Strengthening Monitoring and Evaluation of HIV and AIDS Components in Road Projects

January 31, 2009

Sustainable Development Department
Transport Unit
South Asia Region
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<tr>
<td>APAC</td>
<td>AIDS Prevention and Control</td>
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<tr>
<td>ART</td>
<td>Anti-retroviral therapy</td>
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<tr>
<td>AITD</td>
<td>Asian Institute of Transport Development</td>
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<tr>
<td>BCC</td>
<td>Behavior Change Communication</td>
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<td>BSS</td>
<td>Behavioral Surveillance Survey</td>
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<tr>
<td>CMIS</td>
<td>Computerized Management Information System</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>FSW</td>
<td>Female Sex Worker</td>
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<tr>
<td>HRG</td>
<td>High Risk Group</td>
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<tr>
<td>IDU</td>
<td>Injecting Drug User</td>
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<tr>
<td>IIHMR</td>
<td>Indian Institute of Health Management Research</td>
</tr>
<tr>
<td>KDLOA</td>
<td>Krishna District Lorry Owners Association</td>
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<tr>
<td>MSW</td>
<td>Male Sex Workers</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have Sex with Men</td>
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<tr>
<td>MDGs</td>
<td>Millennium Development Goals</td>
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<tr>
<td>MHRD</td>
<td>Ministry of Human Resource Development</td>
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<tr>
<td>MW&amp;CD</td>
<td>Ministry of Women and Child Development</td>
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<tr>
<td>MoSJE</td>
<td>Ministry of Social Justice and Empowerment</td>
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<tr>
<td>MTR</td>
<td>Mid-Term Review</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<tr>
<td>MARP</td>
<td>Most-At-Risk Population</td>
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<tr>
<td>NHAI</td>
<td>National Highway Authority of India</td>
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<td>NRRDA</td>
<td>National Rural Roads Development Agency</td>
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<tr>
<td>NACP</td>
<td>National AIDS Control Program</td>
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<td>NACO</td>
<td>National AIDS Control Organization</td>
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<td>NCASC</td>
<td>National Centre for AIDS and STD Control</td>
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<tr>
<td>NGO</td>
<td>Non Governmental Organization</td>
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<tr>
<td>PLHIV</td>
<td>People Living with HIV</td>
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<tr>
<td>POP</td>
<td>Program Operational Plan</td>
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<tr>
<td>PATH</td>
<td>Prevention Along the Highways</td>
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<tr>
<td>PRBDB</td>
<td>Punjab Road and Bridge Development Board</td>
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<tr>
<td>PPTCT</td>
<td>Prevention of Parent to Child Transmission</td>
</tr>
<tr>
<td>R&amp;R</td>
<td>Rehabilitation and Resettlement</td>
</tr>
<tr>
<td>RAP</td>
<td>Rural Access Project</td>
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<tr>
<td>STD/STI</td>
<td>Sexually Transmitted Disease/Infection</td>
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<tr>
<td>SPWD</td>
<td>State Public Works Department</td>
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<tr>
<td>SACS</td>
<td>State AIDS Control Society</td>
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<tr>
<td>SAR</td>
<td>South Asia Region</td>
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<tr>
<td>SIMS</td>
<td>Strategic Information Management Systems</td>
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<tr>
<td>TTL</td>
<td>Task Team Leader</td>
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<tr>
<td>TI</td>
<td>Targeted Intervention</td>
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<tr>
<td>TSU</td>
<td>Technical Support Unit</td>
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<tr>
<td>TCI</td>
<td>Transport Corporation of India</td>
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<tr>
<td>UNGASS</td>
<td>United Nations General Assembly Special Session</td>
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<tr>
<td>VCTC</td>
<td>Voluntary Counseling and Testing Center</td>
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ACKNOWLEDGEMENTS

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The conclusions and recommendations of the Report may not necessarily reflect the views of the World Bank.
FOREWORD

The transport sector has a key role to play in tackling HIV and AIDS in South Asia.

First, transport workers and their sexual partners and spouses are often vulnerable groups at high risk of HIV and AIDS. Several factors explain why transport workers are twice as likely to acquire HIV as workers in low-risk occupations, such as their prolonged absence from home, separated from partners and families, which might increase their likelihood to engage in unsafe sex. Most major roads have frequent rest stops which serve as meeting points between sex workers and their clients, mostly truck drivers and their helpers. The presence of other sexually transmitted infections and poor access to care and treatment increase their vulnerability to HIV infection. In addition, lack of knowledge among migrant workers and long-distance truck drivers, coupled with frequent alcohol consumption, can lead to increased risk taking and unsafe sex.

Second, as transport improves and people move around more freely, this mobility can facilitate HIV transmission. Migration of people as a result of opening up of new access routes may increases the probability of spreading the infection from one high prevalent area to another area with low prevalence but high vulnerability.

Third, the transport industry has a large workforce and reach, providing a unique opportunity in combating HIV and AIDS by disseminating information about HIV prevention and increasing access to preventive services among the most-at-risk populations.

In South Asia, the World Bank is mainstreaming HIV in the transport sector. The multi sector approach to combating the HIV/AIDS epidemic, involves screening all new transport projects under preparation to determine whether an HIV/AIDS prevention component could be mainstreamed into the project design and providing seed money to clients for HIV prevention. Increasingly, this involves working with the relevant National and State AIDS Control Programs during project preparation

This report aims to strengthen the monitoring and evaluation (M&E) aspects of HIV/AIDS components in road projects. Result-based M&E helps decision makers assess whether and how goals are being achieved over time, while at the same time identify problems that need to be tackled. The report assesses the extent of M&E in current HIV AIDS components in the portfolio of road projects financed by the World Bank. It provides an overview of work to date to identify core indicators for measuring results of HIV and AIDS prevention, specifically focusing on the monitoring of results of transport related activities, proposing a menu of HIV and AIDS indicators and a sample results framework.

We hope that this report will contribute to the development of quality M&E as an integral part of HIV and AIDS components of road projects in the countries in the South Asia Region and elsewhere.

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Sustainable Development Network
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1. INTRODUCTION

1.1 Transport, Migration and Vulnerability to HIV

1. Evidence suggests that the countries in the South Asia Region (SAR) are currently experiencing concentrated HIV epidemics, except in parts of India and Nepal where there are generalized epidemics. In India, the HIV prevalence varies between and within states, ranging from areas with high prevalence to areas that are experiencing low prevalence but high vulnerability. As in other parts of the world, HIV has tended to move along the highways. Men and women working along the road sides, with trucking companies, road construction companies and a variety of service industries, tend to be at an increased risk for HIV infection.

2. High risk practices tend to be common along the roadways. Epidemics in SAR are characterized by elevated rates of HIV in vulnerable groups that are at high risk of HIV infection: for example, female and male sex workers and their clients, injecting drug users and their partners, and men who have sex with men. Within each of these most-at-risk populations (MARPS), HIV is transmitted rapidly by unsafe sex and injecting drug use, with exchange of dirty needles. Truck and bus terminals, rest stops and roadside eateries along transport routes are meeting points for sex workers and their clients, mostly truckers and their assistants or aides. In Terai (Nepal), 70 percent of clients of sex workers are truckers. From various surveys in the same region, the number of truckers that have visited sex workers ranges from 25 percent to 80 percent. This behavior increases the risk of spreading sexually-transmitted infections. Other groups at risk are roadside eatery workers, mechanics, filling station employees and lodge owners, as well as their sexual partners or spouses.

3. In the fight against HIV AIDS, these groups are important to focus on and work with because they are likely to experience higher rates of HIV infection and to pass it on; for example, transport sector workers might bring HIV infection home to their wives and other sexual partners. In Western Nepal, a large number of new infections are now occurring among women in remote villages whose husbands migrate for employment as road construction workers to India.

4. However it is not merely being a mobile worker that puts an individual at risk of HIV, rather it is the behaviors that are associated with mobile work and long periods away from family. For example, throughout the South Asia region as in other parts of the world, truckers and other workers along the highways have been shown to have higher numbers of concurrent sexual partners than those who do not migrate for work, including sex workers.

5. The behaviors and associated risks are not the same for all transport sector workers. For example, a road laborer in a rural area may not be exposed to the selling and buying of sex or injecting drug use and thus may not be at increased risk of acquiring HIV. A road laborer with a long-term engagement in the construction of an expressway may experience increased exposure
to the sex trade, while workers engaged in the short-term construction of secondary and rural roads may not.

6. The heroin trade also moves along the highways in parts of the region, and injecting drug users can cluster along the highways. For example, evidence from the Punjab State AIDS Control Society suggests cases of HIV clusters among injecting drug users along the Trunk Road. Mobile workers, for example truck drivers, may be tempted to engage in substance abuse (alcohol and/or drug use including injecting drug use) that increases their vulnerability to HIV.

7. Finally, although male-to-male sex is poorly understood in the South Asia region as a whole, it is reported to occur among men living and working away from home for long periods of time, for example, between long distance truck drivers and their assistants. Although conservative cultural norms in the region obfuscate these behaviors, the presence of unprotected sex between men is likely to contribute to the spread of HIV.

1.2 Summary Status of the HIV/AIDS epidemic in South Asia

Overview of HIV/AIDS in South Asia

8. Statistic shows that between 2 and 3.5 million people in South Asia are living with HIV and AIDS. High risk practices, such as sex work and injecting drug use, drive the epidemic in the region. HIV prevalence among vulnerable and often marginalized groups is high throughout the region and rapidly increasing in some places.

9. In India alone approximately 2.5 million are estimated to be living with HIV. In other countries in the region, such as Bangladesh, Nepal, Pakistan, and Sri Lanka, HIV prevalence is low among the general population but significantly higher among those who engage in high-risk behaviors, such as injecting drugs with contaminated needles and engaging in transactional sex.

10. Significant structural and socioeconomic factors across the region put many people at risk of HIV infection:

- Commercial sex and casual sex with non-regular partners
- High rates of injecting drug use in northeastern states of India/Bangladesh border
- More than 35% of the population living below the poverty line
- Low levels of literacy
- Porous borders
- Rural-to-urban and intrastate migration of male populations
- Trafficking of women and girls into prostitution
- Stigma related to sex and HIV
- Male resistance to condom use
- High prevalence of sexually transmitted infections (STIs)
- Low status of women, leading to an inability to negotiate safe sex.

11. The State of the Epidemic by country in South Asia is discussed in the review of the World Bank portfolio of transport projects in Chapter 2. Table 1 provides a summary of HIV (UNAIDS 2006)
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Year</th>
<th>Afghanistan</th>
<th>Bangladesh</th>
<th>Bhutan</th>
<th>India</th>
<th>Nepal</th>
<th>Pakistan</th>
<th>Sri Lanka</th>
<th>Source</th>
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<tr>
<td>Adults and children living with HIV/AIDS (I-1)</td>
<td>2005</td>
<td>&lt;1000</td>
<td>11,000</td>
<td>&lt;500</td>
<td>245000</td>
<td>75,000</td>
<td>85,000</td>
<td>5,000</td>
<td>UNAIDS, 2006</td>
</tr>
<tr>
<td>Adults (ages 15+) living with HIV/AIDS</td>
<td>2005</td>
<td>&lt;1000</td>
<td>11,000</td>
<td>&lt;500</td>
<td>245000</td>
<td>74,000</td>
<td>84,000</td>
<td>5,000</td>
<td>UNAIDS, 2006</td>
</tr>
<tr>
<td>Adults and children AIDS related deaths (I-1)</td>
<td>2005</td>
<td>&lt;100</td>
<td>&lt;500</td>
<td>&lt;100</td>
<td>nd (1)</td>
<td>5,100</td>
<td>3,000</td>
<td>&lt;500</td>
<td>UNAIDS, 2006</td>
</tr>
<tr>
<td>Adults and children newly infected with HIV</td>
<td>2006</td>
<td>nd</td>
<td>nd</td>
<td>nd</td>
<td>nd</td>
<td>nd</td>
<td>Nd</td>
<td>nd</td>
<td>UNAIDS, 2006</td>
</tr>
<tr>
<td>Adult (ages 15-49) HIV prevalence (I-1) (%)</td>
<td>2005</td>
<td>&lt;0.1</td>
<td>&lt;0.1</td>
<td>&lt;0.1</td>
<td>0.38</td>
<td>0.5</td>
<td>0.1</td>
<td>&lt;0.1</td>
<td>UNAIDS, 2006</td>
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nd = No data

Table adapted from HIV In Site, a project of the UCSF Center for HIV Information, Copyright 2007, Regents of the University of California


### 1.4 Necessity to mainstream HIV into Transport Sector

**Rationale for Mainstreaming HIV/AIDS in Infrastructure**

12. HIV/AIDS programs for the transport sector are crucial to prevent the spread of the disease in South Asia. They offer an important opportunity for providing prevention education and services to individuals whose behavior could put them at special risk of HIV. Evidence from the region (Sentinel Surveillance, Behavior Surveillance among high risk groups and highway community) suggests transport sector workers are twice as likely to become infected with HIV as workers in ‘low-risk’ occupations, and that they as a result may be more likely to spread HIV to their wives and other sexual partners.

