ADB, Roads and HIV/AIDS

A Resource Book for the Transport Sector

Asian Development Bank
Foreword

In August 2006 at the XVI World AIDS Conference in Toronto, the Asian Development Bank (ADB) joined the African Development Bank, the United Kingdom’s Department for International Development (DFID), the Japan Bank for International Cooperation (JBIC), the German Development Agency (KfW), and the World Bank to sign a Joint Initiative by Development Agencies for the Infrastructure Sector to Mitigate the Spread of HIV and AIDS. The Joint Initiative “recognizes the urgency for action in the infrastructure sector to tackle the global HIV and AIDS crisis.” It identifies tangible ways for these agencies to strengthen cooperation to increase the scale, scope, and effectiveness of measures to prevent the spread of HIV in relation to infrastructure development in developing countries.

In early 2007, ADB commissioned four case studies in the Greater Mekong Subregion, which reviewed HIV prevention measures in ADB-supported road and highway projects in the People’s Republic of China, Cambodia, Lao People’s Democratic Republic, and Viet Nam. The case studies highlighted the importance of taking gender differences into consideration, including differences in men’s and women’s duties and work schedules. They also showed how prevention programs need to consider the specific needs of ethnic minorities, and differences in language and culture that require messages to be specially tailored to the local context. Programs for some ethnic groups may also need to incorporate complementary livelihood opportunities and life skills training.

HIV and AIDS are today considered in all projects—not just road projects—supported by ADB. We are increasingly managing the risks of HIV and AIDS with responses integrated into the overall design of the project rather than through separate technical assistance components. Progressively, the links between infrastructure development and the spread of HIV are better understood, and we are learning how to better minimize the risks.

This resource book wants to help ADB staff and other key players in the transport sector to design and implement more effective HIV/AIDS programs in the transport sector projects. It also asks decision makers to become more attentive to the risks and opportunities to fight the spread of HIV, guiding them in finding solutions that will reduce the negative impact of transport programs.
This is a living document that we will update continuously, as experience and lessons from the region are accumulating and collected. We are fully aware of the changing nature of the epidemic and, therefore, of the importance of this continuous adjustment to the new challenges of the epidemics.

We would like to thank the Government of Sweden that has provided strategic and financial support for this manual through the Cooperation Fund to Fight HIV/AIDS in Asia and the Pacific.
Acknowledgments

In 2004, ADB approved Technical Assistance 6173: Strengthening ADB’s Response to HIV/AIDS. That was the beginning of this resource book.

Under guidance and supervision of Lisa Studdert and me, Charmaine Cu-Unjieng was the technical consultant and drafted the resource book itself (Part II), drawing from the Greater Mekong Subregion’s experience.

Christine Bradley (Gender Consultant), working with Francesco Tornieri in ADB, helped us highlight the importance of gender concerns in the resource book. Rikard Elfving, from the HIV/AIDS Unit in ADB, drafted the first part of the manual.

Many people contributed to the project: Jean-Marie Lacombe, Takako Yasukawa, Charles Melhuish, Robert Valkovic, Sonomi Tanaka, Natsuka Toba, Indu Bhushan, Adam Bruun, Madhumita Gupta, Marla Huddleston, Kim Jraiw, Jeffrey Miller, Marcelo Minc, Raikhan Sabirova, Robert Siy, Jr., Shunso Tsukada, Olavi Elo, Sri Widowati, Paul Vallely, Yasushi Tanaka, Shireen Lateef, Nianshan Zhang, Pedrito de la Cruz, and Robert Dobias. We also thank our colleagues Karen Mariano, Michelle H. Tan, and the ADB Printing Department.

This resource book is a “living” one: we fully expect that it will be regularly revised and updated as experience and knowledge of the issues grow from our own ADB experience and from our partners. Like many aspects of the HIV epidemic, this is a dynamic field and experience and knowledge must be constantly analyzed and reviewed to ensure that the best available information is being used. With this in mind, we invite and encourage comments, suggestions, and feedback on the document as it is used, and we already thank all the future contributors to this resource book.

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Abbreviations and Acronyms

AIDS acquired immune deficiency syndrome
BCC behavior change communication
BHSA Baolong Healthy and Safe Action
CPS country partnership strategy
DMC developing member country
GMS Greater Mekong Subregion
HIV human immunodeficiency virus
HIV+ HIV-positive (infected by HIV)
IDU injecting drug use/user
IEC information, education, and communication
IPSA initial poverty and social assessment
M&E monitoring and evaluation
MOT Ministry of Transport
MPWT Ministry of Public Works and Transport (Cambodia)
MOU memorandum of understanding
MTCT mother-to-child transmission
MSM men-who-have-sex-with-men
NGO nongovernment organization
OH&S occupational health and safety
PMT project management team
PPC provincial people’s committee
PPMS project performance monitoring system
PPTA project preparation technical assistance
PRC People’s Republic of China
RRP Report and Recommendation of the President
RSDD Regional and Sustainable Development Department
STI sexually transmitted infection
SW sex worker
TA technical assistance
TOR terms of reference
UNAIDS The Joint United Nations Programme on HIV/AIDS
UNDP United Nations Development Programme
VAAC Vietnam’s Administration of HIV/AIDS Control
VCT voluntary counseling and testing
VEC Vietnam Expressway Corporation
WHO World Health Organization

Note:
In this publication, $ refers to US dollars.
Introduction: About the Resource Book

Why a resource book?

Transport and infrastructure are at the core of the activities of the Asian Development Bank (ADB) to achieve poverty reduction in the Asia and Pacific region.

While infrastructure is a powerful instrument for economic growth, it is also well established that transport sector projects and the increased mobility of the populations resulting from better roads may facilitate the spread of less desirable “goods” and services, in particular, communicable diseases, drugs, and trafficking.

Except for a few countries, in most of Asia, the human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) epidemic is still concentrated. Construction projects and increased mobility, however, represent a risk of spreading HIV. Effective interventions exist, which can help prevent the spread of HIV both during construction of roads and infrastructure, and after project completion, when people’s mobility increases and new economic opportunities attract new migrants.

Drawing on international and its own experience, ADB has developed this resource book to provide an easy-to-use reference on HIV/AIDS issues and initiatives in the transport sector, with practical tools and guidelines for incorporating HIV/AIDS concerns into transport projects and loans throughout the ADB project cycle.

Part I gives an overview of the issues and some examples from ADB projects.

Part II takes users through the appropriate steps for easy integration of HIV/AIDS concerns during each stage of the project cycle, from the discussion of transport sector projects in country partnership strategies (CPSs), through project preparation, design, implementation, monitoring, and evaluation.

Part III provides checklists, sample documents, and background information on the recommended interventions.

This resource book focuses on road projects. However, the same issues are raised and similar interventions can easily apply in all ADB infrastructure programs.
For whom is this manual?

The manual is intended for use by ADB operational staff and consultants involved in preparing:

- transport sector analysis for CPSs;
- project documents for transport sector loans; and
- technical assistance (TA) to support transport sector loans.

The materials provided in Part II are organized around the stages of the ADB project cycle to enable operational staff to integrate HIV/AIDS issues into the regular project processing exercise, with minimum effect on existing workloads. The intention is not to turn transport sector specialists into HIV/AIDS experts, but to provide in one place all the necessary information and guidance that will allow them to carry out their core tasks in ways which reduce, rather than contribute to, the spread and impact of HIV/AIDS.

The resource book should also be easily accessible for transport ministries, national AIDS authorities, and key organizations and research institutions working with mobile and migrant populations.
PART I: HIV/AIDS AND TRANSPORT
Chapter 1: Why does HIV/AIDS need to be addressed in ADB transport sector projects?

1.1 HIV spreads around construction sites and along transport corridors

• The spread of HIV and sexually transmitted infections (STIs) through major transport and infrastructure projects is well documented.\(^1\) The connection is so well established that these infections are sometimes called “highway diseases.”

• Better roads bring many benefits but also increase risks through greater mobility and connectivity. Mobile people, especially “mobile men with money” (e.g., truck drivers), are more likely to engage in risk behaviors, such as unprotected sex with casual partners and sex workers, and drug use.

• A large influx of males into a rural area for a construction project increases the demand for sex, especially if they are far from home and lonely. Local communities are affected when women and girls (and sometimes young men and boys) meet that demand, either willingly for money or favors (such as payment of school fees), or unwillingly through rape or abduction into sex work.

• Commercial sex work and the trafficking of drugs and humans, particularly women and girls for sex work, also follow big construction projects and transport routes. “Lack of gender equity is an important element in the spread of HIV along truck routes.”\(^2\)

• In India, a recent study found HIV prevalence rates of 16% along one particular route in southern India, while the national rate was less than 1%.\(^3\) In Bangladesh, a national surveillance study found that those with the highest prevalence of HIV were long-distance truck drivers. In the People’s Republic of China

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1.2 HIV/AIDS may affect infrastructure sector performance

(PRC), a study of truckers found that the STI rates were between two and four times the rates in the general population.\(^4\)

- The Mandalay–Muse Highway was constructed in 1997 to connect Myanmar to the PRC. Drug use expanded along the highway. A year after construction ended, HIV prevalence among injecting drug users (IDUs) in three provinces in Myanmar rose from 51% to 88%, 34% to 74%, and 86% to 92%, respectively.\(^5\)

- The spread of HIV from these high-risk groups (IDUs and sex workers) to the general population happens through the clients of sex workers to their wives and then to children. Men-who-have-sex-with-men (MSM) also play a role because many also have sex with women, including their wives.

1.3 ADB has a significant role in transport and infrastructure in the region

- In construction projects and transport, social norms may become loose and workers and employees may be tempted to engage in high-risk behaviors. If STI and HIV infections increase, workers’ and employees’ absences and sickness may threaten output and profits.\(^6\)

- The costs of replacing workers (advertising, recruiting, and training) can also be substantial, especially for skilled workers and management. Several studies have found that risk levels can be higher among managers than laborers, possibly because of their greater disposable income.\(^7\)

- ADB is a major supporter of transport and infrastructure sector development in the region, with three quarters of all lending in 1970–2005 going to roads and highways.\(^8\)

- Transport is the largest and fastest-growing sector in ADB operations. Its share of lending rose from 16% in 1970s to 20% in the 1990s, and 33% in 2000–2005.

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\(^4\) Footnote 2.

\(^6\) Footnote 3.

