledged technical and managerial capacities, and its national responsibilities in the prevention and control of HIV/AIDS, Tuberculosis and Malaria, the DCDC has been the CCM nominated Principal Recipient (PR) for the Global Fund Projects in the country, with a team of consisting of both seconded government and contract staff that are responsible for the day-to-day grant management activities. The Ministry of Finance issued a decree in 2016 that requires all overseas development assistance (ODA) to be channeled through the Ministry of Finance and onto the relevant Department of Finance in each Ministry. This decree addressed the gap in the public sector financial management which allowed for ODA to flow outside of the public financial management system, therefore not being captured in the official financial transactions of the Government of Lao, the consequence being that Ministry of Finance and the Ministry of Planning and Investment were unable to determine the ‘real’ cost of three diseases. Compliance with the new decree has triggered the requirement for the MOH to bring the Global Fund grants and their financial management into alignment with the Department of Finance (DOF) and the Department of Planning and International Cooperation (DPIC) within the MOH. The DoF and DPIC are responsible for health sector’s overall financial, planning, monitoring and management mechanisms. GF fund flow will be channeled through the Ministry of Finances and into the Department of Finance of the Ministry of Health and onto the sub-recipients. The MOH has begun the change management process to transfer the functions of Principal Recipient office under DCDC related to the budget, procurement and administrative functions to the relevant Units within the DOF and DPIC, requiring strong coordination between all three departments. This unit will have a small number of contracted staff that will support Government staff. It is expected that some of the key existing staff and technical assistance will be transferred ensuring that institutional memory and knowledge is preserved for a smooth transition. Other contract positions will be opened for a competitive recruitment process. The new implementation arrangements will also strengthen the implementation and management of the RSSH interventions as well as their intended outcomes. The RSSH component for Health Information System (HIS) as part of the health information center sits under the DPIC housed within the health information center. With DPIC playing a key role in the management of the grants under the future PR arrangement, the performance of this component will not only be closely monitored, but it will act as ‘coalescing force’ – the HIS will in future become the health information hub for the health sector. Each of the three disease programs will need to work with the HIS team to improve their program data quality and ensure their indicators and data needs are captured. Equally the HIS team will work with programs in training and capacity building program staff in M&E and data use. The DPIC with formal responsibility for PUDR reporting will need to ensure that both the programs and health information center are working together to report against the indicators and perform data quality checking. Similarly, for the strengthening of the procurement and supply chain management – whilst the medical product supply center does not formally sit under either DOF or DPC – the shift in the implementation arrangement will enable greater visibility of essential medicines and commodities costs within planning and finance documents, thus formally including in the system the HIV medicines and commodities to better support the Government of Lao PDR in planning and budgeting with a view to transition and lesser depend on Global Fund support.
2. 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.
3. Procurement of pharmaceuticals and health products will be managed by the MPSC for the PR The core commodities are quantified and forecasted on a semi-annual basis using tools which have been developed with CHAI in the past 3 years under NFM grant; this includes all ARVs for both adults and children, HIV tests and male condoms. These processes will be transferred to the MPSC as the office responsible for Health products/PSM in the new PR structure as proposed for the new funding application implementation period. Sourcing will be undertaken mainly through the Global Fund PPM/Wambo system which assures quality, access to lowest unit prices and reliable lead times (on average 4 months). CD4 machines and supplies continue to be sourced competitively and contracted by the PR. See Annex 7 for detailed Implementation map.