13. The transport sector needs to take responsibility for preventing the spread of HIV/AIDS in the sector in partnership and coordination with existing health initiatives. Efforts made to prevent HIV should not be confined to the health sector but need to be undertaken by the transport sector itself to ensure ownership, efficiency and sustainability of the program. The multiplier effect of such programs is significant. The World Bank is aware of this and as a result, has initiated appropriate steps for mainstreaming HIV/AIDS awareness interventions in the projects that it finances in the transport sector.

**The impact of HIV/AIDS on the transport and infrastructure sector:**

14. As HIV at present is still at manageable levels in most of the region, now is the moment
to make every effort to keep it from growing. If unchecked, the HIV/AIDS epidemic will impede the transport sector from achieving its development objectives, through an increase in morbidity and mortality. The impacts seen in high prevalence countries include:

- **Reduced productivity due to AIDS-related illness** (up to 6-8 percent reduction in profits has been seen in generalized epidemics). Where prevalence rates are high and access to treatment is limited, it is possible that the transport sector experience a drop in productivity due to ill health as the disease progresses. This occurs as a cumulative result of frequent employee turnover due to increased illness and death from AIDS. There is also the risk of attrition of skills and expertise.

- **Increased costs of workers’ benefits and health expenses**. In order to avert losses from reduction in productivity, employers can find themselves faced with increasing health care costs for affected employees, a pattern seen in countries with mature epidemics. With increasing global advocacy for treatment, the need for more expensive health care benefits which provide coverage for treating AIDS-related illnesses and for anti-retroviral therapy (ART) will increase.

- **Increased costs of training and hiring replacements for workers lost to the disease**.

15. It should be noted that although the impact of HIV on economic growth in the South Asia region is small and is likely to remain very small, the epidemic has a disproportionate impact on key population groups, as discussed here, and frequently results in and exacerbates poverty as shown by estimates of the economic impact on households. Access to health services in the countries of the region is uneven, and access to treatment is very low at present. The medical costs of HIV infection alone will put a substantial proportion of the population at risk of poverty. The limited ability of many, including the transport workforce to pay “catastrophic” health expenses associated with treatment is a real concern.

**The impact of the transport and infrastructure sector on the HIV/AIDS epidemic:**

15. The transport industry has a unique opportunity to play a key role in combating HIV/AIDS by:

- Targeting and working with high-risk groups such as truck drivers, mobile workers and sex workers with behavioral change interventions (including condom use and peer education). This is one of the high impact interventions for preventing the spread of HIV in low prevalence areas with concentrated epidemics.

- Disseminating information about HIV prevention. For example, passengers of transport modes are a captive audience, irrespective of the mode of transportation (rail, road, etc), and information and educational messages can be directed at them.

1.5 **South Asia best Practice: An Encouraging Trend in Tamil Nadu**

16. Tamil Nadu’s high profile prevention efforts have reduced unprotected commercial sex in the state. In 1996, 45% of truck drivers and their staff reported buying unprotected sex. By 2003 this declined to 22% resulting from an increase condom use by both truck drivers and staff.
1.6 World Bank Efforts in Mainstreaming HIV/AIDS prevention programs in road projects

17. The World Bank through its transport unit in the South Asia region is strongly committed to mainstreaming HIV/AIDS interventions programs in its road projects. Currently there are twenty one transport projects in the South Asia region and HIV/AIDS activities are being carried out in eleven projects under execution and included in the plans for five projects under preparation.

18. The World Bank recognizes that the unintended consequences of increased accessibility in previously-isolated communities as well as mobility of workers due to road construction can potentially increase the risk of HIV. The road projects financed by the World Bank in the region are rapidly expanding peoples’ access to roads in rural and some urban areas. Major projects in India are extending primary and secondary roads, including efforts to reach many small rural communities without prior access to them. These projects as well as similar ones in Nepal, Bhutan, Bangladesh and Sri Lanka are simultaneously bringing in thousands of transport sector workers and laborers to build or upgrade roads.

19. In order to be responsive to this situation World Bank projects have begun to fund some HIV/AIDS intervention activities targeted at road construction workers. A standard clause included in some “but not all” civil works contracts requires that the:

"Contractor shall conduct an HIV-AIDS awareness programme via an approved service provider, and shall undertake such other measures as specified in the Contract to reduce the risk of the transfer of the HIV virus between and among the Contractor’s Personnel and the local community, to promote early diagnosis and to assist affected individuals".

Also, projects are required to engage in some educational activities to limit the spread of HIV in communities along the highways that are under construction.

20. As with the other activities it funds in the transport sector, the World Bank intends to monitor the implementation (outputs) and results (outcomes) of the HIV prevention and
awareness-raising activities undertaken by its contractors. Because these programs are currently in their earliest stages of development and implementation, the time is right to recommend standard methodologies and measures to be used in monitoring the conduct of these activities and, where possible, link them to result matrices.

1.7 The Objective of this Study

The objective of this study is to review the status of HIV/AIDS components in road projects and to propose a monitoring and evaluation (M&E) framework to strengthen the monitoring and evaluation aspects of these components in transport projects.
2. REVIEW OF PORTFOLIO OF COUNTRY PROJECTS

2.1 Afghanistan

_HIV/AIDS Country profile_

30. Reliable data on HIV prevalence in Afghanistan is sparse. To date, 245 HIV cases have been reported. However, UNAIDS and WHO estimate that there could be between 1,000 and 2,000 Afghans living with HIV. The HIV epidemic is at an early stage in Afghanistan, and is concentrated among high risk groups, mainly injecting drug users (IDUs) and their partners. Afghanistan’s emerging epidemic likely hinges on a combination of injecting drug use and unsafe paid sex.

31. The Ministry of Public Health has developed a national strategic plan (2006-2010), with goals to maintain low HIV prevalence (less than 0.5 percent) and to reduce the mortality and morbidity associated with HIV/AIDS. This strategic framework has been translated into a Program Operational Plan (POP), financed in part by the World Bank.

32. The development objectives of the Bank supported national HIV and AIDS Prevention Project is to prevent the spread of HIV and to build the national capacity to respond to the epidemic by i) changing behavior among vulnerable high risk groups, and ii) improving knowledge of HIV prevention and reducing stigma related to HIV/AIDS in the general population. Truckers and their staff are among the groups targeted by the project. Currently, the

33. **Status of HIV intervention programs in WB road projects**

33. Transport sector of the Bank has not carried out any intervention programs in its projects and is exploring the ways to scale up intervention activities based on lessons learned from the National Prevention Project.

2.2 Bhutan

_HIV/AIDS Country profile_

34. HIV prevalence in the general population is less than 1 percent. Although low prevalence, there is high vulnerability among population groups at high risk. A goal of the country’s National Strategic Plan for HIV/AIDS and Sexually Transmitted Infections is to “Integrate STI and HIV prevention into the core activities of multi-sectoral partners”. The National AIDS Control Program and partners from multiple sectors have been asked to contribute to the national response to HIV/AIDS, in addition to concentrating on other development goals.

35. The National AIDS Control Program with support from the World Bank is implementing
a major HIV/AIDS and STI Prevention and Control Project (Grant H103 of 4 million SDR, the equivalent of US$5.77 million) with the goal of reducing the risk of HIV and STI transmission in Bhutan. The grant supports multi-sectoral collaboration, including proposed HIV/AIDS surveillance and prevention activities in the transit sector. In this respect, collaboration between the Ministries of Health and Transport will be key to curb the spread of HIV/AIDS along roadways as they undergo major programs of construction and maintenance.

36. Bhutan has not yet defined its most at risk populations. The best evidence on the state of the HIV/AIDS epidemic in Bhutan comes from two sources, annual sentinel surveillance data from 2006 and the cumulative cases of HIV that have been reported since the start of the epidemic (first known case reported in 1998). Existing evidence suggests that cases are broadly spread across society.

Status of HIV intervention programs in WB road projects

37. Arrangements are being made to execute HIV prevention activities designed to mitigate the impact of the Rural Access Project II (RAP II) (Project ID P107818). Discussions are underway between administrators of the project, which has recently begun (April 23, 2007), and the HIV/AIDS and STI Prevention and Control Project funded by the World Bank. The Government has determined that all HIV/AIDS activities related to RAP II will be executed by the National AIDS Control Program under the World Bank funded HIV/AIDS project in the Ministry of Health. RAP II has agreed to collaborate closely with this project, rather than implement its own program of activities.

38. Activities being discussed include awareness campaigns aimed at changing behavior to complement the distribution of condoms already undertaken by the focal point for HIV/AIDS in place in the Ministry of Works and Human Services. The objective is to include the standard clause on HIV/AIDS in World Bank-funded civil works contracts.

2.3 Nepal

HIV/AIDS Country profile

39. Since the detection of the first case of HIV in Nepal in 1988, the country has progressed from a low prevalence country to one with concentrated epidemics. UNAIDS estimates that there are about 75,000 adults infected with HIV in Nepal; many of Nepal’s AIDS cases occur among young adults between the ages of 20 and 34. If prevalence continues to increase at the current rate, AIDS could become the leading cause of death in Nepal by 2010.

40. The HIV epidemic is characterized by high prevalence among sub-groups whose sexual or drug use behavior places them at risk of HIV, including injecting drug use and sex work. Among the most at risk groups are female sex workers and their clients, men who have unprotected sex with men and returning migrants. These sub-groups have prevalence levels that are higher than the rest of general population.

41. Nepal’s National Centre for AIDS and STD Control (NCASC) is charged with implementing Nepal’s AIDS strategy, which focuses on achieving improved HIV prevention, treatment, care, and support for at-risk populations, as well as counseling and testing, to stem the spread of HIV in the general population and to reduce transmission in most-at-risk populations.
Status of HIV intervention activities in WB road projects

42. With funding from the World Bank and other sources, the Government of Nepal is expanding the development of its road network throughout the country. Progress in this sector has continued despite a recent history of civil and social unrest that has affected rural and, increasingly, urban regions in the country. The World Bank is currently engaged in a couple of lending projects in Nepal, including the Road Sector Development Project (Project ID P095977) and Rural Access additional funds (Project ID P107853).

43. The Road Sector Development Project is being implemented in the Mid-West and Far-West Development Regions, more specifically within the districts of Baitadi, Darchula, Bhajang, Kalikot and Dailekh. These areas are experiencing an increase in HIV prevalence with sizeable proportion of cases occurring among women in the hills infected by labor migrant husbands. These areas have also experienced considerable social unrest during the recent conflict.