\(^7\) Footnote 2. Also Katz, C. and X. Sun. 2006. The Baolong Healthy and Safe Action Project, 6. Available from che.katz@attglobal.net

1.4 Reducing the impact of HIV/AIDS requires a multi-sectoral approach

- As a 3-year moving average, lending for transport and communications increased 105% (1996–2004) while for all other sectors combined, it declined by 42%. All large developing member countries (DMCs) have borrowed heavily for transport sector projects, and smaller DMCs have borrowed at least once. Those that have not used transport loans, like a few Pacific countries, have taken multi-sector loans that included transport components.9

- At the end of 2005, 104 transport loans were under disbursement, worth $1.11 billion. Loan approvals in 2004 and 2005 amounted to $2.03 billion and $1.87 billion, with 18 projects approved each year.10

1.5 ADB has made commitments to address HIV/AIDS

- At the beginning of the epidemic, HIV/AIDS was considered a health problem, to be addressed by the health sector. Clearly, the health sector alone cannot effectively control the spread of HIV. An effective response to the AIDS pandemic calls for involving other sectors, including education, transport, agriculture, communication, finance, and tourism.

- “Multi-stakeholder and multi-sectoral response involving a range of partners from government, civil society, private sector, and others is therefore an essential imperative.”11 Engineers also need to become involved and understand how they can help fight the spread of HIV in their own sector of activity. ADB’s experience in supporting transport ministries in the Greater Mekong Subregion (GMS) to develop policy frameworks and action plans is a good example of a multi-sectoral response.

In August 2006, at the XVI International AIDS Conference in Toronto, Canada, ADB joined five other development agencies12 to sign a Joint Initiative by Development Agencies for the Infrastructure Sectors to Mitigate the Spread of HIV/AIDS. The signatories committed to “mainstream HIV/AIDS prevention and treatment programs in infrastructure sectors to reduce the impacts of HIV/AIDS as a result

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9 Footnote 8.
10 Footnote 8.
12 African Development Bank, UK Department for International Development (DFID), Japan Bank for International Cooperation (JBIC), German Development Bank (KfW), and World Bank.
Why does HIV/AIDS need to be addressed in ADB transport sector projects?

of infrastructure interventions, to take opportunities for implementing further counter measures against HIV/AIDS and to contribute to strengthening the HIV/AIDS strategies of partner countries.”  

- In April 2005, ADB adopted a strategic directions paper for ADB activities on HIV/AIDS, *Development Poverty and HIV/AIDS: ADB’s Strategic Response to a Growing Epidemic*. This document specifically recommends, as a priority for action, targeted programs to “integrate HIV/AIDS activities in ADB infrastructure projects that potentially interact with, create, or enhance high-risk environments for HIV/AIDS,” and “support for HIV/AIDS projects that specifically target women and girls.”

- In February 2005, ADB signed an agreement with the Government of Sweden to establish a multi-donor Cooperation Fund for Fighting HIV/AIDS in Asia and the Pacific, with an initial commitment of $14.4 million. The Fund resources support ADB’s efforts to fight the spread of HIV and AIDS in its core sectors of activities, taking opportunity of ADB’s comparative advantage to adopt a multi-sectoral approach to fighting HIV and AIDS.

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Chapter 2: Who is vulnerable and why?

A range of sociocultural, political, and economic factors increase people’s vulnerability of some groups to HIV and AIDS:

- Cultural or religious resistance to talk openly about sexual matters, especially in mixed company;
- Lack of accurate information and the proliferation of inaccurate information about prevention of STI and HIV/AIDS;
- Difficulties in accessing good quality male and female condoms;
- Lack of access to good quality, confidential, and gender-specific services for treatment of STI and for voluntary counseling and testing for HIV; and
- Stigma of having (or even being tested for) STI and HIV, especially for women.

In the context of roads and transport sector projects, some groups are at higher risks, during construction and/or after project completion, and require our attention:

- Migrant workers (construction personnel, truck drivers\textsuperscript{15}) and people ready to provide them services (including sex workers [SWs] and food and other service providers);
- Men, women, and youth in communities around the construction site and along the transport corridors;
- The wives/husbands/partners in the home communities of migrant workers who are vulnerable through their partners’ high-risk behaviors while away from home.

\textsuperscript{15} Construction personnel and truck drivers are mostly male and commercial and/or casual sex transactions are mostly with women.
Beware of stigmatization!

It is important to understand that some particular risk factors are listed below to draw attention of staff and professionals on the risks that have been observed in various transport sector projects to help them understand why some interventions are necessary to mitigate these risks. Majority of workers and migrants involved in construction projects or mobile workers do not adopt these high-risk behaviors.

And surrounding communities do not necessarily engage in high-risk behaviors.

Why are these people more vulnerable to HIV and AIDS?

**Construction personnel**

- Disposable income available for spending on sexual services, alcohol, and drugs, including injected drugs; this can be especially relevant for higher-paid male personnel, such as managers, engineers, and supervisors;

- Accessibility to, and availability of, formal and informal sex workers\(^{16}\) near the construction sites;

- Possibility of anal sex between males, if females are not available\(^{17}\);

- Separation from partner, families, and familiar norms of sexual behavior;

- Peer pressure in all-male groups to impress each other with sexual exploits;

- Isolated and difficult work conditions, with pressure of tight deadlines;

- Lack of attention to the needs of female employees for protection against sexual violence (e.g., sexual harassment policies and procedures, safe ablution, and accommodation areas);

- Difficulties of ensuring privacy and confidentiality for persons seeking STI and/or HIV testing in the close confines of a construction campsite; and

- Fear of losing employment if found to be HIV positive.

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\(^{16}\) Formal sex workers are those who belong to an organized form of sex work. Informal sex workers often work as freelancers and/or use sex work to supplement other sources of income.

\(^{17}\) Anal sexual relations without condoms are riskier than oral or vaginal relations because they often create abrasions that facilitate transmission of HIV.
**Truck drivers and their assistants**

- Reliance on illicit drugs to cope with long hours of driving;
- Lack of safe options for rest and recreation;
- Long waiting times in weighing facilities, customs, and border checks, etc;
- Accessibility and availability of sex workers along the transport route and at rest and recreation facilities;
- Separation from partner, family, and familiar norms of sexual behavior; and
- Sexual relations between drivers and their assistants (in some countries).

**Sex workers**

- Little power or skill for negotiating condom use with clients;
- Exposure to violence by clients, and exploitation by police and other authorities;
- Reliance on illicit drugs to cope with difficult life situations;
- Vulnerabilities associated with being mobile—many are migrant sex workers who follow the movement of construction camps (e.g., language barriers and social isolation);
- Stigma and discrimination attached to sex work and being sex workers (especially for male sex workers);
- Fear of not being able to engage in sex work once found out to have an STI and/or HIV; and
- Vulnerabilities associated with being an illegal immigrant to an area, particularly via human trafficking.

**Sex partners of the above groups**
(Wives/partners of male workers, especially seasonal workers)

- Social, cultural, and economic barriers that inhibit women from questioning the sexual decisions of men, particularly their husbands, and that limit their access to STI and HIV-prevention information and services;
• Husbands/partners of male workers whose wives faced hardship in the absence of their partners, and engaged in sex for money or food;

• Homophobia, which motivates many MSM to hide their behavior and to seek social approval by maintaining heterosexual relationships;

• Sexual and physical violence against women and girls, and sometimes boys; and

• Widespread resistance to using condoms with a regular or stable sex partner, including between sex workers and their spouses.

**Local communities affected by the project**

• Greatly increased opportunities for mobility, increased income, and risk-taking behaviors, for both males and females:
  a. during the construction phase (e.g., informal businesses supplying the project);
  b. long-term post-construction increase in “connectivity” (as locals and outsiders use the road);

• Where resettlement is involved, loss of immediate income and shelter threatens the financial security of families, and disproportionately disadvantages women;

• Young girls and women engaging, either by choice or by force, in transactional sex with migrant workers for material benefits (e.g., school fees, clothes, food, etc.);

• Increased potential risk to women and girls of being trafficked;

• Traditions of male leadership, which limit women’s ability to express their needs or participate in formal consultations or decision making;

• Introduction of illegal drugs into local communities, or expansion (facilitation) of existing drug trade; and

• Traditional values and social systems may be disrupted or weakened because of activities related to the project.
Chapter 3: HIV/AIDS in Asia and the Pacific

3.1 Overview of the epidemic

- At the global level, the latest figures published by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO) estimate that 33.2 million were living with HIV in 2007—30.8 million adults (15.4 million women) and 2.5 million children.  

**Figure 1: Estimated Number of People Living with HIV Globally, 1990–2007**

AIDS = acquired immune deficiency syndrome, HIV = human immunodeficiency virus, UNAIDS = The Joint United Nations Programme on HIV/AIDS.

Source: UNAIDS. 2007 AIDS Update.

- HIV and AIDS do affect Asia and the Pacific: UNAIDS reported in August 2007 that 5.4 million people in the region are living with the disease. Nearly a million new infections occurred in the last 2 years—50% of whom were young people. In addition 640,000 people died from AIDS-related diseases despite scaling up treatment services by many countries in the region.

- The numbers of new infections continue rising in the PRC, Bangladesh, Indonesia, Nepal, Pakistan, and Viet Nam, even if the decreasing prevalence in Cambodia and Thailand seems to be real (lower figures for India result from better surveillance.

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Table 1: Classification of the HIV/AIDS Epidemic in ADB Developing Member Countries

<table>
<thead>
<tr>
<th>Stage of Development</th>
<th>Stage Description</th>
<th>Country or Region</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Generalized epidemic</strong></td>
<td>HIV is firmly established in the general population. Proxy indicator: HIV prevalence is consistently over 1% among tested pregnant women in sentinel sites.</td>
<td>Cambodia, Thailand, Myanmar, PNG, and six states in India</td>
</tr>
<tr>
<td><strong>Concentrated Epidemic</strong></td>
<td>HIV/AIDS has spread in a defined subpopulation, but not in the general population. Proxy indicator: HIV prevalence consistently over 5% in at least one defined subpopulation, such as MSM, IDUs, SWs, etc; and HIV prevalence less than 1% among pregnant women attending urban antenatal clinics.</td>
<td>Indonesia, Nepal, Malaysia, Viet Nam, PRC</td>
</tr>
<tr>
<td><strong>Low prevalence</strong></td>
<td>Proxy indicator: HIV prevalence is less than 5% in any defined subpopulation.</td>
<td>Other ADB DMCs in Asia and the Pacific</td>
</tr>
</tbody>
</table>


and methodology, not from control of the epidemic). Table 1 indicates the level of the HIV/AIDS epidemic in ADB’s DMCs.