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| 3.2 Key implementation risks | | | |
| Using the table below, outline key risks foreseen, including those that were provided in the *Key Program Risks* table shared by the Global Fund during the Country Dialogue process. You can also add key operational and implementation risks, which you identified as outstanding from the previous implementation period, and the specific mitigation measures planned to address each of these challenges/risks to ensure effective program performance in the given context.  Applicant response:  Important risk areas, whether programmatic or pertaining to implementation, may include, but are not limited to:  \*Notes: These risks have been enumerated by Laos HIV Grant Risks matrix | | | |
| Risk Category  (Functional area) | Key Risk | Mitigating actions | Timeline |
| Programmatic/ monitoring and evaluation risks (e.g. data quality and program quality, access and promotion of equity and human rights, sustainability, etc.) | 1. Limited capacity of health care providers | The existing HIV/AIDS programs will provide extensive trainings to in-service health care providers where CHAS will improve and update the contents of teaching curricula to ensure that pre-service medical/health cadres have sufficient knowledge on HIV/AIDS. Funding support: USAID/PEPFAR | During grant making and throughout grant implementation |
| 2. Lack of gender sensitized outreach workers (Annex 23) | Capacity building by CSO and by key affected populations through regular reviews and meetings. Funding support: PEPFAR through USAID/FHI 360 in 3 provinces (VTC, SVK and CPS) under Linkages project (MSM/TG).2. French Red Cross until mid-2017 funded by EU.3. French 5% Initiative for 5 provinces until end of 2017. |
| 3. Inadequacy of a nuanced strategy to reach migrant/ mobile/ seasonal sex workers | 1) Lao Ministry of Health has MOU with Thailand, Vietnam to strengthen cooperation in communicable diseases control. CHAS has worked through the existing mechanism to address the cross border collaboration on HIV and migration, including Vietnamese female sex workers. CHAS has a joint framework and action plan with Ministry of Public Health, Thailand on cross border collaboration, including referral system and access to HIV intervention for Lao migrant workers working in Thailand. Funding support: AIDSCare China and MoH (Annex 24)  2. Services are available for Vietnamese migrants in Attapeu, Houaphanh and Phongsaly provinces which include HIV awareness raising, HIV counselling and testing. Funding support: ADB/HIV till December 2017  3. HIV outreach activities and condom distribution for migrant workers (Chinese and Vietnamese)- AIDS Care China project (2018 and beyond) is currently being prepared and action plan developed; expected in end of 2017  4. Technical assistance required for designing prevention program to address part-time/seasonal FSW (Funding source: None yet) |
| 4. Lack of on-ground collaboration between HIV and TB services | PR PMU to monitor plans for joint review and collaboration. Funding support: GF NFC (2018-2020) under both HIV and TB grants |
| 5. Lack of collaboration between ART and ANC services affecting the scale up of PMTCT interventions | 1.PMTCT will be included in national ANC guideline, HIV and Syphilis testing included into national maternal child health (MCH) service delivery package) by development partners; and the government resources have been mobilized for procurement of HIV test kits, trainings on couple HIV Testing and Counselling and field supervision. Funding support: MOH  2. Provider initiated counselling and testing (PICT) is given to all pregnant women at ANC and delivery rooms especially in health facilities especially in Vientiane capital, Savannakhet, Champasak, and LPB. All positive pregnant women and their infants will be referred to receive ART. MCHC will closely work with CHAS and development partners to reach the implementing goal of 50% HCT coverage of pregnant women by 2020 and 70% by 2025. Capacity building for MCH staff has been already included in the MCHC annual work plan supported by the government for new establishment.  Funding support: MOH |
| 6. Difficulties in accessing HTC and treatment facilities - OOP expenditure, stigma and discrimination | 1. CHAS will conduct the assessment of key health centers in all provinces. The assessment report could identify the additional TB Clinics that could include HIV testing and PICT. The results and recommendations will be used for SOP development. Funding support: USCDC/PEPFAR  2. Community referred testing will be provided by CSO under GF NFM (2018-2020). |
| 7. Stigma and discrimination leading to drop-outs from treatment | 1. Legal assessment undertaken in 2016, with recommendations for S and D trainings for health care providers (Annex 44). Already included as key indicator in quality improvement and trainings planned. Funding support: PEPFAR  2. CHAS will continue working with National Taskforce on Penal Code, Ministry of Justice to address relevant articles in HIV/AIDS law in order to reduce S&D. Funding support: MOH  3. Training for health care providers on S&D reduction is planned for June 2017 in 4 hospitals followed by development of national policy and guidelines on S&D. Funding support: MoH and GF current grant 2016-2017,GF NFC (2018-2020), UNDP and UNAIDS planned TA |
| 8. Insufficient program monitoring and data management capacity of the program team leading to inefficient data utilization | Technical assistance for strengthening capacity to analyze and utilize data. Funding support: PEPFAR through USCDC and WHO, UNAIDS for AEM and Spectrum training and actual estimations. |
|  | 9. Insufficient attention to reducing the legal and human rights barriers to access to services | 1. Specific measures will be undertaken to address the legal and human rights barriers identified in the 2016 Legal assessment (Annex 44). Funding support: UNAIDS, WHO TA  2. Emphasis will be given on policy advocacy at national and provincial levels to reduce stigma and discrimination against key affected populations. Funding support: MOH  3. Consideration will also be given to the use of patient charter and patient empowerment model in ongoing capacity building and awareness raising efforts. Funding support: UNAIDS, WHO | During grant implementation |
| Procurement and supply management risks | 1. Lack of proper MIS in place which prevents access to hands on information on patient data, treatment regimes. | Routine data validation of the data received in HMIS and face to face coordination meetings at all various service levels will be implemented. Handholding support for IT related challenges by M and E Unit. Funding support: GF FR 2018-2020 ,PEPFAR through USCDC /WHO and through MOH | During grant making and throughout grant implementation |
| Financial Risks | 1. Financial inefficiencies due to lack of monitoring/ capacity of grant manager | Routine capacity building and technical assistance through the grant implementation to ensure proper systems and processes are followed. Funding support: ADB capacity building project for 8 provinces (will end in December 2017), Government fund (2017 part of planning meeting for all 18 provinces) and field monitoring and coaching for 2018 | During grant making and throughout grant implementation |
| Governance and program management risks | 1. Removal of incentives for government staff leading to poor motivation to take additional roles of HIV program. | CHAS will work with all the departments within MOH to sensitize the importance of serving key populations and the urgency of PLHIV care and support. Funding support: MOH | During grant making and throughout grant implementation |