44. The Road Sector Development Project Appraisal Document includes the following paragraph calling for HIV/AIDS prevention activities to be conducted during the course of the project:

“For the first time in Nepal, a Bank project in the sector is to include HIV/AIDS awareness activities. The project will support HIV/AIDS prevention through awareness and education. The Department of Roads (DOR) will recruit NGOs with track records of working in HIV/AIDS awareness and education areas in the respective districts. The selected NGOs will follow the national guidelines prepared by the National AIDS and Sexually Transmitted Infections Centre (NCASC) for the targeted activities including periodic screening for STIs. NGOs will work closely with local public health centers and district health offices to deliver their services to construction workers, tea shop owners and transport workers throughout the construction periods.”

45. The Road Sector Development Project is in its earliest phase and the HIV/AIDS activities are yet to be implemented. The project includes within its Institutional Support component about $200,000 worth of HIV/AIDS activities.

2.4 Sri Lanka

HIV/AIDS Country Profile

46. HIV prevalence has remained below 1 percent in Sri Lanka even among the most at risk groups. The UN estimates that, as of December 2006, there were 3,000-5,000 people living with HIV in Sri Lanka. The HIV prevalence in the general population is less than 0.1 percent.

47. The National HIV/AIDS strategic plan provides direction and leadership for the national HIV/AIDS response during the 2007-2011 period. The program is coordinated by the National STD/AIDS Control Program.

48. Despite its low HIV prevalence, there are concerns because of the presence of risk and vulnerability factors.

- Low Condom Use: although research on sexual behavior has been limited, a few studies conducted suggest low condom use among men.
• Commercial Sex: it is estimated that there are between 30,000 and 50,000 female sex workers in Sri Lanka. In addition, there are networks of men who have sex with men, who have multiple partners including paying clients. Preliminary findings from the 2006 BSS suggest that STIs among female sex workers are relatively low, they see few clients per day and there is reasonable condom use. Women and children engaged in sex work are considered most vulnerable to HIV infection because they often lack the ability or power to negotiate condom use with clients or to seek STI treatment. They are often "hidden," making it a challenge for HIV prevention services to reach them.

• Sexually Transmitted Infections: every year, estimates of detected STI cases in Sri Lanka range from about 60,000 to 200,000, of which only 10 to 15 percent are reported by government clinics. STIs facilitate the spread of HIV infection and their presence is indicative of low condom use and other high-risk sexual behaviors.

• High Mobility: migration within Sri Lanka and emigration to the Middle East and neighboring countries is necessary for the economic survival of many households in both rural and urban areas. Thousands of women and men live away from their families as migrants abroad. Being removed from traditional social structures such as family and friends has been shown to foster unsafe sexual practices, such as having multiple sexual partners and engaging in casual and commercial sex, as well as to increase the vulnerability of women and girls with regards to sexual abuse. An estimated 1.2 million Sri Lankans work in the Middle East and 79.1 percent of unskilled migrants are women.

• Injecting Drug Use (IDU): according to UNAIDS, Sri Lanka has a high number of heroin users and, although few of them currently inject drugs, if there were a substantial change in drug-use patterns to more injecting drug use, this would result in the increase in the number of people who are likely to be exposed to HIV. In addition, drug users often experience difficulty in accessing information and services for both HIV prevention and treatment.

• Low Levels of Awareness among Poor People: HIV awareness and knowledge levels in underserved communities remain drastically low. Only 40 percent of women working in rural tea estates, for example, have even heard of HIV/AIDS, as compared to 90 percent of women in other rural and urban areas.

Status of HIV intervention activities in WB road projects

49. Road Sector Assistance Projects (RSAP, Project ID P086411) was approved on December 15, 2005 and is currently being implemented by the Road Development Authority (RDA). RSAP consists of 13 packages of road works. Implementation started in March 2006 and construction activities under all 13 packages are expected to be completed by late 2008 or mid-2009.

50. The standard contract clause on HIV/AIDS is included in all packages. The consultant supervising works execution has initiated activities related to conceptualization and operation of the HIV/AIDS program under the project. Because of a number of considerations such as the low prevalence, it was not considered efficient to have a stand-alone prevention program for HIV. Therefore, HIV/AIDS activities were included as part of the Health and Safety Awareness, Training and Surveillance Program in the project. The program is being piloted in one package and will be refined and scaled up to other packages as well. It has been suggested to add IEC and condom distribution.
2.5 India

HIV/AIDS Country Profile

51. The HIV epidemic has been evolving in the country since the first case was detected in Tamil Nadu in 1986. The Government of India estimates that in 2006, about 2.45 million Indians were living with HIV (within the range of 1.75 - 3.15 million) with an adult prevalence rate of 0.41%. India’s highly heterogeneous epidemic is largely concentrated in six states: in the industrialized south and west, and in the north-eastern tip. On average, HIV prevalence in those states is 4-5 times higher than in the other Indian states. HIV prevalence is highest in the Mumbai-Karnataka corridor, the Nagpur area of Maharashtra, the Namakkal district of Tamil Nadu, coastal Andhra Pradesh, and parts of Manipur and Nagaland. These estimates indicate that there has been no dramatic upsurge in the spread of HIV infection across the country since 1998. The number of HIV infected population has been revised in 2007 at 2.8 to 3.2 million, due to adjustments made for the proportion of high risk population and estimates as obtained through population based surveys, (National Family Health Survey III, 2006). However, state specific variations in the profile of the epidemic have been observed. Several states in southern India and the north-eastern part of the country have shown higher HIV prevalence and multiple routes of HIV transmission between and within states. Some positive trends have been found in South India, such as the reduction in HIV prevalence among women. The low HIV-prevalence states are also characterized by the presence of some high risk pockets. The HIV infection burden seen during the 80’s and 90’s has resulted in an increase in the number of AIDS patients with medical, economic and social implications.

The AIDS Prevention and Control Project (APAC) has been working among the truck drivers and helpers along the major national and state highways in Tamil Nadu since 1997. It is being implemented by 11 partners under the theme Prevention Along the Highways (PATH). This project has achieved the following behavioral changes:

- Knowledge on prevention of STDs/HIV has increased to 99% as compared to the initial years at 20-25%.
- Knowledge without any misconception has increased from a low 8% in 1996 to 46% in 2006.
- Involvement in non-repeat sex partners has declined from 48% in 1996 to 34% in 2006; involvement in paid sex has declined from 38% in 1996 to 29% in 2006; involvement in casual sex has also declined from 16.4 to 12.1%.
- Condom usage in non-regular sex has increased from 55% in 1996 to nearly 91% in 2006; condom usage in paid sex has also exhibited an increasing trend from 48.2% in 1996 to 80.1% in 2006; condom usage in casual sex has increased from 18.6% in 1996 to 38% in 2006.
- Risk perception among truck drivers and helpers with respect to HIV has increased from 35.7% to 83.3%.

52. Heterogeneity of the HIV epidemic. The epidemic in India is very heterogeneous with diverse modes of infection, and has clustered in southern and western states, including Tamil Nadu, Karnataka, Andhra Pradesh, Maharashtra and two North Eastern states, Nagaland and Manipur. Even within the states, there is remarkable variability in HIV prevalence between districts and within districts as evidenced by data from Voluntary Counseling and Testing Centers (VCTCs). HIV sentinel surveillance in 2005 has shown that HIV prevalence was >1% among antenatal mothers in 95 districts, including 9 districts in the low prevalence states. Similarly, HIV
prevalence was >10% in 34 STI sites across the country, indicating multiple heterogeneous epidemics.

53. **Routes of Transmission.** Information from AIDS case reporting indicates that the primary means of transmission in most parts of the country remains unsafe sex (86%). The other routes are through blood products, injecting drug use and prenatal transmission. Injecting drug use is the predominant route of transmission in the North Eastern states of India.

54. **Increasing feminization of the Indian epidemic.** In the general population, women and young people are becoming increasingly more vulnerable to infection. In many states more and more women are getting infected by their husbands and, as a result, there is a growing feminization of the epidemic. According to the 2005 sentinel surveillance findings, 38.4% of HIV infected persons in the country are women. The female - male ratio of infected people has shifted from 55 per 100 males in 2001 to 60 per 100 males in 2005.

55. **Urban rural distribution.** Initially, the HIV epidemic was predominantly urban and high-risk group based. Of late, there has been disturbing evidence of spread to the general population, particularly to rural areas, where 72% of the country’s population lives.

56. **Knowledge and behavior.** In 2001, a nationwide Behavioral Surveillance Survey (BSS) was conducted to provide baseline information on risky behavior patterns in the country, both for the general population and high-risk groups like female sex workers and their clients, men who have sex with men (MSM) and injecting drug users (IDUs). The BSS revealed variations in knowledge of HIV/AIDS between different states and between rural and urban populations. While 76.1% of the Indian population had heard of HIV/AIDS, the figure was 93.2% for urban males and 65.2% for rural women. The values ranged from 99.5% for urban males in Kerala to 21.5% for rural females in Bihar. Only 46.8% of the respondents were aware of the two important methods of transmission prevention i.e. consistent condom use and sex with uninfected partner. These responses however, masked regional and gender based variations. For example, the lowest awareness rates were recorded among rural women in Gujarat, Bihar and UP (21.5% - 27.6%). The BSS survey indicated that 50% of the people at the national level used condoms with non-regular sex partners. This figure varies considerably between different geographical regions and states of India.

57. **Prevalence of Sexually Transmitted Infections (STIs) in the country.** STI prevalence is a good surrogate marker for HIV as they share common modes of transmission and the presence of STI multiplies the probability of exposure to HIV infection. Over 5% of the adult population in India suffers from STIs and most regions of the country show relatively high levels of STIs. HIV prevalence rates among STI patients also remains high: 22.8% in Andhra Pradesh, 15.2% in Maharashtra, 12.2% in Manipur and 7.47% in Delhi. Among women, 14% of those attending STI clinics were found to be HIV positive in some states.

58. The community-based prevalence study conducted by NACO substantiated the findings of regional studies undertaken in some southern states of India. Vulnerability to HIV of rural and urban population is evident from the community-level data collected in this study.

59. **Risk and vulnerability to HIV infection.** The risk of and vulnerability to HIV infection differs between sub-population. Sex workers, IDUs, MSM, including transgender sub-populations, are at highest risk. However, these groups are not isolated communities but often intersect. For instance, many drug users are also sellers and buyers of sex. Men who have sex with men may also be married and have sexual relations with spouses and sometimes with female
High Risk Groups (HRGs) in India. Most of the states in India are experiencing a concentrated HIV epidemic, focused on sub-populations relatively more at risk of acquiring HIV due to their occupation (ex workers), sexual preferences (men who have sex with men) or recreational patterns (injecting drug users). In 2005, the prevalence of HIV in HRGs showed relatively high levels (sex workers: Maharashtra 23.62%, Karnataka 18.39%, Andhra Pradesh 12.97%; MSM: Delhi 20.4%, Karnataka 11.6%, Gujarat 10.67%; IDUs: Manipur 24.10%, Delhi 22.80, Tamil Nadu 18%, Tripura 10.9%). An expert group carried out size estimations of the core groups at risk in 2006, using secondary data analysis. The future of India’s HIV epidemic will depend on the scope and effectiveness of programs for these groups.

The third National AIDS Control Program (NACP III). The overall goal of NACP III is to reverse the trend of the epidemic in India over the next 5 years by integrating programmes for prevention, care, support and treatment. This will be achieved through four strategic objectives:

- Preventing new infections in high risk groups and general population through:
  - Saturation of coverage of high risk groups with targeted interventions (TIs)
  - Scaled up interventions in the general population
- Increasing the proportion of people living with HIV/AIDS who receive care, support and treatment.
- Strengthening the infrastructure, systems and human resources for prevention, care, support and treatment programmes at the district, state and national levels.
- Strengthening the national Strategic Information Management System (SIMS).

The specific objective of NACP III is to reduce new infections as estimated in year one (1) of the program by:

- Sixty percent (60%) in high prevalence states so as to obtain the reversal of the epidemic; and
- Forty percent (40%) in the vulnerable states so as to stabilize the epidemic.