3.2 How is HIV spread in the region

**Injecting Drug Use**

- Injecting drug users (IDUs) become infected through sharing contaminated injecting equipment (syringes and needles). Often marginalized, many of them poor and young, they often turn for sex to SWs, or offer themselves sex services to pay for the drug.

- IDU is the major driver of the HIV epidemic in Asia. Countries with documented HIV infection among IDUs include Bangladesh, Cambodia, PRC, India, Indonesia, Kazakhstan, Lao People’s Democratic Republic (Lao PDR), Malaysia, Myanmar, Pakistan, Tajikistan, Thailand, Uzbekistan, and

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Viet Nam. As each epidemic progresses, the proportion of infections due to IDU drops while sexual transmission rises.

**Sexual Transmission**

- From IDUs and SWs, the epidemic will start spreading to the other people with whom they have sex: their regular partners and the clients of sex workers. Clients of SWs come from all backgrounds (though “mobile men with money” predominate), and usually have other sexual partners and/or are married.

- The HIV virus passes from the sexual secretions of the infected partner into the blood stream of the other partner if there are minute breaks or sores (such as those caused by STI) in the skin or mucosa. Unless condoms are used, HIV will eventually spread to the general population through sexual intercourses, especially where rates of untreated STI are high.

- Another important but neglected group “bridging” transmission to the general population is MSM. They are referred to in this way because many of these men have sex with women too, and do not see themselves as homosexual. Studies show that 3–5% of men in Asia have sex regularly with men and that 20–50% of them have sex also with women, including their wives. Anal sex is more common in isolated, predominantly male settings, such as construction camps, prisons, or the military.

- The recipient of anal sex is up to 15 times more likely to become infected with HIV, and again, unless condoms are used, infected MSM will pass the virus to their wives and other sex partners. Discriminatory laws and attitudes mean that sex between males usually remain hidden, making it difficult to reach MSM with appropriate information and services.

**Prevention of Mother-to-Child Transmission**

- About one third of babies born to HIV-infected mothers will acquire the virus during childbirth or later through breast milk. Transmission risk can be cut by more than 50% by treating the mother and the baby with inexpensive drugs at the time of birth, and by using safe breast milk substitutes. However,

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fear of stigmatization deters many women from giving birth in a health facility, or from using alternative infant feeding methods.

- To reduce the blame and other harsh consequences often experienced by HIV-positive mothers, WHO and UNAIDS recommend referring to this mode of transmission as “parent to child,” since in most cases the father is also HIV-positive, and may well have transmitted the infection to his wife.

**Contact with Infected Blood**

- The HIV virus can pass directly into a person’s bloodstream, through transfusion, or injection, or accidentally through sores or damaged skin. Blood transfusions and the use of contaminated needles in formal or informal health care settings remain a source of infection in many parts of the region. WHO estimated in 2000 that 5–10% of HIV infections in Southeast Asia were acquired through contaminated blood, while for Pakistan, UNAIDS reported a figure of 17% in 2003.

- Cultural practices, which involve cutting the skin with shared unsterilized implements, such as tattooing, piercing, traditional initiation rituals and circumcision, and body scarring, also carry a potential risk of HIV infection. These practices are common in all-male setting, such as construction camps, and in many Pacific island countries.

**Additional Risk Factors**

- **Mobility and migration:** “The vast numbers of people in Asia who are on the move for economic reasons create wide networks for the spread of diseases.” A growing proportion of these people are victims of trafficking, often for the purposes of sex work, which further increases their risk. Both men and women migrate, but men tend to dominate in long-distance and cross-border migration in most regions of the world. Male migrants and groups of mobile men have also been the focus of discussions and research on the migration–HIV/AIDS connection. Long-distance lorry drivers are one such male migrant group, often showing higher HIV prevalence.

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3.3 “Feminization” of the epidemic

- **Youth**: Like everywhere, young people in the region are sexually active, yet often denied, for cultural and religious reasons, the knowledge and services for preventing HIV infection. Young people between 15 and 24 years old represent 22% of those in Asia living with HIV/AIDS.

- **Weak health systems**: STI increases the risk of HIV transmission by a factor of 5, yet health services throughout most of the region are not adequately equipped to treat STI. Services related to the control of HIV, such as voluntary counseling and testing (VCT), prevention of transmission to infants, safe blood supplies, and universal health and safety precautions, are also too often inadequate.

- **Gender inequality**: being female, particularly a poor female, in a male-dominated society is itself a risk factor for HIV infection, for reasons that will be explained in the next section.

- **Stigma and discrimination**: As soon as scientists identified HIV and AIDS, social responses of fear, denial, stigma, and discrimination have marked the epidemic. Discrimination has spread rapidly, fueling anxiety and prejudice against the groups most affected, as well as those living with HIV or AIDS, often preventing them to obtain appropriate information and services.

- In the early stages of an epidemic, infection is concentrated among high-risk groups such as IDUs, SWs, MSM, and mobile populations. As the epidemic spreads to the wider population through sexual transmission, women represent an ever-growing proportion of those infected. This is clearly the case in Asia and the Pacific.

- Patterns of economic, social, and cultural discrimination against women generally make it difficult or impossible for them to control the conditions under which they have sex. Marriage increases the risk for women when it is combined with cultural requirements for wifely obedience and tacit cultural tolerance of male extramarital sex, as is often the case throughout the region.

- Sexual and physical violence against women and girls increases the risk of HIV for females, and therefore of further spread to men, and to unborn infants. Rough or forced sex directly increases the risk of genital trauma, especially with children or teenagers. Evidence from around the world indicates that between one third and two thirds of sexual assault victims are 15 years or younger.25

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Women and girls are not the only victims of male violence. Male-to-male acts of violence impacting on HIV transmission are, for example, rape in prisons and rape of boys. To ensure effective HIV/AIDS interventions, all situations need to be considered.\textsuperscript{26}

- Risk and vulnerability are different for men and women, as shown in Table 2.

### Table 2: Gender-Linked Differences in Vulnerability to HIV/AIDS

<table>
<thead>
<tr>
<th>Women</th>
<th>Men</th>
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<tbody>
<tr>
<td><strong>Physiological factors</strong></td>
<td></td>
</tr>
<tr>
<td>- Usually infected 5–10 years earlier than men because of biological and sociocultural factors. Infection often detected during routine antenatal testing.</td>
<td>- Infection usually detected at a later age (30&lt;), when testing for illness, or in VCT.</td>
</tr>
<tr>
<td>- Women are up to four times more likely to contract HIV from unprotected vaginal intercourse than men because of larger surface area of reproductive organs, higher concentration of the virus in semen than in women’s secretions, and abrasion of the mucosa (including damage through forced sex, particularly for young women/girls).</td>
<td>- Anal sex, commonly practiced by MSM or boys, has a very high risk of transmission for HIV, particularly for boys (up to 15 times higher than unprotected vaginal sex).</td>
</tr>
<tr>
<td>- Higher rates of untreated STI (facilitating HIV transmission) because symptoms are often not clear in women.</td>
<td>- Where several men have sex with the same woman or man, men can be infected from the semen of men ahead of them.</td>
</tr>
<tr>
<td><strong>Sociocultural factors</strong></td>
<td></td>
</tr>
<tr>
<td>- Norms of female sexual behavior encourage passivity, modesty, fidelity, and innocence or ignorance about sexual matters, and discourage females from controlling the conditions under which they have sex.</td>
<td>- Norms of male sexual behavior often allow/encourage men to have multiple sex partners, to seek sex frequently, and to demonstrate control over women through sex; they discourage men from admitting lack of knowledge about sexual matters.</td>
</tr>
<tr>
<td>- Cultural norms require women to marry and have children, preventing condom use.</td>
<td>- Peer pressure and “macho” culture in male-dominated environments encourage risk-taking behavior.</td>
</tr>
<tr>
<td>- Cultural norms push MSM, in some societies, to marry and so doing put their wife at higher risk.</td>
<td></td>
</tr>
<tr>
<td>- Tolerance of male physical and sexual violence against women/girls increases women’s/girls’ risk of HIV infection.</td>
<td></td>
</tr>
</tbody>
</table>

\[Continued on next page...\]

\textsuperscript{26} Swedish international development agency (Sida). 2007. AIDS and Gender relations.
<table>
<thead>
<tr>
<th>Sociocultural factors</th>
<th>Economic factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Less access to information about HIV prevention and treatment because of lower levels of literacy and education and limited involvement in public life.</td>
<td>• Cultural practices involving cutting the skin, e.g., tattooing, body piercing.</td>
</tr>
<tr>
<td>• Less access to STI or VCT services because of restrictions on mobility.</td>
<td>• Fear of job consequences inhibits men’s use of VCT.</td>
</tr>
<tr>
<td>• Less confidentiality when looking for STI or VCT services because of the need for women/girls in some cultures to be accompanied by their husband or a female relative.</td>
<td></td>
</tr>
<tr>
<td>• Stigma linking HIV with promiscuity makes it more shameful for women to use VCT.</td>
<td>• Homophobia and discriminatory laws marginalize MSM.</td>
</tr>
<tr>
<td>• Discriminatory laws which penalize FSWs but not their clients make FSWs vulnerable to violence and exploitation.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Economic factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Economic dependence on men, inability to negotiate safe sex, whether with husbands or in sex work.</td>
</tr>
<tr>
<td>• Few or no legal rights to own or inherit land or property, which increases female insecurity and makes widows especially vulnerable.</td>
</tr>
<tr>
<td>• Limited opportunities for earning income other than through formal or informal sex work, especially for migrant or refugee women, and for women/girls left behind when men migrate.</td>
</tr>
<tr>
<td>• Drug use may lead to selling sex.</td>
</tr>
<tr>
<td>• Greater number of women and girls in absolute poverty.</td>
</tr>
</tbody>
</table>

AIDS = Acquired immune deficiency syndrome, FSW = female sex worker, HIV = Human immunodeficiency virus, MSM = men-who-have-sex-with-men, STI = sexually transmitted infection, VCT = voluntary counseling and testing.

Source: ADB Consultants
PART II: RESOURCE BOOK
INTEGRATING HIV/AIDS ISSUES INTO THE ADB PROJECT CYCLE
Objectives

The resource book was developed to help ADB staff plan, design, implement, monitor, and evaluate HIV-prevention initiatives in transport projects.

The resource book provides a step-by-step methodology on how to address HIV and AIDS issues at each phase of the ADB project cycle.

Target Audience

- Mission leaders,
- Project team members,
- Consultants,
- Resident missions, and
- Others who will be responsible and/or involved in preparing, implementing, monitoring, and evaluating of HIV-prevention initiatives in ADB-funded roads and transport projects.