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| SECTION 4: FUNDING LANDSCAPE, CO-FINANCING AND SUSTAINABILITY |
| This section details trends in overall health financing, government commitments to co-financing, and key plans for sustainability.  Refer the Funding Landscape Table(s) and supporting documents as applicable.  To respond, refer to additional guidance provided in the *Instructions.* |

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| 4.1 Funding Landscape and Co-financing | |
| 1. Are there any current and/or planned actions or reforms to increase domestic resources for health as well as to enable greater efficiency and effectiveness of health spending? If yes, provide details below. | ☒ Yes  ☐ No |
| 1. Is this current application requesting Global Fund support for developing a health financing strategy and/or implementing health-financing reforms? If yes, provide a brief description below. | ☐Yes  ☒ No |
| 1. Have previous government commitments for the 2014-16 allocation been realized? If not, provide reasons below. | ☒Yes  ☐No |
| 1. Do current co-financing commitments for the 2017-19 allocation meet minimum requirements to fully access the co-financing incentive, as set forth in the Sustainability, Transition and Co-financing Policy?[[15]](#footnote-14)If not, provide reasons below. | ☒Yes  ☐ No |
| 1. Does this application request Global Fund support for the institutionalization of expenditure tracking mechanisms such as National Health Accounts? If yes or no, specify below how realization of co-financing commitments will be tracked and reported. | ☐Yes  ☒ No |
| (maximum 2 pages) | |

Increasing domestic allocation for HIV has been challenging, given both the low burden of HIV and the low overall proportion of total government expenditure on health (2% of GDP – National Health Account). Increasing domestic financing for the National HIV AIDS response has proven challenging in the Lao context – stigma and prejudice towards HIV reflects socio-political sensitivities that prevail towards the disease and the nature of its transmission in key affected populations. It 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 support from other donors and a major portion of the government contribution is through salaries for health workers, infrastructure and maintenance of health facilities and other running costs. Government contribution for disease specific interventions is limited by availability of resources. See Annex 3 for details on funding landscape.

Other development partners have been providing support and investment in a number of critical areas (Annex 25) for details.

including:

1. WHO/US CDC and prevention provided technical support for Quality Improvement on HTC and ART services

4. European Union (EU) supports French Red Cross in Lao PDR for care and support to PLHIV networks in community levels to reduce stigma discrimination and lost to follow up cases, capacity building for local civil society organizations (CSOs) and research activities in Houanphanh, Vientiane capital and Champassak. The project will end of July 2017.

5. USAID through FHI 360 provides support in implementing the “Linkages” Project for MSM and TG populations in three provinces namely, Vientiane Capital, Savannakhet and Champasak

6. CHAS - US CDC Cooperative Agreement supported financially and technically in improvement care and treatment program especially quality improvement of antiretroviral therapy and HCT for general and MSM in target provinces VTC capital, Savanakhet and Champasak. These programs complement the ongoing GF supported programs.

Based on the five year Health Sector Development Plan (November 2015), the planned needs for the health sector continues to increase. The government is committed to ensure that the needs of the health sector are met despite continued reduction in donor funding. This will require establishment of sustainable financing mechanisms. (See Annex 26)

The government of Laos has approved so far 200,000 US$ for WTP (2016-2017) for renovation of 7 ART and 50 HTC sites. The money is already available and some hospitals have started the work.