The significant features of the NACP-III program implementation plan are as follows:

- The goal, objectives and strategies have been informed by a set of guiding principles that include the Three Ones, equity, legal, ethical and human rights, PLHA and civil society participation, etc. The programme priorities include integration of prevention with care, support and treatment. HRGs, and among them MSM and IDUs, would receive priority attention. Gender and age-specific strategies will be followed to address specific needs of women, youth and adolescents, migrants and mobile populations. National, state and district plans will be evidence-based and subjected to sound monitoring and evaluation (M&E) mechanism. Service delivery will be improved and scaled up. Capacities will be strengthened at all levels. Mainstreaming and partnerships will be a key approach to facilitate a multi-sectoral response engaging a wide range of stakeholders including the private sector, civil society, PLHIV networks and line ministries.
- The programme strategies of NACP III include preventive interventions for HRGs (TI) and other vulnerable populations e.g. truckers, migrants, prison inmates, youth/adolescents, vulnerable children and sexually active women and men. 2,100 targeted intervention sites are planned to cover 80% of HRGs through STI services, condoms, Behavioral Change Communication (BCC) and an enabling environment. The
programme envisages covering 95% of young people by 2011 through collaboration with the ministries of Youth Affairs, Human Resource Development (HRD), Women and Child Development (W&CD) and Ministry of Social Justice and Empowerment (MSJE), among others, volunteer networks and youth friendly information centers. A package of services is proposed for the high-risk groups and other vulnerable populations. This will include a range of preventive services that includes treatment of STIs, condom promotion, integrated counseling and testing, prevention of parent to child transmission (PPTCT), supply of safe blood and infection control.

- The existing Computerized Management Information System (CMIS) will be revamped to address gaps and support decentralization at the district level. A Strategic Information Management System (SIMS) unit will be set up at national and state levels to address issues relating to planning, monitoring, evaluation, surveillance and research. The proposed surveillance system will focus on tracking the epidemic, identifying pockets of infection and estimating the burden of infection. Two types of Behavioral Surveillance Surveys (BSS) will be conducted: (a) for annual risk assessment at the district level and (b) for risk assessment at the national/state level once in every three years. A Multi-disciplinary Advisory Committee will be constituted to implement and guide the research agenda to be monitored by the research division at NACO. Regional centers of excellence will be identified to provide the needed technical support while Technical Support Units (TSUs) will be expanded to cover all the states.

Evidences of risk in transport sector

64. The national BSS from 1999 indicates high-risk sexual contacts during transit (87%) and poor condom usage (11%) among truckers, making them vulnerable to STIs, including HIV/AIDS. Surveillance studies indicate that the prevalence of HIV among truckers in general may be more than 10 times higher than in the general population (7.4% among truckers as compared to 0.7% in the general population). Given an estimated HIV prevalence of 11.16% among long-distance truckers in India, there could be an estimated 0.6-0.7 million HIV positive truckers based on 2005 figures.

65. India has about 3.3 million km of roads network, making it one of the largest networks in the world. This figure includes National expressways, National Highways, State highways, and major district roads and rural roads. It is estimated that 65% to 70% of the nation’s cargo handling is done by road, with the remaining 35% by rail. National Highways are the prime arterial route, covering about 65,559 km. Although National Highways constitute only 2% of the total road network, they bear approximately 40% of the total traffic.

66. The Asian Institute of Transport Development (AITD) gives a figure of around 5 million truck drivers in India. This estimate is based on the assumption that there are about 2.5 million trucks in the country and that each truck has two drivers. Similarly, a study by the Indian Institute of Health Management Research quotes a figure of about 5-6 million truckers (i.e. truck drivers and other crew members) in India. Among them, about 40% to 50% (or about 2-2.5 million) ply on long-distance routes. Given the rise in the number of trucks operated for goods transportation, the total number of truck drivers in the country is expected to double in the next ten years.

67. Long-distance truck drivers and their helpers spend months on the road and thus are away from their family members for extended periods of time. These truckers are more likely to engage in high-risk sexual behavior than short-distance truckers. They may have multiple sexual partners, including male partners and female sex workers (FSWs) along the highways, or have other fixed partners en route or at places where they stop for rest or food. Reportedly, close to
36%\(^1\) of truckers are clients of sex workers and 15-20%\(^2\) of sex workers’ clients appear to be truckers. Therefore, truckers represent a key “sub-segment” of the total male client population of sex workers. This explains higher prevalence of sexually transmitted infections among truckers than among the general population. Truckers in turn risk transmitting HIV from areas of higher prevalence to those of lower prevalence but high risk.

**Status of HIV intervention activities in WB road projects**

68. The road projects in India are implemented by three types of agencies:
   - National Highway Authority of India (NHAI)
   - State Public Works Departments (SPWD)
   - National Rural Roads Development Agency (NRRDA)

69. NHAI programs. NHAI is an autonomous body under the Ministry of Shipping, Highways and Surface Transport. This organization is vested with the responsibility of construction and maintenance of highways that pass through long stretches across the different states providing a corridor of connectivity to the nation.

70. NHAI is currently engaged in construction of the Lucknow-Muzzafarpur highway and on this stretch has commenced implementation of an HIV prevention intervention. This corridor is sliced into four sections of the 150-kilometer corridor. The implementation of HIV/AIDS activities is being carried out by four non governmental organizations that have been selected through a competitive selection process.

71. The NGOs typically implement the following activities:
   - Behavior Change Communication (BCC) covering both the mobile and static populations along the corridor
   - Referral for STI services
   - Condom promotion
   - Referral for counseling and testing

72. The structure of the project implementation team at the NGO level is as follows: Project Coordinator; Field Coordinator; and, Outreach workers (5-6)

73. Other services such as STI Counseling and Testing are provided through linkage with the facilities available in the public health system or set up by the National AIDS Control Program. Implementation of the interventions is based on an approved implementation plan submitted by the NGOs after signing the contract.

74. The interventions by NGOs are overseen by an experienced consultant located within the project office of NHAI at Lucknow. The NGOs submit progress reports covering their activities every quarter. These reports are reviewed by the consultant and feedback is provided. At NHAI a very senior official at the level of General Manager has been assigned the responsibility to

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\(^{1}\)Healthy Highways Behavior Surveillance Survey, First Round, 2000

\(^{2}\) National Behaviors Surveillance Surveys among Clients of Sex workers
coordinate and oversee the implementation of the HIV/AIDS interventions. The organization is putting in place a coordination unit at its headquarters in Delhi to manage the programme. This unit will have staff with experience in HIV and control project management. In a similar project that involves construction of a highway between Agra and Bhandur, the NHAI is following a similar model of implementation of HIV/AIDS prevention activities through NGOs. The selection of NGOs is at an advanced stage and they are expected to be on board soon. A total of 8 NGOs are expected to be working along this corridor.

75. The following are the lessons learned from NGOs implementing HIV and AIDS programs for NHAI:

- Many of the NGOs which have been selected have just Rehabilitation and Resettlement (R&R) background and, thus do not have experience in implementing HIV prevention interventions.
- The existing experience of the NGOs in social mobilization needs to be leveraged to help mobilize the community along the corridors for prevention of HIV.
- The capacity of the implementing NGOs needs to be strengthened so that they may plan and deliver effectively HIV AIDS activities.
- The implementation plans prepared by the NGOs are not based on any needs assessment carried out in the intervention areas.
- Studies must be conducted to assess knowledge and behavior levels and provide baseline indicators for developing communication and service delivery strategies.
- Monitoring mechanisms must be strengthened in order to increase the effectiveness of the interventions.
- The capacity of the technical personnel in sector agencies also must be strengthened to increase their ability to understand and monitor the NGOs.

76. State Roads Programs. State road construction programs are managed and implemented by the State Public Works Departments through their Roads and Bridges construction wing or through other autonomous bodies. The states that are actively implementing World Bank-financed projects with HIV/AIDS activities are Punjab, Andhra Pradesh, Karnataka, Mizoram and Uttar Pradesh.

77. Punjab is constructing roads along several segments and is executing the works through contractors engaged and managed by Punjab Roads and Bridges Corporation, an autonomous body. This body has been able to ensure that the contractors agree to the special clause on HIV AIDS in civil works contracts and has also contracted an NGO to carry out the implementation of HIV AIDS activities along the construction corridors. A senior level official (Executive Engineer) has been designated to manage the HIV/AIDS intervention program. The NGO has been recently contracted and has submitted a plan for the program and is in the process of mobilizing human resources for implementation.

78. The contractors are also engaged in the implementation of the intervention program at the construction site by targeting the labor force. Contractors are also working with the population in adjoining villages. At various sites visited, it was observed that the contractors have promoted BCC messages regarding HIV prevention and the officers of the contractors in charge of labor welfare are overseeing the implementation of these activities at the level of the contractors. An

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3 The observations made for the interventions carried out by NHAI apply equally to the interventions at the state level.
important lesson learned is that:

The linkages with the State AIDS Control Society (SACO) need to be further established and assistance of SACO sought for provision of BCC materials, training of staff, provision of prevention measures such as free condoms to the intervention. It is necessary to strengthen the relationships in order to ensure a collaborative working environment.

79. In the states of Andhra Pradesh and Karnataka the WB projects in the road sector are under preparation and institutional structures are being put in place to carry out HIV/AIDS interventions; therefore the time is ripe to actively include an HIV component in the projects. As the projects are at the initial stage of preparation, they can benefit from lessons learned from completed projects to strengthen their HIV AIDS component. The institutional framework requires one agency to coordinate the management of both HIV and R&R NGO interventions with appropriate structures and human resources. As Karnataka and Andhra Pradesh are high prevalence states, and in view of the generalized nature of the epidemic, it is important to make use of the data already available from the State AIDS Control Societies and involve them for technical assistance from the initial planning stage.

80. National Rural Roads Programs. The rural roads construction programs are implemented by the NRRDA as part of the Prime Minister’s Rural Roads Plan. This plan aims to improve the connectivity of the rural areas to the main towns in order to facilitate access to services such as education and health.

81. In Mizoram the rural road project financed by the World Bank has initiated interventions in the rural areas for prevention of HIV. A local lead NGO has assisted the implementation agency to manage the interventions. Local resources and regional agencies having relevant experience in the sector such as Faith Based Organization (FBOs) have been involved to enhance the effectiveness of the programs. The main thrust of implementation has taken the form of IEC campaigns at different project locations by involving local organizations through community outreach. The mode of implementation has been through lecture-based methods using local resource persons. Though this initiative makes a strong start, the following improvements are suggested:

- Seek involvement of local agencies and build their capacities to implement interventions
- Move from campaign mode to interventions through interpersonal communication and word-of-mouth communication and include the distribution of educational materials to strengthen campaigns
- Involve faith-based organizations to foster trust in local communities
- Include training and capacity building of the personnel and organizations involved
- Involve State AIDS Control Society to piggy back on the rural programmes that these organizations have developed.

82. In Uttar Pradesh Roads Project, extensive HIV/AIDS awareness campaigns have been carried out in all civil works packages by an NGO. In addition, contractors have also carried out awareness campaigns in their camps on AIDS Awareness Day. The NGO recently conducted four awareness campaigns using thematic magic shows, which were well received by the community.

Extent to which HIV issues have been addressed in the WB road portfolio  

22
The issues have been well articulated and the special clause for HIV prevention has been included in the civil works contract documents at all levels of implementation (National, State and rural). The contractors, with the aid of NGOs, are implementing interventions at the work sites. There are structures in place to manage and supervise implementation.

The work initiated is impressive but the capacity of the implementing organizations and the technical personnel must be strengthened within the next year in order to improve the quality of interventions. Capacity building of the technical staff will enhance the quality of supervision and improve the planning of interventions.