The resource book was specifically designed to address HIV vulnerabilities in the construction and rehabilitation of roads and highways. It can, however, be useful to other ADB sectors and subsectors as well.

How to Use the Resource Book

The resource book is organized into five interrelated modules that correspond to a particular phase of the ADB project cycle.

<table>
<thead>
<tr>
<th>Module 1</th>
<th>Project Identification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Module 2</td>
<td>Predesign</td>
</tr>
<tr>
<td>Module 3</td>
<td>Design</td>
</tr>
<tr>
<td>Module 5</td>
<td>Implementation</td>
</tr>
<tr>
<td>Module 6</td>
<td>Monitoring and Evaluation</td>
</tr>
</tbody>
</table>

Each module contains step-by-step methodology for addressing HIV/AIDS issues in that particular phase. An index for related materials and resources is also provided, which includes:

-[Issue] Brief overviews or explanations of key issues and themes relevant to that phase of the project cycle.

-[Link] Publications and other source materials relevant to that phase.

-[Tool] Checklists, sample terms of reference (TOR) for consultants, sample technical assistance (TA) papers, sample bidding documents, and other materials relevant to that phase/stage.
Module 1
Country Partnership Strategy: PROJECT IDENTIFICATION

ADB defines its medium-term development strategy and operational program in the country partnership strategy (CPS). Based on thematic and sector assessments, ADB identifies how it will support the DMCs’ development priorities and poverty reduction programs.

With sound analytical basis, ADB can advocate for HIV prevention to be mainstreamed into the transport sectors of the DMCs and region.

Objectives

- To understand if and how HIV vulnerability is created and/or exacerbated during and after the construction (and rehabilitation) of major roads and highways in the country’s local context; and

- To develop strategies and programs that can leverage ADB transport projects as effective mechanisms for HIV prevention, rather than contributing factors to the AIDS epidemic.

Outputs

Issues of HIV vulnerability in the transport sector addressed and incorporated (when needed) in the:

- CPS,
- health sector road map, and
- transport sector road map.

Key Questions

- What is the HIV and AIDS situation in the country and surrounding region?

- What geographical areas are being proposed for transport infrastructure development? What is the HIV and AIDS
situation in the proposed project sites and surrounding areas, especially in the towns/cities that will be connected by the road or highway?

- Has the National AIDS Authority identified the transport and infrastructure sectors as focus areas for HIV prevention? What prevention strategy does it have for migrant and mobile populations? Does it have a multi-sectoral strategy that includes the transport sector?

- Has the Ministry of Transport (or equivalent) identified HIV prevention as part of its sectoral work? If so, are there policies, strategies, programs, or mechanisms in place to support this?

- How can ADB support in developing or strengthening sustainable strategies and programs to address HIV vulnerability in the transport sector through TA and/or ADB-funded transport projects?

### Table 3: Addressing HIV/AIDS in the Formulation of the Country Partnership Strategy

<table>
<thead>
<tr>
<th>When</th>
<th>How Prevention Could be Taken into Account</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-CPS Analyses and</td>
<td>• Ensure that HIV is discussed as a key issue in the thematic analytical work on health, particularly as it is associated with mobility, migration, and the transport sector</td>
</tr>
<tr>
<td>Assessments</td>
<td>• Ensure that HIV is discussed as a key issue in the transport sector analysis as possible negative effects of major transport projects</td>
</tr>
<tr>
<td></td>
<td>• If potential investment in the transport sector is substantial, and data on HIV vulnerability in the transport sector are weak, then an in-depth assessment on the topic should be conducted, which should include related issues such as drug and human trafficking</td>
</tr>
<tr>
<td></td>
<td>• Ensure that key stakeholders from both health and transport sectors are consulted, which include:</td>
</tr>
<tr>
<td></td>
<td>- National AIDS Authority</td>
</tr>
<tr>
<td></td>
<td>- Ministry of Transport, including its HIV/AIDS committee and/or department/division that is responsible for addressing the social and environmental impacts of transport projects</td>
</tr>
<tr>
<td></td>
<td>- Donors who have experience and/or interest in HIV prevention in the transport and infrastructure sectors</td>
</tr>
<tr>
<td></td>
<td>- Civil society organizations that work on HIV prevention with relevant groups, e.g., migrant workers (including transport and construction workers), other mobile and migrant populations, ethnic minority groups, women, and children, etc.</td>
</tr>
<tr>
<td></td>
<td>- Labor unions and/or workers’ associations</td>
</tr>
<tr>
<td></td>
<td>- Private sector, e.g., HIV business coalitions (especially in the transport and construction industries), business forums for corporate social responsibility, etc.</td>
</tr>
</tbody>
</table>
Table 3 continued...

<table>
<thead>
<tr>
<th>When</th>
<th>How Prevention Could be Taken into Account</th>
</tr>
</thead>
</table>
| Preparation of CPS Initiating Paper | • Based on the pre-CPS analyses and key stakeholder consultations, explain why HIV prevention in the infrastructure sector (including transport) is one of ADB’s priority areas as articulated in the strategic directions paper, Development, Poverty, and HIV/AIDS: ADB’s Strategic Response to a Growing Epidemic, endorsed by the Board in April 2005\(^a\)  
  
  - Recommend strategies and programs that can effectively mainstream HIV prevention in the transport sector by focusing on:  
  - A multi-sectoral, programmatic approach rather than being limited to project-level interventions  
  - Establishing a functional relationship between the Ministry of Health (and/or National AIDS Authority) and Ministry of Transport  
  - Supporting the “Three Ones Principle”: one national HIV/AIDS coordinating authority, framework, and monitoring and evaluation (M&E) system\(^b\)  
  - Promoting institutional capacity building |
| Updating of Sector and Thematic Road Maps | • Ensure that HIV vulnerability is discussed as a key issue in preparing the transport sector road map  
  - Coordinate with the health sector in streamlining strategies and programs for HIV prevention in the transport sector to avoid duplication of efforts between sectors and at country level |
| CPS Mission | • Advocate with Government to mainstream HIV prevention in the transport sector through a sustainable, programmatic approach  
  - If the national HIV/AIDS framework promotes a broad-based multi-sectoral approach, discuss how to support the Ministry of Transport in strengthening its HIV response, e.g., developing an HIV/AIDS strategic plan, establishing an HIV/AIDS committee, etc. |
| Country Team Retreat/CPS Stock-Taking Meeting | • If HIV has been flagged as a priority issue during the country team retreat, ensure that the country team is comprised of a qualified member who can provide sound technical inputs on HIV during the preparation of the CPS |
| CPS Initiating Meeting/Informal Board Seminar | • Discuss if HIV prevention in the transport sector should be part of the strategic direction or priority areas for the country  
  - If so, clarify which ministry has the main mandate to ensure that HIV prevention in the transport sector is achieved |
| CPS Formulation Mission | • Identify possible co-financing options and/or collaborative opportunities with other funding agencies/donors based on each one’s comparative advantage\(^c\)  
  - Determine which ministry should take the lead responsibility for HIV prevention in the transport sector and what mechanism should be in place to facilitate effective coordination and collaboration with other ministries and key players |

\(^b\) The Three Ones Principle was launched in Washington on 25 April 2004 by UNAIDS in collaboration with national HIV/AIDS programs, bilateral donors, and the Global Fund to reinforce international stakeholders’ commitment to harmonize the HIV/AIDS epidemic response.  
\(^c\) Explore for example opportunities to collaborate with the Joint Initiative partners (see Part I, page 3).  
Suggested Tools and Resources

A number of tools and resources are available to assist governments in assessing national HIV/AIDS situations and in formulating strategic HIV and AIDS responses accordingly. Presented below are some examples.

[Link] Sample HIV/AIDS policy of a Ministry of Transport
Ministry of Public Works and Transport, Kingdom of Cambodia, 2006
In 2006, the HIV/AIDS Working Group of the Ministry of Public Works and Transport (MPWT) developed the Policies on HIV/AIDS Prevention: In Response to Activities of Public Works and Transport Sectors in the Kingdom of Cambodia. This was done in collaboration with the National AIDS Authority, with support from the Canada South East Asia Regional HIV/AIDS Program. Available from MPWT upon request.

[Link] Sample country action plans
United Nations Development Programme South East Asia HIV (UNDP-SEAHIV), 2004
These are samples of country action plans for mainstreaming HIV prevention in the transport sector from Cambodia, Lao PDR, Myanmar, Thailand, and Viet Nam. They were produced during a workshop, Building Regional HIV Resilience along the ASEAN Highway Network, held on 13–15 October 2003 in Bangkok, Thailand. UNDP-SEAHIV and Development Project, Association of Southeast Asian Nations (ASEAN), and World Vision organized the workshop.

[Link] ILO Code of Practice on HIV/AIDS
International Labour Organization (ILO), 2002
The ILO Code of Practice on HIV/AIDS and the World of Work: An Education and Training Manual provides guidelines to apply the “ILO Code of Practice on HIV/AIDS” to national strategic plans and to develop effective workplace policies and programs. The document also contains core information on HIV and the workplace, case studies, practical learning activities, and examples of laws and policies.

ILO, 2005
These guidelines for the transport sector respond to the different situations, needs, and interests of workers and employers related to HIV in this particular sector.
[Link] Sample strategy for HIV prevention among migrant workers

UN Regional Task Force on Mobility and HIV Vulnerability Reduction, 2006

The UN Regional Strategy for Mobility and HIV Vulnerability Reduction (2006–2008) covers all Southeast Asian countries and southern provinces of the PRC. It provides recommendations of institutional mechanisms that can be established at the national level to address HIV prevention among mobile and migrant populations, including those in the transport sector. Available: www.hivmobilitysea.org/RegionalStrategy/index.html
Module 2
Project Preparatory Phase: PREDESIGN PHASE

A TA fact-finding mission is usually conducted to validate expectations outlined in the CPS and to collect preliminary information for developing a project proposal.

The predesign phase is the most crucial for incorporating HIV issues into loan-related TA. This is the time when the ADB project team and the executing agency (in consultation with other key stakeholders) determine whether HIV is a significant enough issue to support or justify the inclusion of further HIV-related assessments and activities into project designs.

One output from the TA fact-finding mission is the initial poverty and social assessment (IPSA), which flags key issues that need to be addressed in greater depth during the project preparatory technical assistance (PPTA). As the correlation between major transport projects and the spread of HIV is well documented (Part I), it is highly recommended that HIV be systematically addressed as a key issue in IPSA and feasibility studies for roads and road transport projects.