In the current funding request the co-financing commitment, includes an additional investment of 20% of the allocation to existing government contribution to the program. This includes staff, infrastructure, condoms, review meetings and capacity building activities. See Annex 28. Through Global Fund support in the current HSS grant (2016-2017) and technical assistance from WHO, the Ministry of Health has been trying to build in-house capacity to institutionalize the National Health Accounts, with the objective to have accurate financial data that include health expenditures by provinces, by disease and by health providers among others. Though Lao PDR needs to be ready to transition to fully sustain the HIV program on its own, given the current scenario, it is unlikely that this is possible. (Annex 27 for the consultation on transition).The government will continue to find ways to continuously increase investments in the HIV program to improve sustainability.

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. The following figure shows the government in-kind contributions:

* 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 in 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.

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.

However, there is a need for 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.

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$ 243,989. 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%) .
* 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.

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| SECTION 5.1: PRIORITIZED ABOVE ALLOCATION REQUEST | | | |
| All applicants are requested to detail a prioritized above allocation request. To respond, refer to guidance in the *Instructions* and fill in the table below. | | | |
| Provide in the table below a prioritized above allocation request which, following the TRP review, could be funded using savings or efficiencies identified during grant-making or put on the register of UQD to be financed should additional resources become available. The above allocation request should include clear rationale and should be aligned with programming of the allocation for maximum impact. In line with the Global Fund’s Strategy to maximize impact and end the epidemics, the prioritized above allocation request should be ambitious (for example, representing at least 30-50 percent of the within allocation amount).  Applicant response in the table below. | | | |
| [HIV]*– Copy table as needed, if your funding request includes more than one component* | | | |
|  | Module | Amount requested  [*Specify US$ or EUR*] | Brief Rationale, including expected outcomes and impact  (how the above allocation request builds on the allocation) |
| 1 | Prevention for SW and their clients | 549.986 | Expansion to other provinces, condom programming |
| 2 | Prevention package for MSM | 251,963 | Expansion to other provinces, condom programming |
| 3 | Treatment, care and Support | 832,386 | Expansion of ART sites to all provinces, capacity building |
| 4 | HSS | 536.494 | Mapping, IBBS, research and program design on PWID, prisoners and other vulnerable populations. Data analysis and M and E strengthening |
| 5 | Program Management | 344,882 | Strengthening of DCCA,PCCA through capacity building, staffing |
| TOTAL AMOUNT | | 2,515,711 |

1. We suggest to compare the new allocation amount with the current spending on a yearly basis, past and/or forecasted. For example using the last year spending multiplied by 3. [↑](#footnote-ref-1)
2. Ministry of Health. National HIV and AIDS Strategy and Action Plan 2016-2020. [↑](#footnote-ref-2)
3. Ministry of Health. Routine report 2015. [↑](#footnote-ref-3)
4. Asian Epidemic Model. 10 March 2017 [↑](#footnote-ref-4)
5. Ibid [↑](#footnote-ref-5)
6. Uhrig, Jamie. 4 April 2016. Review of the CHAS Peer Prevention Program. pg. 1-14 [↑](#footnote-ref-6)
7. 3% of country total men aged 15 to 49 years old has been used as one of the input factors for computation to the Asian Epidemic Model. AEM estimations were also used for computing high risk and reachable MSM groups, which account for 30% of total MSM populations based availability of MSM networks. [↑](#endnote-ref-1)
8. Review of epidemiological data for Key populations, French 5% Initiative, 31st January 2017 [↑](#footnote-ref-7)
9. Ibid [↑](#footnote-ref-8)
10. Parnell B, Ishikawa N, Somkhane C. HIV treatment, care and support: Program review and gap analysis. Vientiane: WHO, 2017. [↑](#footnote-ref-9)
11. WHO and Burnet Institute, HIV Treatment, Care and Support Program Review Gap Analysis, January 2017 [↑](#footnote-ref-10)
12. HIV/AIDS Asia Regional Program (HAARP) Law and Policy Review July 2009,United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific [↑](#footnote-ref-11)
13. Condom need for MSM is 180 condoms a year for 15,600 high risk MSM in 2018 to 16,200 in 2020. [↑](#footnote-ref-12)
14. Condom need for FSW is 144 condoms a year for 13,900 FSW in 2018 to 14,300 in 2020 [↑](#footnote-ref-13)
15. [↑](#footnote-ref-14)