**Transport Corporation of India Limited**

Transport Corporation of India (TCI), a major cargo transport company, has recognized the importance of truckers to its business and has consequently launched a project specifically targeting this high risk population, especially long distance truckers. TCI’s comprehensive integrated approach to reducing the transmission of HIV includes providing diagnosis and treatment through project clinics, use of behavior change communication to encourage truckers to adopt to safer sexual behavior and practices, and promoting condom use among the target population. The HIV program is being implemented through a chain of Khushi clinics at 17 high volume transshipment hubs where truckers are delayed for at least 12 hours.

Some of the useful lessons from TCI’s experience include:

- A wide network of implementing NGO partners exists; in fact, they form the backbone of the project.
- Location of clinics along the highways helps to fill the gap in medical services and attracts a large inflow of patients; this has helped the program to earn a national reputation.

**Krishna District Lorry Owners Association – Safe Journey Project (Surakshith Yatra)**

Many programs in India, under the overall umbrella of the NACP, such as the AIDS Prevention and Control Project (APAC), AVERT and the BMGF-Avahaan-TCI have included truckers in their targeted interventions, given that these groups are more vulnerable to the epidemic.

An intervention strategy targeting truck drivers and transport workers must involve them and emerge from within the sector, mobilizing every available public and private resource to combat the further spread of the epidemic. It is in this context that the Surakshith Yatra Project, an endeavor initiated and implemented by the trucking association, the Krishna District Lorry Owners Association (KDLOA), assumes significance. Vijayawada in the Krishna District of Andhra Pradesh was selected to be the intervention area due to its strategic significance. The city is a hub for road transport-related activities with around 30,000 trucks registered in Vijayawada and over 100,000 families involved in this trade. An estimated minimum truck density of around 2,000 trucks cross the city on any given day.

The project attempted to develop an adequate workplace response within the transport sector to prevent the spread of HIV and mitigate its impact. The programme combines advocacy and awareness-building among company owners and member associations. In Vijayawada, the KDLOA focuses on providing prevention services to the truckers, their families and allied
communities, and basic care and support services to PLHIV. The project design is also aligned with the objectives of the implementing organization, the primary of which is to safeguard the business interests of transport operators. It is indeed a healthy sign that the KDLOA took the initiative to at least partially address the welfare needs of the transport work force.

90. The goal of the project has been to prevent the spread of HIV and mitigate its impact on the transport sector by undertaking advocacy activities and increasing access to prevention, and care and support services for the truckers and their families in Vijayawada. The project design rests on the following key strategic approaches:

- BCC interventions to encourage adoption of safer sex practices and reduce high-risk behaviors among the truckers and their families;
- Service provision for STI management including access to Voluntary Counseling and Testing (VCTC) and referrals linkages to facility-based-services;
- Provision of care and support services for people living with HIV/AIDS (PLHIV) and affected families; and
- Sensitization and advocacy activities aimed at reducing stigma and discrimination and strengthening strategic partnerships for long-term sustainability.

91. The outputs of the project after three years include:

- 60,500 people reached through one-to-one and one-to-Group BCC.
- 2,234 trucker families reached with IEC services.
- 92,420 people reached with media services (Street Theatre, Puppet Show and Video Show).
- 120 peer educators trained and enrolled to support outreach activities.
- 6,932 clients of sex workers have been counseled for STI and HIV.
- 121 shops promoted social marketing of condoms.
- 33,320 people attended clinic for services.
- 9,782 people availed STI Treatment (both men and women).
- 1,383 were referred for VCTC.
- 898 underwent HIV testing, of which 287 tested positive.
- 652 PLHIV registered for basic care and support services with the project.
- 31 TB clients were treated.
- Total value of medicines provided was Rs. 953,395.
- Total value of drugs from KDLOA was Rs. 338,123.
- 141 Community and Home based Care centers were also reached.

2.6 Bangladesh

HIV/AIDS Country Profile

92. HIV prevalence in Bangladesh remains at relatively low levels in most at-risk population groups, with the exception of injecting drug users (IDUs) where prevalence is higher and continues to rise. Although national HIV prevalence remains under one percent among the general population, there are risk factors such as unsafe sex and sharing of needles that could fuel
the spread of HIV. Prompt and vigorous action is needed to strengthen the quality and coverage of HIV prevention programs, particularly amongst IDUs.

93. UNAIDS estimated that approximately 11,000 Bangladeshis were infected with HIV at the end of 2005. Bangladesh’s sixth round of sentinel surveillance (2004-2005) showed an overall prevalence of 0.6%. The sixth round was carried out among five groups: injecting drug users (IDUs), female sex workers (FSW), men who have sex with men (MSM), male sex workers (MSW) and bridge population groups (mobile men including rickshaw drivers, truckers and dock workers). While overall HIV prevalence remains low, it is higher among sex workers, injecting drug users and men who have sex with men. Joint borders with India and Myanmar, two high prevalence countries, increase the risk among the migrant population.

94. Bangladesh is vulnerable to escalation of concentrated epidemics due to the following risk factors include:

- Large Commercial Sex Industry: There are over 105,000 male and female sex workers in Bangladesh. Brothel-based female sex workers reportedly see around 18 clients per week, while street-based and hotel-based workers see an average of 17 and 44 clients per week respectively.
- Low Levels of Condom Use: The fifth round (2003-2004) BSS data indicate that between 24 percent (street based) – 40 percent (brothel-based) of sex workers reported using a condom with their most recent (during past week) clients. The rate of condom use is lower with regular clients. MSW showed the highest rate of condom use (44 percent), and transgender showed the lowest rate of condom use (15.6 percent).
- Sexually Transmitted Infections: Syphilis rates have shown a marginal decline over recent years. However, recent surveillance data indicates 44 percent of female IDUs are also sex workers and have a higher prevalence of syphilis (9.2 percent prevalence compared with 2.9 percent of male IDUs). The high rates of syphilis and other STIs confirm the low level of condom use and the presence of other risky sexual behaviors that facilitate the spread of HIV.
- Needle-sharing among Injecting Drug Users: The sixth round sentinel surveillance data shows that there is a concentrated epidemic among IDUs in one neighborhood of Dhaka with an HIV prevalence of 7.1 percent. This level of infection among IDUs poses a significant risk as the infection can spread rapidly – and is spreading – within the group, then or through their sexual partners and clients into the general population. Female IDUs need to be urgently targeted as they have a high potential to spread HIV (none in the sample were found to have HIV although 82 percent had shared needles). Another concern is the significant number of IDUs who sell their blood professionally. Bangladesh continues to rely on professional blood-sellers to meet part of the transfusion needs of its people.
- Lack of Knowledge: Data on knowledge and behavior indicates that only 17 percent of the most-at-risk populations have correct knowledge about prevention and misconceptions regarding HIV/AIDS. A 2005 population-based survey among adolescents and young people (15-24 years) indicated that only one out of three males in urban areas and one out of four in rural areas had correct knowledge of HIV/AIDS. Among the general population, data indicate that 59 percent of ever-married women and 42 percent of men aged 15-54 were unable to name single way to avoid contracting HIV.
- There was high level of stigma associated with people living with HIV and vulnerable people at high risk. Findings showed that people who engaged in high risk behaviors often have limited access to health care.

Status of implementation of HIV interventions activities in WB road projects

25
The Road Sector Reform Project is under preparation and a framework for HIV/AIDS prevention policy and an action plan have being designed and are under discussion. The proposed action plan includes: situational assessment to determine baseline conditions, needs assessment and mapping, IEC and BCC campaigns, condom promotion and distribution, and monitoring and evaluation.
3. REVIEW OF MONITORING AND EVALUATION INDICATORS

96. The United Nations General Assembly Special Session (UNGASS) brings together countries to report on progress towards the Millennium Development Goals (MDGs). A special session brought together the countries implementing HIV programs to agree on a list of standard indicators for reporting on HIV and AIDS.

3.1 UNAIDS Core Indicators

97. UNAIDS in collaboration with development partners, has developed a set of indicators for the different aspects of national AIDS programs. This has been accepted as a standard reporting requirement by 183 countries across the world and by the agencies involved in funding these programs.

98. In the case of prevention interventions the following standard methodologies have been adopted for monitoring behavioral outcomes and practices, including condom use: Behavior Surveillance Survey (BSS) and Integrated Bio-behavior Survey (IBBS). These surveys use the UNAIDS standard set of indicators to effectively measure results, program effectiveness and behavior change. The surveys are population-based, and are carried out annually at decentralized levels and once in every three years at the national level, in some countries. The core indicators are globally accepted and are normally used to measure outcomes (or proxies for outcomes).

99. These indicators have been designed to help countries assess the current state of their national response while simultaneously contributing to a better understanding of the global response to the AIDS pandemic, including progress towards meeting targets established in the Declaration of Commitment on HIV/AIDS. Given the dual purpose of the indicators, they were designed to improve the quality and consistency of data collected at the country level, in order to enhance the accuracy of conclusions drawn from the data at both national and global levels.

100. A subset of these standard indicators that is relevant for evaluating the results, i.e., outcomes, of interventions in the transport sector are listed below. Data on these indicators are generated by household surveys (e.g., BBS and IBBS, DHS) and are best carried out by national programs at national or sub-national levels, while monitoring of transport specific activities that contribute to these results can be conducted by the transport sector projects. Together these data sources can help assess the effectiveness of HIV and AIDS projects.
These program/project evaluation indicators are

- Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know their results
- Percentage of truckers (sex workers and others most at risk) who have received an HIV test in the last 12 months and who know their results
- Percentage of truckers (sex workers and others most at risk) reached with HIV prevention programs
- Percentage of young women and men in the community, aged 15–24, who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission
- Percentage of truckers (sex workers and other most at risk) who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission
- Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months
- Percentage of women and men aged 15–49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse
- Percentage of female and male sex workers reporting the use of a condom with their most recent client
- Percentage of men reporting the use of a condom the last time they had anal sex with a male partner
- Percentage of young women and men aged 15–24 who are HIV infected
- Percentage of truckers (sex workers and other most-at-risk populations) who are HIV infected

These lists of indicators are the most relevant ones to the Transport sector, and could be used to evaluate the effectiveness of Transport Sector HIV prevention programs. It is often difficult, however, to attribute changes in these indicators to specific projects and programs; and these intermittent program evaluations need to be complemented by ongoing monitoring of activities (outputs).

### 3.2 UNAIDS Agreed Indicators for Monitoring Programs

The single greatest effort to standardize indicators was made by the WHO/Global Programme on AIDS which, in 1994, published a methods package for the evaluation of HIV prevention programmes. The package identified 10 prevention indicators, known as PI1 – PI10, using five different methods of data collection. Many countries have used the PIs for some time, often adapting them to local circumstances. Only rarely have they been measured repeatedly over time though PIs were designed principally as a means of tracking trends over time. One of the reasons that PIs have not been widely measured over time is that some countries feel the indicators do not provide the data most relevant to their program assessment and planning needs, particularly in an evolving epidemic. What’s more, conducting a national-level survey of all 10 PIs is an expensive exercise – where outside funding for such an exercise has not been available, countries have tended to substitute other measures on an ad hoc basis. Other countries have no M&E plans that include the PIs.

Among the many indicators agreed by UNAIDS to use in monitoring of programmes, those of greatest relevance to transport projects are included in this list, and some have been
Policy/Mainstreaming (*): Spending on HIV prevention, with budget allocation for HIV and AIDS component

Condom availability and quality
1. Condoms available, retail
2. Condom qualities

Stigma and discrimination
1. Accepting attitudes toward HIV+ people
2. Employers not discriminating

Knowledge
1. Knowledge of HIV prevention*
2. No incorrect beliefs about HIV*

Voluntary counseling and testing
1. People who requested test and received results*
2. Districts with VCT services
3. Quality of counseling and referral
4. VCT centers with minimum conditions
5. Quality of VCT laboratories

Sexual negotiation and attitudes
1. Women’s (sex workers)* ability to negotiate safe sex

Sexual behavior
1. Higher-risk sex in the last year
2. Condom use at last higher-risk sex
3. Commercial sex in last year
4. Condom use by clients at last paid sex
5. Condom use by sex workers with last client
6. Higher-risk male-male sex in last year

These indicators (above) are more specific and related to the behavior changes that are the focus of transport sector interventions on HIV. Indicators related to knowledge, voluntary counseling and testing, sexual behavior and health and social impact are all relevant to HIV/AIDS programs in the transport sector.