Outputs

- Project team member designated for HIV/AIDS issues
- HIV/AIDS issues included in the IPSA
- Terms of reference (TOR) for an HIV/AIDS consultant for the project design phase

Entry Points for Considering HIV in the Predesign Phase

There are two main stages in the predesign phase in which HIV can be addressed accordingly. These are:

The following table summarizes the main steps to address HIV/AIDS during these two stages of the predesign phase. Detailed action points for each stage are provided in the following sections.

### Table 4: Addressing HIV/AIDS in the Predesign Phase

<table>
<thead>
<tr>
<th>Activity</th>
<th>How HIV Could be Taken into Account</th>
</tr>
</thead>
</table>
| **Stage 1: Initial Assessment**                                          | • Ensure that a qualified technical staff or consultant is a member of the project team, who can conduct policy dialogue and analysis of HIV issues with relevant government ministries and key stakeholders  
• Create a work plan that integrates HIV as a key issue in project preparation (e.g., HIV as a key issue in the IPSA report)  
• Include HIV-related questions in the social/poverty assessment questionnaire sent to the governments prior to the PPTA fact-finding mission  
• Consult key people in the National AIDS Authority, Ministry of Health, UNAIDS, and other relevant agencies who could give advice on key issues (and pitfalls) to consider when assessing the HIV situation in the proposed project area  
• Assess whether existing information on HIV is accurate, relevant, adequate, and if more information collection is needed  
• If HIV information for the proposed project area is inadequate, assess whether ADB needs to include resources in the PPTA to conduct a more in-depth HIV assessment  
• Discuss if the results of the HIV assessment constitute an HIV component for the proposed road project, or if further information and assessment are needed during the PPTA phase to determine this  
• If HIV needs to be addressed, seek assurance of assistance from the Government in all aspects of project preparation and implementation for the HIV-prevention component  
• Propose/negotiate TOR for an HIV/AIDS specialist (or qualified social/health professional) to prepare an HIV-prevention component and/or conduct an in-depth HIV assessment, if needed (use findings from the IPSA to design the TOR) |

Continued on next page...
### Predesign Phase

#### Stage 1: Initial Assessment

This stage in the predesign phase is crucial for incorporating HIV issues in the project design as it determines the following:

- The scale and scope of further HIV-related assessments through the project cycle; and
- The estimate of the amount and mix of consultant expertise needed to examine HIV vulnerabilities and other social and poverty issues (e.g., human trafficking) during project preparation.

#### Objectives

To determine the scale and scope of further HIV-related preparatory activities and consultant expertise required, the project team needs to:

- Include a member (staff and/or consultant) with adequate skills and experience on HIV prevention;
- Conduct a rapid HIV assessment during the PPTA fact-finding mission;
- Discuss preliminary HIV-related findings with the executing agency (and other key stakeholders) and identify appropriate measures to design an effective HIV intervention, if needed; and
- Include results from the HIV assessment and stakeholder discussions into the IPSA report.

#### Terms of Reference for Designated Project Team Member

To achieve the objectives mentioned above, there should be project team members who can gather and analyze HIV-related information, discuss findings with key stakeholders, and participate and contribute technical expertise when discussing HIV responses throughout the project cycle.

### Table 4 continued...

<table>
<thead>
<tr>
<th>Activity</th>
<th>How HIV Could be Taken into Account</th>
</tr>
</thead>
<tbody>
<tr>
<td>Invitation documents; shortlist; and CSC meeting</td>
<td>• If agreed upon, prepare the TOR for an HIV/AIDS specialist (or qualified social/health professional) to conduct a more in-depth HIV assessment</td>
</tr>
</tbody>
</table>

AIDS = acquired immune deficiency syndrome, CSC = consultant’s selection committee, HIV = human immunodeficiency virus, IPSA = initial poverty and social assessment, PPTA = project preparatory note, PPTA = project/program preparatory technical assistance, TA = technical assistance, TOR = terms of reference, UNAIDS = Joint United Nations Programme on HIV/AIDS.

Source: ADB Consultants.
To perform the preliminary HIV assessment during the PPTA fact-finding mission, the designated project team member needs to execute the following tasks:

- Gather updated information on policies, strategies, projects, and evaluations related to HIV and the transport sector from the HIV/AIDS Unit of the Gender, Social Development, and Civil Society Division of the Regional and Sustainable Development Department (RSDD) and other ADB departments/divisions;

- Consult with RSDD, UNAIDS, National AIDS Authority, and other relevant agencies that could give advice on key issues and pitfalls to consider when assessing the HIV situation in the proposed project area;

- Include questions on HIV vulnerability and other related social and poverty issues (e.g., drug and human trafficking) in the social/poverty assessment questionnaire sent to the government prior to the PPTA fact-finding mission;

- Identify which key informants to contact for additional information;

- During the PPTA fact-finding mission, conduct key informant interviews and critical observations at site visits;

- Assess if the HIV information collected are accurate, relevant, and adequate;

- Analyze the data collected and prepare preliminary recommendations;

- Discuss with the executing agency (and other key stakeholders) if the preliminary HIV-related findings are sufficient to consider (or not) an HIV component for the proposed transport project, or if further information and assessment are needed during the PPTA phase to determine this;

- If more information collection is needed, assess whether ADB needs to include resources in the PPTA to conduct a more in-depth HIV assessment;

- If the executing agency determines that HIV needs to be addressed, seek assurance of assistance from the government in all aspects of project preparation and implementation for the HIV-prevention component; and

- Propose/negotiate TOR for an HIV/AIDS specialist (or qualified social/health professional) to prepare an HIV-
Collecting HIV Information

Given time and resource limitations at the initial assessment stage, information gathering cannot be comprehensive. It is helpful to determine the parameters of the HIV assessment early on to ensure the systematic collection of pertinent information.

**[Tool]** A Checklist of Key HIV Issues is provided in Attachment 1.1 as minimum standards for data collection.

**[Tool]** Gender issues must be systematically and comprehensively addressed in the HIV assessment. A Checklist on Gender-Responsive Design for HIV Components in Transport Sector Projects is provided in Attachment 1.2.

Accessing Existing Information

Existing information can be accessed through the Internet and by requesting key documents from government ministries and other relevant organizations or agencies. The resources provided below are for different types of information that might be sought or used in the initial assessment.

**[Link]** Structural factors affecting HIV vulnerability
The YouandAIDS.org is an HIV and AIDS portal for Asia and the Pacific that provides HIV information and analyses in the overall development context. This is an initiative of the UNDP Regional HIV and Development Programme for South and North East Asia (REACH Beyond Borders). Available: www.youandaids.org/index.asp

**[Link]** Epidemiological data
The UNAIDS/WHO Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections provide basic information to understand the patterns and major routes of HIV transmission for member countries. Available: www.who.int/GlobalAtlas/predefinedReports/EFS2006/index.asp

**[Link]** Research studies on HIV vulnerability and the transport sector
There have been studies looking at the association of HIV vulnerability and development-related projects, particularly in the transport sector. The UNDP South East Asia HIV and Development Project, which ended in 2004, produced
numerous research and policy studies on this issue. Available: http://hivdevelopment.org/First.htm

[Link] Existing program review
Look for government and donor-funded projects that may have program write-ups and evaluations. These can often be found in web sites of multilateral and bilateral donors, international nongovernment organizations (NGOs), academic and applied research institutions, and government agencies.

Key Informant Interviews
Information gathered from the published reports should be checked and supplemented with firsthand information from interviews with individuals who are knowledgeable about the needs, living conditions, or services required by target populations in the proposed project area(s).

Key informant interviews should be informal and loosely structured. Since the purpose of the initial HIV assessment is to explore what HIV issues are significant to the local context of the proposed project area(s), it is best to keep the interview questions open-ended and flexible. Aside from being a method for gathering information, the key informant interviews can also be used for advocacy and to encourage/strengthen multi-stakeholder involvement in the HIV response.

Possible key informants can be found within the following groups:

- Ministry of Health;
- National AIDS Authority and their local counterparts;
- UNAIDS—there is a national or international country coordinator in most countries;
- Ministry of Transport (or equivalent);
- Other government agencies (e.g., Ministry of Labor, border police, etc.);
- Local hospitals and clinics;
- Nongovernment and community-based organizations;
- International donors and partners involved in HIV and AIDS work (e.g., Global Fund to Fight AIDS, Tuberculosis, and Malaria);
- National and/or regional associations of people living with HIV/AIDS (PLWHA);
- Academic and other research institutions;
- Private companies (e.g., construction and trucking companies); and
- Media.
Analyzing HIV Information

It is important to emphasize that special factors can exacerbate HIV vulnerability in the project area and may require special attention during the HIV assessment. These include:

- Existence of vulnerable communities along the project roads (e.g., tribal caste/ethnic minority communities that do not have much exposure to other subcultures, communities that are prone to drought or flood calamities, conflict-afflicted communities, etc.);
- Prevalence of generally low status for women and girls and existence of gender discriminatory practices;
- Projects that provide transport links between existing and/or developing key commercial points or junctions;
- Project areas situated near trade/industrial economic zones that attract a high number of migrant and mobile populations;
- Project area with high prevalence for STIs, HIV and AIDS, IDU, drug and human trafficking, and child labor abuse;
- Projects that will link high HIV-prevalent areas to each other, or to low HIV-prevalent areas, upon completion; and
- Cross-border areas.

[Link] The Checklist of Key HIV Issues found in Attachment 1.1 can assist the project team in the HIV assessment during the PPTA fact-finding mission.

[Link] The Checklist on Gender-Responsive Design for HIV Components in Transport Sector Projects is provided in Attachment 1.2.

Writing the Initial Poverty and Social Assessment

Below are suggested ways to incorporate the results from the HIV assessment and stakeholder discussions into the IPSA report.

Table 5: Addressing HIV/AIDS in the Initial Poverty and Social Assessment Report

<table>
<thead>
<tr>
<th>Section</th>
<th>HIV and AIDS Issues to be Considered</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Introduction</td>
<td>• HIV and AIDS situation in the country or region and, if information exists, in the proposed project area</td>
</tr>
<tr>
<td></td>
<td>• Relevance of HIV vulnerability to the road project (e.g., among construction workers and local communities residing near the project site)</td>
</tr>
<tr>
<td>II. Target Group for the Proposed Project</td>
<td>• Potential benefits of HIV-prevention activities for the construction workforce, local communities (especially the vulnerable poor and ethnic minority groups), and other vulnerable groups</td>
</tr>
</tbody>
</table>

Continued on next page...
### Table 5 continued...

<table>
<thead>
<tr>
<th>Section</th>
<th>HIV and AIDS Issues to be Considered</th>
</tr>
</thead>
<tbody>
<tr>
<td>III. Land Acquisition and Resettlement</td>
<td>• How resettlement and temporary loss of income can increase the HIV vulnerability of the local community (e.g., local women and girls engaging in commercial sex work)</td>
</tr>
<tr>
<td>IV. Minorities and Gender</td>
<td>• How women and girls are particularly vulnerable to HIV</td>
</tr>
<tr>
<td></td>
<td>• If and how ethnic minority communities are HIV vulnerable</td>
</tr>
<tr>
<td>V. Government’s Poverty Reduction Efforts</td>
<td>• Scale and scope of the government’s response to HIV and AIDS</td>
</tr>
<tr>
<td>VI. Absorptive Capacity</td>
<td>• Need to establish a collaborative framework among interministerial agencies to address HIV vulnerabilities</td>
</tr>
<tr>
<td>VII. Conclusion</td>
<td>• Relevance (or irrelevance) of HIV and AIDS to the project</td>
</tr>
<tr>
<td></td>
<td>• Identify need for more in-depth research and analysis, if relevant</td>
</tr>
<tr>
<td></td>
<td>• Recommendations</td>
</tr>
</tbody>
</table>

AIDS = acquired immune deficiency syndrome, CSC = consultant’s selection committee, HIV = human immunodeficiency virus.  
Source: ADB Consultants.
The project design for loan and TA projects is often developed by consultants. The type and mix of consulting expertise and the scope of work for each consultant are agreed upon by the project team and the executing agency during the PPTA fact-finding mission.

If HIV vulnerabilities are identified in association with the proposed project, it will be necessary to hire an HIV/AIDS specialist (or a qualified health/social sector professional) to conduct a more in-depth HIV assessment and design effective responses that are appropriate to the project setting.

The subsequent results of the HIV assessment will be incorporated into the poverty and social analysis report, which, in turn, will be used as basis for hiring an organization/agency to implement the HIV component of the transport project. Thus, it is important that qualified consultants are engaged to effectively examine key HIV issues during the predesign phase.

To task an HIV/AIDS specialist or qualified health/social sector professional to do the following:

- Conduct a rapid HIV/AIDS assessment in the proposed project areas;
- Recommend specific measures and strategies to mitigate the spread of HIV during and after road construction activities (based on discussions with the executing agency, key stakeholders, and beneficiaries); and
- Assist in preparing the invitation documents for the organization/agency to be hired for implementing the HIV activities.

The sample TOR for an HIV/AIDS specialist (or qualified health/social sector professional) to help in assessing and designing HIV interventions for ADB roads and road transport projects is provided in Attachment 2.1.

The TOR can be modified to fit different approaches in addressing HIV vulnerabilities in ADB roads and road transport projects, which can include: (i) HIV issues and interventions incorporated into the main project design (preferred option), or (ii) HIV addressed in a stand-alone TA.

**Issue**  It is preferred to hire an international consultant who has extensive knowledge and work experience in the project area, including relevant language skills. If not, arrangements should...
be made to recruit an interpreter/translator who is familiar with the language and sociocultural profile of the proposed target sites (to the extent possible).

[Link] HIV/AIDS Rapid Assessment Guide
David Wilson and Family Health International, 2001
This practical guide is meant to help program designers and managers to gather information and generate reports that explain the spatial, qualitative, and quantitative overview of a project area in relation to HIV and AIDS. It contains useful worksheets and exercises to direct users through the rapid assessment process. Available: www.fhi.org/en/HIVAIDS/pub/guide/HIV_Rapid_Assessment_Guide.htm
Module 3: DESIGN PHASE

Guided by key HIV and AIDS issues identified in the IPSA report, the consultant team conducts a more in-depth HIV assessment during the project design phase.

As they unfold, findings from the HIV assessment should be progressively incorporated into the project design. The expert/consultant will prepare detailed recommendations on how to best mitigate HIV vulnerabilities in the proposed project area(s).

The project team should have the capacity to evaluate the quality and appropriateness of the consultant’s work during this project design phase.

The final output will be key HIV issues identified, and an HIV/AIDS project proposal that will be presented either as a TA attached to the project, or as a component of the project itself incorporated into the Report and Recommendation of the President (RRP).

Objectives

To assist the ADB project team, the executing agency, and TA consultants in incorporating HIV concerns and component design into a TA paper or an RRP. There are three steps for addressing HIV in the project design phase:

- Identify and select appropriate HIV-related interventions and determine their costs;
- Determine the implementation and funding arrangements: implementing agency, funding mechanism, implementation schedule, and monitoring and evaluation; and
- Help recruit a qualified HIV/AIDS service provider.

Outputs

- HIV/AIDS component design, and
- TOR for HIV/AIDS service provider
Design Phase

Stage 1: Selecting HIV-Prevention Activities—Costing Interventions

The type of activities included in the HIV component will vary according to the context of each project. For project areas with high HIV prevalence, or for other reasons likely to increase HIV vulnerability, a more comprehensive component will be needed compared to areas with relatively low HIV vulnerability.

Presented below are HIV-prevention strategies that can be considered in designing HIV interventions for ADB transport projects. These strategies—either taken individually or all together—do not fit every situation. Each should always be analyzed for relevance, sensitivity, and applicability based on the unique local context of each proposed project area. Applied correctly, these actions can strengthen the HIV resilience of groups/communities made vulnerable by road development activities. These strategies are also aimed to support and strengthen national and local governments in systematically responding to HIV issues in transport projects.

Advocacy and Capacity Building

To ensure commitment and cooperation across a wide range of stakeholders, awareness can be raised to prevent HIV and other health and social impacts (e.g., malaria, drug and human trafficking, etc.) in a sustainable way through:

- Workshops targeting the construction workforce (management, consultants, contractors, subcontractors, and workers), provincial and district government authorities, border police (if in border area), local communities, health providers (private and public clinics, and pharmacies), commercial and entertainment establishment owners and staff, and other groups located in the project area;
- Development of HIV/AIDS policies in the construction workplace including preemployment screening, confidentiality of medical status, and workers’ rights to ongoing employment if found positive for HIV and other STIs;
- If project is near a border area, strengthening cross-border cooperation for HIV and other health and social issues (e.g., malaria, drug and human trafficking prevention, etc.); and
- Mid- and end-of-project workshops among key stakeholders to discuss lessons observed and recommendations for midterm remedial measures and improving strategies for future prevention programs in the infrastructure sector.

Factors increasing HIV vulnerability can include an influx of migrant workers, human trafficking of women and children, illegal drug trade, activities associated with cross-border areas, etc.

Adapted from the proposed GMS: Kunming-Hai Phong Transport Corridor–Noi Bai-Lao Cai Highway Project (footnote 27).
Information, Education, and Behavior Change Campaign

Awareness on HIV and other identified health and social issues can be raised and positive behavior changes can be created through:

- Integrating HIV prevention and other relevant issues (e.g., malaria) into the occupational health and safety program of the consultants, contractors, and subcontractors;
- Developing and using customized information, education, and communication (IEC) materials and behavior change communication (BCC) methods for construction sites and camps, commercial and entertainment settings, transport corridors and hubs including border areas (if applicable), local communities affected by the road project including by the construction of access roads, and health service delivery;
- Ensuring that education and training sessions in the construction sites/camps are conducted, and at an appropriate time for people to attend;
- Considering the specificity of women’s issues, and difference in women’s duties and work schedules;
- Using IEC and BCC materials and methods for ethnic minority groups that are culturally and linguistically appropriate, participative, and taking into account possible low literacy and education levels;
- Providing condoms throughout the project duration and ensuring the availability of condoms after project completion (e.g., through condom social marketing);
- Supporting, strengthening, and/or partnering with agencies/organizations working in specialized fields, e.g., drug and human trafficking;
- Supporting, coordinating, and collaborating with the resettlement and social development team of the project supervision consultant in implementing HIV prevention and other activities; and
- Ensuring that a confidential referral system is in place for construction workers who want to be tested and treated for HIV.

Provision of Medical Packages

In collaboration with the provincial health authorities, it should be ensured that the construction workforce, transport workers, local communities, and entertainment workers have access to quality HIV, STI, and other health services through:

- Preparing and/or updating protocols on HIV and STI voluntary counseling and testing, treatment, and care and support, especially for migrant and mobile clients;
Designing and implementing training sessions for health workers at the construction work sites and in the health centers and pharmacies serving the local communities in the project area;

Ensuring the availability of STI diagnostic tools and drugs in project-affected districts; and

Establishing a system to ensure that those diagnosed with HIV are provided with or referred to counseling and support services, information about clinical support services and treatment options, and information about rights to employment and protection from discrimination.

In 2004, ADB collaborated with UNAIDS to produce costing guidelines for HIV/AIDS intervention strategies. This tool aims to assist planners and program managers estimate overall financial resources needed to operationalize local responses to stop the spread of HIV/AIDS. According to these guidelines, to effectively estimate the budget needed to implement and monitor an HIV/AIDS intervention strategy, the following key factors should be considered:

- Prioritize the target population;
- Set coverage targets for reaching a specific subpopulation;
- Choose and design effective intervention packages and activities for the target population(s);
- Compute the costs of interventions as unit costs;
- Estimate the total resource needs based on the size of the population; and
- Examine (reallocating and reexamining as well) the impact of the planned intervention on the prevalence and incidence of HIV.30

The costing guideline can be accessed through the link provided below. Sample cost estimate and financing plans for an HIV component in a road project is also provided in Attachment 4.4.

[Link] Costing Guidelines for HIV/AIDS Intervention Strategies
ADB and UNAIDS, 2004

Design Phase

Stage 2: Determining Implementation and Funding Arrangements

No one model can fit all project settings. Every HIV component needs to be designed to fit the unique needs and context of each transport project. The scale and scope of the HIV intervention will vary according to the nature of the national and local HIV epidemic; national and provincial policies and strategies on how to respond to HIV risks in association with mobility and infrastructure development; and the existence of other donor resources, among others. The project team should give careful attention in determining which HIV activities and component design (e.g., implementation and funding mechanisms) best meet the requirements of each specific transport project.

ADB Experience

Over the years, ADB has increasingly developed both basic and comprehensive HIV-prevention-focused packages for its infrastructure sector projects, particularly in the construction of roads and highways. In a review of ADB infrastructure projects from 1999 to 2004, it was found that 44% (out of 111) had incorporated some measure for HIV prevention. The models used varied widely—ranging from loan covenants that require construction companies to provide HIV education to its workforce, as a minimum, to stand-alone, comprehensive TA packages that reach out to a broader range of vulnerable groups (e.g., local communities affected by the road construction processes). The implementation and funding arrangements also vary across projects, mainly determined by two factors: (i) which line ministry is ultimately responsible for addressing HIV issues in the transport sector, and (ii) what type of funding is available. (For a comparative analysis of the different design models used in selected ADB transport projects, refer to Attachment 4.1.)