3.3 Options for Retrofitting HIV/AIDS components in Road Projects

This section proposes options to incorporate HIV and AIDS activities in projects which do not include such activities already. How to monitor these activities are discussed in the next chapter. Projects with civil works contracts already under execution in which the special clause on HIV/AIDS in civil works contracts has not been included will not be able to incorporate this clause nor implement HIV intervention during the remaining execution period. These projects must adopt strategies that are different from the ones that envisage HIV AIDS activities since the early stages of preparation.
105. In working with NGOs to carry our the HIV and AIDS components,, there are several options:

- To provide the interventions through contracting of NGOs identified by the borrowing agency directly. This will involve having the NGOs working along the corridors of construction works as well as at the work sites where labor is employed.

- To link up with the national/regional programs in the countries, and, through them, identify and select NGOs to work in the areas where construction is taking place. The contracting and managing of the NGO implementing the intervention can be done directly by the respective country program implementing agency.

- To extend the scope of the work of an NGO already involved in implementing a prevention program in the areas of construction by mutual agreement with the country program agencies.

- To incorporate the HIV prevention activities into the work of R&R NGOs engaged with the construction projects. These NGOs may receive additional funding and be requested to recruit additional staff with HIV work experience or collaborate with other NGOs with HIV-related expertise.

In order to effectively provide HIV prevention services, the preferred strategy in most instances is to directly contract NGOs with HIV experience through the main borrowing agency.
4. MONITORING AND EVALUATION FRAMEWORK

4.1 Structure of the M&E Framework

106. The overall framework for monitoring and evaluation has been drawn from the analysis of HIV/AIDS components in World Bank-funded road projects complemented by the vast knowledge on monitoring and evaluation in global HIV/AIDS programs.

107. The components of the M&E framework for HIV/AIDS components in road projects include:

- Development objective;
- Overall outcome indicators of HIV/AIDS prevention components to measure impact;
- Intermediary outcome indicators to measure results achieved;
- Output indicators to measure the effectiveness of activities;
- Activities included in HIV/AIDS prevention components
- Sources of data to measure the authenticity of information collected.

The following table provides an example of the link between an objective, outputs and activities:

<table>
<thead>
<tr>
<th>Objective</th>
<th>Activities</th>
<th>Output</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent truckers using condom during last time they had higher risk sex</td>
<td>BCC, STI referral, peer education, condom promotion</td>
<td>Knowledge about safe sex, access and use of condoms they had higher risk sex</td>
</tr>
</tbody>
</table>

4.2 Development objective and measurable indicators of progress

108. The overall development objective of many HIV/AIDS prevention components in road projects is to reduce HIV and STI high risk behaviors in road projects. Since it is difficult to
monitor changes in HIV transmission, there are a set of useful proxies, or intermediate indicators that can be used to monitor progress towards the development objective, such as:

- Percentage of at-risk population (mobile workers) who correctly identify ways of preventing sexual transmission of HIV
- Percentage of high-risk population reporting consistent condom use

4.3 **Activities Included in HIV/AIDS Components**

Four types of activity categories can be envisaged in HIV/AIDS prevention components in road projects:

- Provision of behavioral change IEC services to the mobile labor population and the population living along transport corridors
- Provision of STI services through referral
- Provision of condoms at work locations and to other high-risk populations along the corridor
- Provision of HIV testing for transport corridor communities/populations through referral linkages to government accredited testing facilities

**M&E Framework**

109. The following table provides a sample M&E framework for HIV/AIDS prevention activities in road projects. It would have to be adapted given the country context, local environment and the dynamics of the HIV epidemic.
Table 2: Proposed sample menu of M&E Framework For HIV/AIDS Prevention Activities In Road Projects

<table>
<thead>
<tr>
<th>Design Summary</th>
<th>Performance Indicators</th>
<th>Monitoring Mechanisms</th>
<th>Assumptions and Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To reduce HIV and STI high risk behaviors in road projects</td>
<td>• Percentage of at-risk population (mobile workers) who correctly identify ways of preventing sexual transmission and HIV</td>
<td>• Behavioral surveillance every three years</td>
<td>• Distribution of good quality condoms</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Percentage of high-risk population reporting consistent condom use</td>
<td>• Provincial and country statistics</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Behavioral surveillance every three years</td>
<td>• Project progress report</td>
</tr>
<tr>
<td><strong>Purposes:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To increase awareness and reduce risks of transmission of STI and HIV among construction workers and communities along the construction corridor.</td>
<td>• Increase use of condoms among men to 60% among the population at risk by the end of the road project</td>
<td>• Annual behavior survey</td>
<td>• Program interventions increase safe behavioral change</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Reduce STI prevalence to 40% among target groups in the communities</td>
<td>• Annual clinical survey</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Specific survey reports by NGOs</td>
<td>• Program interventions increase safe behavioral change</td>
</tr>
<tr>
<td><strong>Outputs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Awareness programs established in each construction site</td>
<td>• Two workshops in each construction site in the first year of the project and once every year until end of project</td>
<td>• Quarterly progress report</td>
<td>• Service provider have adequate capacity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Annual workshop for contractors during the life of the project</td>
<td>• State AIDS program to assist with materials</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Specific survey reports by NGOs.</td>
<td>• Implementation agency ensure condoms are made available by contractors</td>
</tr>
<tr>
<td><strong>Activities</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 Conduct IEC campaigns concerning the risks, dangers and impact, and appropriate avoidance behavior for STIs including HIV by contractors at construction sites and by NGOs along the corridors of construction.</td>
<td>1. Recruitment of national NGO as service provider</td>
<td>• Signed contract with national NGO</td>
<td>• Have an agreement with State and Local AIDS program to provide some kits and personnel</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Print information materials</td>
<td>• Implementation agency ensure condoms are made available by contractors</td>
</tr>
<tr>
<td>1.2 Carry out advocacy programs through workshops and seminars</td>
<td>2. Number of population reached through IEC</td>
<td>• Signed contract with service providers</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Signed contract with service providers</td>
<td>•</td>
</tr>
<tr>
<td>1.3 Provide condoms free of charge at construction sites during the life of the project</td>
<td>1. Procurement of testing kits</td>
<td>• Signed contract with service providers</td>
<td>•</td>
</tr>
<tr>
<td>1.4 Carry out voluntary confidential counseling and testing</td>
<td>1.3 Procurement of condoms</td>
<td>• Signed contract with service providers</td>
<td>•</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Signed contract with service providers</td>
<td>•</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Signed contract with service providers</td>
<td>•</td>
</tr>
</tbody>
</table>
### Inputs

1. National NGO/Road agencies and road transport associations

2. Training workshops and advocacy programs

3. Quality condoms

4. Provide for STI and HIV/AIDS screening, diagnosis, counseling and referral to dedicated national STI and HIV/AIDS programs (unless otherwise agreed) for all Site staff and labor population along the corridors.

5. Provide implementation oversight

| National NGOs in associations with Road agencies and transport association |
| Due diligence with procurement process |
| Due diligence with procurement process |
| Task Team Leader/Focal Person |
| NGO reports |
| Quarterly progress report from road agencies |
| Reporting by NGO |
| Progress report by road agency |
| Progress report by road agency |
| WB implementation mission |
| Qualified and experienced service providers |
| Agreement by service providers, road agencies to carry out programs and disseminate, inform and educate on HIV/STI. |
| Agreement by service providers, road agencies to carry out programs and disseminate, inform and educate on HIV/STI. |
| Effective monitoring, management and evaluation |

### 4.4 Program Implementation

The program content can be divided into two parts:

- Prevention program targeted at the contract laborers and the other transport sector personnel who deliver goods and materials at the work site; and
- Prevention program targeted at the population living along the corridors where the construction activity takes place.

### Execution by Contractors at Sites

110. The standard contract clause in the civil works contracts with contractors executing the road construction works packages requires them to undertake the following services:

- Conduct Information, Education and Communication (IEC) campaigns, at least every other month, addressed to all site staff and labor (including all the contractor’s employees, all sub-contractor’s and consultant’s employees and all truck drivers and
crew making deliveries to site for construction activities) and to the immediate local communities, concerning the risks, dangers and impact, and appropriate avoidance behavior with respect to STI in general and HIV/AIDS in particular.

- Provide male or female condoms for all site staff and laborers as appropriate.
- Provide for STI and HIV/AIDS screening, diagnosis, counseling and referral to a dedicated national STI and HIV/AIDS program (unless otherwise agreed) to all site staff and labor.

111. The Standard Contract clause further requires a plan regarding when, how and at what cost the contractor plans to satisfy the requirements of this clause and related specifications. For each component, the program shall detail the resources to be provided or utilized and any related sub-contracting necessary. The program shall also include a detailed cost estimate with supporting documentation. Payment for preparation and implementation of the program must be included within the provisional sum dedicated for this purpose in the contract.

**Execution by NGOs along Transport Corridors**

112. These prevention interventions are carried out along the corridors among high-risk behavior groups such as sex workers, MSM, IDUs and with a bridge population such as the truck drivers, helpers and mobile labor. Coverage of the general population is also required in order to reduce their risk of exposure due to the increased mobility that the project facilitates. Prevention programs along the corridors include the following activities:

- Behavior change communication for bridge population groups along the corridors regarding prevention practices for STI, HIV in particular
- Provision of referral services to high risk population, bridge population and general population for STI and HIV screening facilities
- Provision of male and/or female condoms to the population through country programs networks
- Building an enabling environment to reduce stigma and discrimination at the community level

**4.5 Data Collection and Reporting**

113. The data the transport projects would routinely collect are the outputs (for example, number of people reached), while the intermediary outcomes (for example, percentages that are reached) would be measured by special surveys (conducted by NGOs contracted by transport sector) and outcomes by the national AIDS program though BBS or the like. In India, for example, the data collection of outcomes will be done in accordance with the Computerized Monitoring and Information System (CMIS) of the National AIDS Control Organization (NACO). The implementation at the state level will feed into the State AIDS Control Society (SACS) and the implementation at the National level will feed into the system at NACO as another reporting unit.

**Data Collection by Contractors**

114. The labor welfare officer employed by the contractor must maintain a register of activities that includes the following:
IEC Activities:
- Activity date
- Coverage in terms of numbers classified as company site staff, labor of subcontractors, family of staff and members of the local community. The type of activity (e.g. events, campaigns, film shows) also needs to be documented.
- Number of peer educators who are trained to carry out prevention activities among peers such as staff, labor and the community
- Numbers covered during the period of reporting by peer educators
- Any special events observed such as World AIDS day

Condoms
- Number of condoms distributed or sold

STI/HIV
- Number of cases referred to STI facilities and number who received treatment.
- Number referred to HIV testing centers and number who were tested.

Standard registers may be used to record these numbers so that the recording may be carried out on a regular basis

Data Collection by NGOs

115. The main sources of data for the different aspects of the program are:

BCC Activities:
- Outreach worker diary that captures the information on the number of high-risk behavior population met through one-to-one, one-to-group, mass media etc
- Peer educator dairy that captures similar information with respect to outreach workers
- The data from the peer educators are collected by the outreach worker and the consolidated efforts of both peer educators and outreach workers are posted in the consolidated BCC register

STI Activities
- Outreach workers and peer educators refer the cases of identified STI to the public health units of the national program by issuing a referral slip. These referrals are also noted in the outreach worker diary
- The STI referrals are posted in the STI referral register
- The outreach workers periodically visit the referral centers and collect the referral slips that are deposited by the patients at these centers
- The referral slips are correlated in the STI referral register to track the number of people identified and referred and the number actually visiting the center and receiving treatment

Condom Promotion
- The outreach worker diary records the number of condom demonstrations carried out
- It records the number of condom off take from the free distribution outlets
- It tracks the number of outlets that are stocking and selling condoms in the area of intervention
It also tracks the condoms sold in the area.
- The details from the outreach worker are posted in the condom register.