In early 2007, ADB conducted a more in-depth review of its experiences in implementing HIV-prevention measures in association with infrastructure projects. Since different HIV-prevention models have been developed and adapted over the years, it was important to take lessons from these interventions to improve project designs and enhance institutional mechanisms for future ADB projects. Four transport projects in the Greater Mekong Subregion (GMS) were selected for the case study review.31 The findings and recommendations from this review were used to develop this module (refer to Attachment 5 for the full publication).

31 ADB transport projects selected are: (i) Northern Economic Corridor Project in the Lao People’s Republic (Lao PDR) (Loan 1989), (ii) East–West Corridor Project in Viet Nam and the Lao PDR (Loan 1944), (iii) Cambodia Roads Improvement Project (Loan 1945), and (iv) Western Yunnan Roads Development Project in the People’s Republic of China (PRC) (Loan 2014).
Two Main Design Options

From the past reviews, two models have been identified as key options for responding to varying structural and contextual settings, described in Table 6.

Table 6: Options for Implementation and Funding Arrangements

<table>
<thead>
<tr>
<th>Model</th>
<th>Type of Project</th>
<th>Executing Agency</th>
<th>Type of Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Ministry of Transport—Lead Agency</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>A.1. Main component of transport project</td>
<td>Ministry of Transport</td>
<td>Project loan or government subsidy</td>
</tr>
<tr>
<td></td>
<td>A.2. TA component added on to the transport project</td>
<td>Ministry of Transport</td>
<td>TA grant</td>
</tr>
<tr>
<td>B</td>
<td>Ministry of Health (or National AIDS Authority) — Lead Agency</td>
<td>Ministry of Health (or National AIDS Authority)</td>
<td>TA grant</td>
</tr>
</tbody>
</table>

AIDS = acquired immune deficiency syndrome, TA = technical assistance.
Source: ADB Consultants.

[Issue] The consideration of what model to use should always be based on the HIV/AIDS strategies and priorities of the government at the national and local levels. However, at some appropriate stage during government discussions, the project team should be able to advocate and/or discuss with government counterparts the possibility of adopting a multi-sectoral, programmatic approach to HIV prevention in the transport sector as explained in Module 1. A model that supports the Ministry of Transport (MOT) in taking ownership and addressing HIV issues in its sectoral work, through close collaboration with the National AIDS Authority, is preferred.32

Descriptions for these models are provided in the next sections, including key issues to consider for each design type.

Model A: Ministry of Transport — Lead Agency

Model A is possible if the government strongly supports and implements a multi-sectoral, programmatic approach to HIV prevention. This means that non-health line ministries are made responsible to address HIV

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32 This is in line with UNAIDS’ Three Ones Principle, particularly for having one national HIV/AIDS framework with a multi-sectoral, broad-based mandate.
issues in their respective sectoral work, with support and TA from the National AIDS Authority. The MOT, for example, will take the lead in ensuring that its projects are not spreading HIV by adequate prevention and mitigation measures in place.

Several ministries of transport in the Asia and Pacific region have shown strong leadership on HIV advocacy, prevention, and mitigation in their own sectors over the years. The National Highways Authority of India, Ministry of Public Works and Transport (MPWT) of Cambodia, MOT of Viet Nam, and the MPWT of the Lao PDR, are only some of the region’s champions on mainstreaming HIV prevention in the transport sector. These ministries have established their own HIV/AIDS committees and developed, or are in the process of developing, HIV/AIDS strategic and action plans. They have also designated specific departments/units to be responsible for HIV issues, often the same entities dealing with other social issues associated with transport projects, such as resettlement.

**Types of Funding Arrangement: Loan vs. Grant**

There is ongoing debate on whether HIV interventions in transport projects should be financed using project loans or funded through TA grants. This was discussed at length during the High-Level Meeting on Mobility, AIDS, and Infrastructure, organized by ADB and UNDP at the 8th International Congress on AIDS in Asia and the Pacific (ICAAP) in August 2007. While some donors would like to see governments subsidizing the HIV initiatives as a show of political commitment, some ministries of transport felt that donors should instead fund these through TA grants as part of a comprehensive development assistance package. The discussion on this issue is ongoing, especially between the signatories of the Joint Initiative by Development Agencies for the Infrastructure Sectors to Mitigate the Spread of HIV/AIDS and government counterparts.

**Sample Projects**

Some good examples of ADB transport projects that have the model A type of design are: (i) Northern Economic Corridor Project (loan-funded) and (ii) the proposed GMS: Kunming-Hai Phong Transport Corridor—Noi Bai-Lao Cai Highway Project (grant-funded).

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33 8th International Congress on AIDS in Asia and the Pacific. 19–23 August 2007, Colombo.
34 ADB has proposed to take the lead role in coordinating discussions on this issue (and other relevant topics) among the cosignatories to the Joint Initiative by Development Agencies for the Infrastructure Sectors to Mitigate the Spread of HIV/AIDS. This work is being coordinated by the Gender, Social Development, and Civil Society Division of the Regional and Sustainable Development Department (RSCS/RSDD), through its HIV/AIDS Unit.
35 ADB. 2002. Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the Lao PDR for the Northern Economic Corridor Project. Manila.
36 Project number: 33307 (as of 1 December 2007).
• **Loan-funded.** The Northern Economic Corridor Project upgraded a 22-kilometer (km) road in the north-western area of the Lao PDR, linking Thailand and the PRC. The project incorporated an awareness and prevention education program on HIV, and drug and human trafficking as a stand-alone project component. The total cost of the road project was $95.8 million through tripartite funding (ADB provided $30 million), while the total budget of the HIV, drug, and human trafficking component was $340,459 (0.36%). The HIV, drug, and human trafficking component was executed by MPWT and implemented by a local NGO, Lao Red Cross. The TA paper can be downloaded from the ADB website and the case study review on the project is found in Attachment 5.

• **Grant-funded.** The proposed GMS: Kunming-Hai Phong Transport Corridor–Noi Bai-Lao Cai Highway Project aims to build a 244-km highway that will be part of the GMS North–South Economic Corridor, connecting Kunming in Yunnan, and the PRC with Hai Phong, Viet Nam. An HIV, illicit drugs, and human trafficking prevention program has been proposed as a stand-alone TA project component. The total estimated cost of the proposed road project is $1.2 billion, while a $1 million grant (0.08% of project cost) for the HIV intervention is being negotiated under the ADB Cooperation Fund for Fighting HIV/AIDS in Asia and the Pacific, funded by the Swedish Government. The proposed executing agency is the Vietnam Expressway Corporation (VEC), the state enterprise of the MOT, while the implementing agency is proposed to be a consultant team in partnership with the provincial people’s committees (PPCs) or provincial government units. This sample HIV/AIDS component design can be found in Attachments 4.2–4.4.

**Model B: Ministry of Health (or National AIDS Authority) — Lead Agency**

Model B is appropriate if the government—after thoroughly discussing alternate options with the project team—decides that the Ministry of Health (or National AIDS Authority) should be the executing agency of the HIV intervention in the proposed transport project. This means that the Ministry of Health (or National AIDS Authority) will have the lead responsibility for designing, implementing, and monitoring all HIV activities associated with the road project. Although the Government may provide counterpart funding, ADB will most likely have to provide TA grant funding for the HIV component.
Sample Project

A good example of model B is the Baolong Healthy and Safe Action (BHSA). This project was designed as a stand-alone TA project to help prevent the spread of HIV during the construction of the Baolong Highway, under ADB’s Western Yunnan Roads Development Project. The total cost of the road project is estimated at $582 million, while the total budget for the HIV-prevention program is $1 million (0.17% of the road project cost). The BHSA project has been executed by the provincial AIDS authority (Office of Yunnan Provincial Working Committee for HIV/AIDS Control) and implemented by an international NGO (Marie Stopes International Australia/the PRC) under a contract awarded by ADB. The TA paper can be downloaded from the ADB website and the midterm evaluation report can be accessed through the link below. As the Western Yunnan Roads Development Project was one of the transport projects reviewed for its HIV component in 2007, the case study review findings are also provided in Attachment 5.

[Link] Baolong Healthy and Safe Action (BHSA) Case Study
This is a report prepared by the BHSA project team on their experiences and lessons learned. Available: www.mariestopes.org.au/Preventing_HIV_on_Highways_in_China.pdf

Key Issues to Consider

Based on the case study reviews conducted for the ADB publication HIV and Infrastructure: ADB Experience (refer to Attachment 5), the following key issues and recommendations should be considered when selecting an appropriate design model.

For Model A:

- Develop program support through capacity building of the transport and infrastructure sector institutions. With increased experience and capacity, there is a growing potential for sustained, programmatic approaches to be used in support of, or as an alternative to, stand-alone HIV interventions that exist only in conjunction with a specific infrastructure project. Technical support and capacity building for specific skills—such as monitoring and evaluation (M&E) for the staff of the ministries of transport (or their equivalent)—will increase the potential for such long-term mechanisms. In addition, developing HIV-prevention strategies and action plans with

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appropriate coordinating mechanisms linked to the national authority for HIV and AIDS will ensure that the design, implementation, monitoring, and evaluation of the HIV interventions remain technically sound and consistent with international standards.

- **Consolidate HIV implementing arrangements.** Where possible and appropriate, implementation arrangements should avoid having more than one organization and/or agency implementing HIV-related activities in association with a single infrastructure development activity. The HIV-prevention program should be part of a specific project component or in a parallel intervention that is explicitly linked to ensure that adequate funding is earmarked and that the MOT (or its equivalent) has some direct responsibility or role for the actions of the implementing organization and/or agency. At the same time, implementation arrangements that rely solely on construction contractors to directly hire and monitor HIV implementing subcontractors make it difficult to ensure quality and compliance.

- **Collaborate with local AIDS authorities.** Future HIV-prevention initiatives should ensure that local health providers and a multi-sectoral HIV/AIDS committee, where they exist (particularly at the local provincial or district level), are closely involved in planning and implementation stages. Capacity building and ongoing technical and financial support will increase the effectiveness and sustainability of the government’s HIV initiatives.