**Enabling Environment**
- Number of village level leaders and dairy local self government representatives met are recorded in the activities of the outreach workers in their diary.
- The type of issues discussed is also recorded in the diary.
- The number of school teachers, religious leaders sensitized to the issue of HIV prevention is also captured in the diary
- These are consolidated and posted into the enabling environment register

**Reporting**

116. The NGO reports on the high-risk population covered should be categorized depending on the epidemiology of HIV and mapping of high risk groups into, for example, sex workers, MSM and IDUS and the clients of sex workers: truck drivers and mobile labor. The number of people in the villages will be covered through the general awareness program will be recorded. The report will also include the STI cases identified and referred as well as those who actually sought treatment, the volume of condoms distributed and the volume of condoms sold in the area, the awareness activities and the number of persons reached. Sample report form is attached as an appendix.

4.6 **Condom Needs Assessment or Market Analysis**

117. In order to plan and monitor performance, including condom distribution, it is necessary to estimate the number of people that the contractor/NGO is planning to cover with each intervention. This is also essential in order to develop a detailed cost estimate for the interventions.

118. The numbers for construction site-related people can be estimated as follows:

- The labor requirement for construction of road per kilometer can be estimated for the different stages of road construction, providing an estimate of the total labor expected to be covered.
- A survey of the area under construction will allow for an estimate of the number of people in the community to be covered.
- Based on their experience, the contractors can estimate the number of people who will be delivering materials to the site.
- The existing prevalence of STI among the general population can be used to estimate the number of anticipated STI cases.
- A rough calculation of the market for condom can be derived from assuming 150 to 200 condoms are required for staff protection per year and accordingly by estimating the total number of condoms needed for the period of contract execution.

119. The numbers for truckers and local community people can be estimated by NGOs as follows:

- Data can be obtained from the mapping of the high risk population groups and onto different micro-sites. These estimates can be used to assess the numbers of high-risk individuals to be targeted by the project.
A discussion with the Transport Unions/Associations can provide the number of trucks that ply on average along the highways in the project area. This can be used to estimate the targeted number of truckers to be covered by the project as well as their location.

The census figures can provide an idea of the extent of mobile labor in the area and the number of mobile laborers that can be covered. A discussion with local officials regarding these numbers would be helpful.

The general population along the corridors in need of coverage can be arrived at by counting the villages that need to be covered along the corridor, estimating an average population size per village and calculating the total population as the average population per village times the number of villages.

The STI prevalence rate applicable for the different population segments listed in national surveys may be used to estimate the possible number of STI cases to be identified within the project area.

The number of free condom outlets to be established can be arrived at by using a rule of thumb estimate of about 3 per village and about every second gas station or equivalent on the highway.

The BCC activities will therefore provide the number to be covered and also the mode of coverage such as one-to-one, one-to-group and mass events by taking an average coverage figure.

### 4.7 Pre-requisites

121. In order to plan for effective implementation, it is necessary to assess the situation on the ground through needs and situational assessments that serve to do the following:

- Estimate the number of people who belong to the high-risk population by adopting a key informant approach.
- Where high-risk population can be reached and during what periods of the day.
- Whether any NGO is working with these populations.
- Knowledge, awareness, myths and misconceptions prevailing among high-risk populations regarding health, STI, HIV/AIDS and condom usage.

122. Data from Behavior Surveillance Survey (BSS) conducted among the general population and high risk groups if available) can be used as for base line estimates to assess existing knowledge, attitude and awareness levels of the target population and their health-seeking behavior. BSS can also provide information on where the population is seeking treatment for their general health and sexual health requirements and the preferred providers are for treatment.

123. The needs and situation assessment provides the information needed to develop strategic responses based on a clear understanding of the area’s population sub-groups. It enables the providers of HIV AIDS prevention services under the project to familiarize themselves with the project area of influence. It also provides them an opportunity to establish relations within the local community.

### 4.8 Data Sources

124. Different countries generate data annually that can be used to measure the outcomes and impacts of the projects such as:
• Sentinel Surveillance Data carried out annually to estimate HIV prevalence and arrive at the number of People Living With HIV/AIDS (PLWHA)
• Behavior Surveillance Survey data annually in some countries and once every two or three years in others
• Data available through STI prevalence studies that are undertaken in different regions annually;
• Integrated Bio-behavior Surveillance Surveys conducted in certain countries; and
• Family Health Surveys carried out once every five years in certain countries.

These data sources can provide insights into macro-level outcome and impact. These can be used as corroborative evidence for evaluation.
5. SUGGESTIONS AND RECOMMENDATIONS – TO BE FINALIZED AFTER GDLN DISCUSSIONS

5.1 Monitoring and Coordinating Agency Requirement

125. It is suggested that a Monitoring and Coordinating Agency/unit be established within the transport sector. This agency/unit ought to be a lean body that provides guidance regarding program design in the transport sector and facilitates the interface with the national programs. The Agency/unit will be staffed by a monitoring team who will visit the different projects on a pre-determined monitoring cycle and provide assistance in implementation. This team will also be able to monitor progress and facilitate programs commencement and design.

5.2 Capacity Building of Potential NGO Partners

126. The concept of road agencies working in the field of HIV/AIDS itself is has been ongoing for over a four year period in the sector and among clients. Implementation of HIV/AIDS prevention activities on civil works sites or in communities and high-risk populations living along transport corridors as well as working on World Bank projects has been through NGOs operating in HIV, health and other development sectors. In the case of India, the majority of NGOs selected through a competitive bidding process are R&R NGOs who lack significant experience in HIV/AIDS work in transport sector. In order to attract NGOs working in the HIV sector in road projects financed by the World Bank, it is essential that they acquire the capacity to bid according to World Bank bidding requirements.

5.3 Project Design

The project design needs to be clearly understood. There is often a lack of clarity in intervention design. The interventions are often not planned well because their requirements had not been assessed and understood. A detailed guideline note should be prepared in order to ensure that the design of the project is clearly understood. To assist the sector in mainstreaming HIV and to respond accurately to the epidemic, a toolkit named The Road to Good Health has been designed by the East Asia and Pacific Transport Unit of the World Bank. A detailed guideline can be downloaded from the toolkit. The link to the toolkit is www.theroadtogoodhealth.org.

5.4 Capacity building for NGOs already chosen

127. The capacity of the NGOs contracted for implementation of HIV AIDS activities need to be strengthened in the following areas:

- Needs and situation assessments to understand interventions requirements of the?
• Planning process and intervention design based available data
• Plans for coverage and execution
• Clear understanding of the expectations of the interventions.
• Understanding of the requirements of the monitoring system and how to gather data that feeds into the monitoring system
• Periodic review and redesign

5.5 Capacity Building of Technical and Engineering Staff

128. Capacity building is critical to ensure that the technical and engineering staff understands the HIV prevention components in the transport sector, and the necessity to include them in the transport sector programs. This will facilitate acceptance of the interventions and will enable the technical staff to monitor the progress of the interventions in a supervised manner.

5.6 National and Regional Level Coordination and Facilitation

129. HIV/AIDS prevention in road projects must be integrated into national and regional HIV/AIDS Program to contribute to the national program goals, and to facilitate coordination. The projects are mainstreaming HIV/AIDS prevention efforts, complementing the work of National and regional programs. The National program and the regional programs have nationally guidelines, technical know how and materials, for example BCC material available in the local languages. These can be used by NGOs and contractors as models for conducting BCC sessions as part of the road projects.

130. The facilities created by the National and regional HIV/AIDS preventions programs such as STI clinics, Counseling and Testing Centers and condom access can be utilized/referred to by the road projects. This requires coordination with the National and regional HIV/AIDS prevention programs.

5.7 Reporting to Regional and National AIDS Control Programs

131. As reciprocation for the facilities and other arrangements provided by the regional/provincial or state level programs, it will be necessary to provide information on the progress of the project to these bodies. Further, involving these bodies in periodic monitoring visits can allow for valuable insights and is likely to sustain their interests in the program. This can be done by involving the national or sub-national agencies in the NGO selection and also by inviting them to the training programs provided by the road projects, which should be consistent with national AIDS program training.
APPENDICES
Appendix A: Asian Development Bank, TAR: PRC 36399

Technical Assistance Framework: Preventing HIV/AIDS on Road Projects In Yunnan Province - People’s Republic Of China

<table>
<thead>
<tr>
<th>Design Summary</th>
<th>Performance Indicators/Targets</th>
<th>Monitoring Mechanisms</th>
<th>Assumptions and Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal</strong></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
| To prevent an increase in poverty by reducing potential negative social impacts associated with the implementation and operation of the Western Yunnan Roads Development Project (the Road Project) in an HIV/AIDS prevalent area | 1.1 HIV and sexually transmitted infection (STI) prevalence rate among target groups not higher than 2003 rates | • Project performance and management system (PPMS)  
• Provincial and county HIV/AIDS and STI surveillance network  
• Social indicators, in particular the incidence of HIV/AIDS and STIs and poverty rates, to be monitored under the Road Project  
• Provincial and county statistics |                       |
| **Purposes**   |                               |                       |                       |
| 1. To reduce the risk of transmission of HIV/AIDS and STIs among construction workers; local resident communities, particularly the vulnerable poor and minority people; commercial sex workers (CSWs); and truck drivers in the context of infrastructure projects in high HIV/AIDS risk areas. | 1.1 Reduced prevalence of urethral discharge in men by 30% among targeted groups by the end of the Road Project  
1.2 Reduced prevalence of syphilis in women by 30% among targeted groups upon completion of the Road Project  
1.3 Increased use of condoms to 50% among the populations at risk by the end of Road project. | • Annual clinical survey  
• Annual behavior Survey  
• PPMS | • Adequate financing  
• mechanisms, availability of funds, and timely payments to project implementation partners  
• Efficient implementation of the HIV/AIDS and STI prevention program  
• Commitment by the national and provincial governments, particularly the provincial health department and provincial communications department  
• Injecting drug use, contaminated blood transfusion, and organ transplantation do not increase among target groups.  
• Social disturbance or natural disasters do not affect the project areas.  
• Good quality of condoms |
### Design Summary

#### Outputs

1. Advocacy program established with each target group of local communities, contractors, and business communities involved in the road sector, i.e., transport companies and expressway corporations

   - **1.1** Three workshops in each county of the project area in the first year and once a year thereafter
   - **1.2** Three workshops for contractors in the first year and once a year thereafter
   - **1.3** One annual workshop for business community over the 3-year implementation period.

2. Effective behavior change program established through information and education campaigns (IECs), community mobilization, social marketing, and condom distribution

   - **2.1** Posters and pamphlets disseminated to construction companies, construction worksites, restaurants, bars, hotels and public areas
   - **2.2** 50 trained peer educators among construction workers, 10 among CSWs, and 50 among local population each year
   - **2.3** 25% of target workers and CSWs and 5% of the local population contacted by peer-educators each year
   - **2.4** 100% of the workers and CSWs know the benefit of use of condoms.
   - **2.5** 50% use of condoms

3. Comprehensive HIV testing and STI treatment packages delivered at clinics and medical centers in the Road Project area

   - **3.1** 50 health workers trained in STI management and HIV voluntary testing and counseling
   - **3.2** STI diagnostic kits and treatment provided to clinics and medical centers
   - **3.3** 50% of STI patients seek treatment among target populations.

4. Development of a model for

#### Performance Indicators/Targets

<table>
<thead>
<tr>
<th>Outputs</th>
<th>Performance Indicators/Targets</th>
<th>Monitoring Mechanisms</th>
<th>Assumptions and Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Advocacy program established with each target group of local communities, contractors, and business communities involved in the road sector, i.e., transport companies and expressway corporations</td>
<td>1.1 Three workshops in each county of the project area in the first year and once a year thereafter</td>
<td>Participation level by target groups</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.2 Three workshops for contractors in the first year and once a year thereafter</td>
<td>Quarterly progress reports</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.3 One annual workshop for business community over the 3-year implementation period.</td>
<td>PPMS</td>
<td></td>
</tr>
<tr>
<td>2. Effective behavior change program established through information and education campaigns (IECs), community mobilization, social marketing, and condom distribution</td>
<td>2.1 Posters and pamphlets disseminated to construction companies, construction worksites, restaurants, bars, hotels and public areas</td>
<td>PPMS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.2 50 trained peer educators among construction workers, 10 among CSWs, and 50 among local population each year</td>
<td>Annual behavior surveys</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.3 25% of target workers and CSWs and 5% of the local population contacted by peer-educators each year</td>
<td>Selected peer educators are welcomed by the target groups.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.4 100% of the workers and CSWs know the benefit of use of condoms.</td>
<td>Construction companies facilitate information sessions at worksites and allow selected workers to attend training courses.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.5 50% use of condoms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Comprehensive HIV testing and STI treatment packages delivered at clinics and medical centers in the Road Project area</td>
<td>3.1 50 health workers trained in STI management and HIV voluntary testing and counseling</td>
<td>- PPMS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.2 STI diagnostic kits and treatment provided to clinics and medical centers</td>
<td>- Annual behavior surveys</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.3 50% of STI patients seek treatment among target populations.</td>
<td>Trained health workers are engaged in STI treatment.</td>
<td></td>
</tr>
<tr>
<td>4. Development of a model for</td>
<td>4.1 HIV/AIDS prevention</td>
<td>Scope of</td>
<td></td>
</tr>
</tbody>
</table>

#### Monitoring Mechanisms

- Participation level by target groups
- Quarterly progress reports
- PPMS

#### Assumptions and Risks

- Increased awareness translates into attitudinal changes.
- Interventions do not cause negative reactions.
<table>
<thead>
<tr>
<th>Designing HIV/AIDS prevention programs to be incorporated into future infrastructure projects in HIV/AIDS prevalent areas</th>
<th>Program associated with infrastructure projects in targeted areas</th>
<th>Infrastructure projects to be associated with infrastructure projects in targeted areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.2 Evaluation reports for these prevention programs</td>
<td>Contractual documents for civil works implementation</td>
<td></td>
</tr>
<tr>
<td>5. Benefit monitoring and evaluation system set up and implemented</td>
<td>5.1 Indicators to be identified; 30 sites selected; 30 data collectors and 2 data analysts from the Executing Agency trained each year</td>
<td>• Baseline data surveys and project records monitoring reports</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• PPMS consultants have adequate capability.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Timely baseline data survey</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Government commitment to continue PPMS after completion of the Road Project</td>
</tr>
<tr>
<td>Design Summary</td>
<td>Performance Indicators/Targets</td>
<td>Monitoring Mechanisms</td>
</tr>
<tr>
<td>----------------</td>
<td>--------------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td><strong>Activities</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 1.1 Advocacy actions on the HIV/AIDS prevention program organized through workshops highlighting the role and responsibilities of the business community in disseminating the information and implementing and monitoring HIV/AIDS prevention programs as part of business activities | L. Recruitment of an International organization/institution in association with domestic organization/institute as service providers | • Signed contract with service providers  
• Detailed workshop Program | • - The service providers have adequate capacity and experience.  
• The Government mobilizes the business community. |
| 1.2 Design of an information campaign to be implemented along the Road Project once it opens to traffic | | • Detailed content of the information campaign | |
| **2.1** IECs widely disseminate HIV/AIDS and STI information among construction workers, CSWs, and local communities through posters, pamphlets, events, and focus group discussions in the Road Project area. | 2.1 Recruitment of international and domestic service providers | • - Signed contract with services providers  
• Detailed workshop program  
• Printing of posters, leaflets, and pamphlets | • -Local government, contractors to cooperate and facilitate dissemination of information. |
<p>| | 2.2 Peer educators selected from construction workers, CSWs, and local communities, and trained to achieve deep-rooted effective behavior change. | 2.2 Recruitment of international and domestic service providers | • Construction companies allow selected workers to be trained and, once trained, to conduct information sessions. |
| | 2.3 Condoms to be made available free of charge during first implementation year; afterwards condoms made available at affordable costs. | 2.3 Procurement of condoms through international bidding procedure according to ADB’s Guidelines for Procurement | • Government, contractors to cooperate in making condoms available at affordable cost People willing to use condoms |
| 2.4 In case drug use or trafficking cases are detected, victims directed to other government agencies and support services; follow up on the remedial actions. | 2.4 Recruitment of international and domestic service providers | • Progress and monitoring reports | • People willing to talk |
| 3.1 Assistance to contractors and local communities in providing health services including STI case management and counseling, and HIV voluntary testing and counseling (VTC) at least cost methodologies. | 3.1 Procurement of HIV testing kits and STI treatment packages through international bidding procedure according to ADB’s <em>Guidelines for Procurement</em>. | • Signed contract for procurement of medical treatment packages. | • Local clinics and medical centers to cooperate in treating patients at affordable costs |
| 3.2 Training of health workers in STI management and VTC in order to ensure efficient, quality, and client-friendly services | 3.2 Recruitment of international and domestic services providers Selection of health workers | • Detailed training programs • Training evaluation reports | • Contractors to cooperate in allowing patients to be treated |
| 4.1 Development and implementation of a PPMS including a complete set of indicators and monitoring methods | 4.1 Recruitment of a team of international and domestic consultants highly qualified and experienced in evaluating and monitoring HIV/AIDS prevention programs | • Signed contract with individual consultants | • Government to assist in improving STI treatment and reducing treatment cost. |
| 4.2 Baseline data collection in the first 3 months of the construction works | | | • Local government to cooperate in identifying and selecting health workers to be trained |
| 4.3 Clinical and behavior data collection once a year during project implementation, and subsequently 1 year and 3 years after completion of the Road Project. | | | • Consultants have adequate expertise and experience. |
| | | | • Commitment of Government, contractors and civil society to evaluate and implement where required corrective measures |</p>
<table>
<thead>
<tr>
<th>Design Summary</th>
<th>Performance Indicators/Targets</th>
<th>Monitoring Mechanisms</th>
<th>Assumptions and Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inputs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. International and domestic organization/institutions</td>
<td>1. International organization/institutions in association with domestic organization/institutes</td>
<td>• ADB disbursement Reports</td>
<td>• Qualified and experienced service providers.</td>
</tr>
<tr>
<td>2. Training, workshops, and seminars</td>
<td>3. Procurement of Condoms</td>
<td>• Reporting by service providers</td>
<td>• Commitment of provincial government, contractors, and business partners to disseminate, inform, and educate on HIV/AIDS</td>
</tr>
<tr>
<td>3. Condoms</td>
<td>4. Procurement of HIV testing kits and STI treatment packages</td>
<td>• ADB disbursement reports.</td>
<td>• Provincial government’s commitment to prevent epidemic spread</td>
</tr>
<tr>
<td>4. HIV testing kits and STI treatment packages</td>
<td>5. One individual international consultant and two domestic consultants.</td>
<td>• ADB disbursement reports.</td>
<td>• Provincial government’s commitment to treat STIs at least cost methodologies, and to control spread of HIV/AIDS</td>
</tr>
<tr>
<td>5. PPMS consultants</td>
<td>6. Provincial Leading Group for HIV/AIDS Control</td>
<td>• ADB review missions</td>
<td>• Qualified and experienced consultants.</td>
</tr>
<tr>
<td>6. Administrative and logistical support</td>
<td></td>
<td>• ADB review missions</td>
<td>Effective management and monitoring of TA activities</td>
</tr>
</tbody>
</table>
### Appendix B: Short Baseline Survey, Pre- and Post-Test for Training, Monitoring & Evaluation Framework

#### Target Group:

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Indicators</th>
</tr>
</thead>
</table>
| Knowledge about HIV transmission and prevention                         | • Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?  
• Can a person reduce the risk of getting HIV by using a condom every time they have sex?  
• Can a healthy-looking person have HIV?  
• Can a person get HIV from mosquito bites (or substitute local misconception)?  
• Can a person get HIV by sharing food (or substitute local misconception) with someone who is HIV+. |
| Condoms                                                                 | • Do you know where to access condoms?                                                                                                                                                                     |
| Condom Use                                                              | • Have you had sexual intercourse with more than one partner during the past 12 months? If yes:  
  o Did you or your partner use a condom during your last sexual encounter?  
• If married, have you had sexual intercourse with someone other than your spouse in the past 12 months? If yes:  
  o Did you or your partner use a condom during your last sexual encounter? |
| Knowledge about C&T                                                     | • Do you know where you can get tested for HIV?                                                                                                                                                            |
| Demand for Counseling                                                   | • I don't want to know the results, but have you been tested for HIV in the past 12 months? If yes:                                                                                                           |

#### Table

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>F</th>
<th>M</th>
<th>Yes</th>
<th>No</th>
<th>DK</th>
<th>Other Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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### Appendix C: Short Baseline Survey, Pre- and Post-Test for Training, Monitoring & Evaluation Framework

#### Target Group:

| and Testing |  
| --- | --- |
| • I don't want to know the results, but did you get the results of that test? |  
|  
| Increase skills to negotiate safe practices |  
| • Are you able to use or ask your husband/wife to use a condom during sex? |  
| • Are you able to ask a girlfriend/boyfriend to use a condom during sex? |  
| • Can you say "no" to friends who ask you to visit a sex worker? |  
|  
| Treatment & Care  
Comfort with people living with HIV or AIDS |  
| • If you or a family member was HIV+ would you feel comfortable going to a clinic for treatment? |  
| • Would you share food from the same bowl (or other locally appropriate thing) with a person living with AID? |  
| • If a family member had AIDS would you care for him or her at home? |  
| • How many incidents of stigma or discrimination against persons living with HIV or AIDS can you recall in the past 12 months? |  
|  
| Knowledge of gender-based power dynamics |  
| • Do you believe a woman has a right to say no to sex with her husband? Boyfriend? |  
| • Do you believe a man has a right to hit a woman, even if she is not fulfilling her responsibilities as a wife, mother, girlfriend, sister, daughter? |  
|  
| Knowledge of human rights issues |  
| • Do people who are HIV positive have the right to keep their jobs? |  
| • If a female teacher at the local school was HIV positive should she be allowed to continue teaching? |
**Appendix D: Sample Quarterly HIV/AIDS reporting**

**Summary of activities:**

**Recording Sheet**

<table>
<thead>
<tr>
<th>Working Area</th>
<th>Population</th>
<th>Distributed</th>
<th># of information sessions</th>
<th># of people at information sessions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>F</td>
<td>Total</td>
<td>Condoms</td>
</tr>
<tr>
<td>1 Base camp office</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Base camp</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Laboratory</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Site 1a</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Site 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Site 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Site 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 A/Plant</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Paving</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Culvert 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 Culvert 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 Workshop</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 C/Plant</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 Subcontractor</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 Engineer camp</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix D: Sample Quarterly HIV/AIDS reporting continue

Condom distribution Points

<table>
<thead>
<tr>
<th>Location</th>
<th>Period/Month</th>
<th># of condoms distributed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base camp toilet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Base camp clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Base camp restaurant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engineer’s office</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Workshops report

<table>
<thead>
<tr>
<th>Location</th>
<th>Period/Month</th>
<th># of condoms distributed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workshop clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workshop restaurant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foremen</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Collected by: _____________________

Date: ___________________________
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Kingdom of Bhutan National Strategic Plan for HIV/AIDS and Sexually Transmitted Infections, 2007


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**Related Websites**

www.theroadtogoodhealth.org

www.worldbank.org/sartransport

www.worldbank.org/saraids