**For Model B:**

- **Ensure the involvement of the MOT.** Since the Ministry of Health executes the TA project, there is a real risk that non-health line ministries will regard HIV as only a health issue—unrelated to their sectoral work. Thus, the Ministry of Health will need the commitment and collaboration of the MOT to ensure that (i) the HIV project design fits the unique demands and context of the construction setting, and (ii) road project consultants, contractors, and subcontracts fully support and cooperate with the HIV program (e.g., allowing the workforce to attend HIV-awareness sessions and peer education training).

**For Both Models:**

- **Integrate HIV prevention into the contractor’s occupational health and safety program.** In countries such as the PRC, which require an occupational health and safety (OH&S) program in association with all infrastructure projects, HIV-prevention
messages could also be integrated into the OH&S program as a means of reinforcing and mainstreaming HIV-related messages. This is especially relevant if the OH&S program is subsidized through a medical insurance program for workers.

- **Partner with other specialized agencies.** If social issues apart from HIV (such as drug and human trafficking) are identified as important vulnerabilities associated with the infrastructure project, implementation arrangements should allow for specialized inputs in these areas. This may require an additional agency, perhaps as a joint partner, with the agency engaged for HIV-related measures. Experience has shown that it is difficult to find one agency or organization with the capacity to address all these issues competently and comprehensively, especially where locally based NGOs are the implementing partner(s). Working with a team with varying specializations can ensure that all issues are given equal and competent attention.

- **Implementation schedules.** Since HIV risks will remain high as long as the confluence of “men, mobility, and money” exists, HIV-prevention activities should be conducted throughout the construction period. Moreover, programs need to be scaled up during peak construction periods and scaled down when construction activities might subside (such as in the rainy season). The number and nature of construction workers will vary over the life of a project and the HIV program should adjust accordingly.

### Design Phase

**Stage 3: Finalizing the Component Design**

1. Monitoring and Evaluation
2. A Comprehensive Approach

### Establishing a Monitoring and Evaluation System

In close collaboration with the National AIDS Authority, an independent monitoring program should be developed during the design phase and incorporated in the HIV/AIDS component of the project. The objective is to:

- Develop a program performance and management system (PPMS) to be applied throughout the project duration (baseline, midterm, and end-term) that is streamlined with the national monitoring and evaluation (M&E) framework; and
• Undertake program monitoring at regular intervals and report to the executing agency, ADB, steering committees (mechanism through which the National AIDS Authority can provide TA to the project), and local AIDS authorities.

For details on how to establish an M&E system for an HIV component in a transport project and terms of reference for an M&E consultant, refer to Module 5.

A Comprehensive Approach

To assist in incorporating HIV/AIDS issues and component designs into a TA paper or an RRP for a project loan, a sample document is provided as a reference tool.

[Tool] Sample TA Paper in a Loan Project
This has been taken from Supplementary Appendix A of the proposed GMS: Kunming-Hai Phong Transport Corridor-Noi Bai-Lao Cai Highway Project (footnote 27). Refer to Attachments 4.2–4.4.

However, these documents only serve as a general reference and a starting point. These should all be modified to the unique needs and context of each particular project.
Module 4: IMPLEMENTATION PHASE

This phase is characterized by the executing agency implementing the project according to the agreed schedule and procedures set out in the final project/loan/TA documentation. This will include:

- Preparation of a detailed engineering design and bidding documents,
- Procurement of machinery and equipment, and
- Construction and installation of civil works.\(^{39}\)

To assist in the preparation of contracts that incorporate the HIV/AIDS activities agreed on in the project design.\(^ {40}\)

Available Tools

The following documents\(^ {41}\) are available in the attachments to this section:

[Tool] Draft HIV clause for inclusion in construction contracts can be found in Attachment 3.1.

[Tool] Draft explanatory note (for inclusion in bidding documents) can be found in Attachment 3.2.

The content of the contract should be modified according to the scale and scope of the proposed HIV/AIDS component.

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\(^{40}\) The timing for the preparation of the contractor’s bidding documents can vary according to the executing agency’s capacity and available resources. Some executing agencies prepare it before the loan receives ADB Board Approval; some afterwards. Nevertheless, the tools available in this section can be used at any stage in the project cycle, when applicable.

Module 5: Monitoring and Evaluation

M&E start at the predesign phase of every project. The need for quality HIV assessments at the beginning of the project cycle cannot be emphasized enough. The impact of any HIV intervention will depend on how relevant and appropriate the activities are to the local context, which can only be determined by accurate, gender-disaggregated, and project-specific baseline data. Likewise, a midterm evaluation is as crucial as the baseline study to determine if the project is (i) doing the right thing and (ii) doing the interventions right. By doing so, strategies can be modified and resources appropriately reallocated. Lastly, end-term evaluations should not only measure the project’s impact, but should also capture valuable lessons from implementing the project and provide recommendations for future projects.

The types of evaluation needed throughout the project cycle are shown in Table 7.

Table 7: Types of Evaluation According to the Project Cycle

<table>
<thead>
<tr>
<th>Types of Evaluation</th>
<th>Questions Answered by the Different Types of Evaluation</th>
<th>Phase of the ADB Project Cycle</th>
</tr>
</thead>
</table>
| Formative Evaluation Research (Determines concept and design) | Is an intervention needed?  
Who needs the intervention?  
How should the intervention be carried out? | Predesign phase / Design phase |
| Process Evaluation (Monitors inputs and outputs; assesses service quality) | To what extent are planned activities actually realized?  
How well are the services provided? | Implementation phase |
| Cost-Effectiveness Analysis (Including sustainability issues) | Should programs/priorities be changed or expanded?  
To what extent should resources be reallocated? | Evaluation phase (mid- and end-term) |

Continued on next page...
Terms of Reference for the M&E Consultant

ADB uses the PPMS in its projects. The project team should ensure that adequate resources are allocated for engaging a PPMS consultant for the HIV component that is congruent with the scale and scope of the HIV intervention. The PPMS consultant should start at least 4 months before the start of civil works (construction work) to design the baseline survey. The baseline study should be conducted weeks before civil works commence, targeting local communities along the proposed project area (consider teaming up with the resettlement team). The baseline study should continue a few weeks after construction work has started so the survey can capture the newly arriving construction workforce.

A sample TOR for an M&E consultant can be found in Attachment 2.3.

Key Issues to Consider

In designing PPMS for an HIV component in a transport project, the following key issues should be considered:

- Align performance and outcome indicators with the national HIV/AIDS framework;
- Design and collect gender-disaggregated data;
- Design and collect ethnic-disaggregated data using culturally and linguistically appropriate methods;
- Ensure that all surveys used are ethically sound, culturally appropriate, and do not facilitate and/or create stigma and discrimination;
- Segment target groups and subgroups (e.g., in a construction worksite, segment the construction workforce into subgroups such as managers/consultants, midlevel officers, contractors, subcontractors, long/mid-/short-term workers, female workers, etc.);
- Design surveys that consider the high turnover of employees in the construction site according to the construction stage, as well as the mobility/migratory patterns of the local communities (e.g., seasonal migration);

Table 7 continued...

<table>
<thead>
<tr>
<th>Types of Evaluation</th>
<th>Questions Answered by the Different Types of Evaluation</th>
<th>Phase of the ADB Project Cycle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective Evaluation (Assesses outcome and Impact)</td>
<td>What outcomes are observed? What do the outcomes mean? Does the program make a difference?</td>
<td>Evaluation phase (end-term)</td>
</tr>
</tbody>
</table>

Monitor availability of condoms outside the government’s reproductive health program;

- Conduct on-the-job training for government counterparts in PPMS to ensure sustainability;

- Capture and document valuable lessons from the implementation process of the project, not only collecting output-specific data; and

- Require the PPMS consultant to prepare a PPMS manual based on experiences and lessons from the project for use by relevant government agencies on similar projects in the future.

**Monitoring and Evaluation Tools**

Much sensitivity surrounds HIV/AIDS work, particularly in the risk of introducing or exacerbating stigma and discrimination against particular groups who are targeted by the HIV intervention. Every M&E undertaking in projects should be ethically sound and not promote and/or cause stigma and discrimination. The project team should engage HIV-related specialists to develop the PPMS. However, there are some M&E tools on HIV/AIDS to guide the project team in determining the appropriate nature of the PPMS developed by the consultants. These tools are provided in the links below.

- **[Link] IMPACT Handbook**
  *Family Health International, 2005*

- **[Link] HIV/AIDS Survey Indicators Database**
  *MEASURE DHS Project*
  The HIV/AIDS Survey Indicators Database provides an easily accessible comprehensive source of information on HIV/AIDS indicators derived from sample surveys. Available: www.measuredhs.com/hivdata/start.cfm
PART III: ATTACHMENTS
### Attachment 1: Checklists

1.1 Checklist of Key HIV Issues

1.2 Checklist on Gender-Responsive Design for HIV/AIDS Components in Transport Sector Projects

### Attachment 2: Sample Terms of Reference

2.1 Sample TOR: HIV/AIDS Specialist during the Project Design Phase

2.2 Sample TOR: HIV/AIDS Service Providers

2.3 Sample TOR: Monitoring and Evaluation Consultant

### Attachment 3: Bidding Documents

3.1 Draft HIV Clause for Inclusion in Construction Contracts

3.2 Draft Explanatory Note (for Inclusion in Bidding Documents)

### Attachment 4: Examples from ADB Projects

4.1 Comparative Analysis of HIV/AIDS Components in ADB Transport Projects

4.2 Example: Technical Assistance for HIV, Illicit Drugs, and Human Trafficking Prevention Program

4.3 Example: Design and Monitoring Framework

4.4 Example: Cost Estimates for the Program

### Attachment 5: Case Studies

5.1 Case Study Review of HIV Prevention in Four ADB Transport Projects in the Greater Mekong Subregion
### Attachment 1: Checklists

#### Attachment 1.1: Checklist of Key HIV Issues

<table>
<thead>
<tr>
<th>Types of Impacts (Social and Economic Risks)</th>
<th>Not known</th>
<th>Yes</th>
<th>No</th>
<th>If yes, consider potential scope of HIV vulnerability</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Potential for increasing HIV vulnerability</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the road construction project situated in an area with high HIV prevalence? Will it eventually connect to areas with high HIV prevalence?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Will there be increased mobility of the general population to the project site (e.g., laborers, itinerant traders, mobile sex workers)? If yes,  
  (i) Can (should) this be reduced?  
  (ii) Can they be targeted with specific HIV-prevention messages? |            |   |    |                                                       |
| Will subgroups be increasingly mobile during or as a result of the project (e.g., construction workforce, truck drivers, and sex workers)? If yes,  
  (i) Can (should) mobility be reduced or can the situation be managed to ensure they spend less time away from home, e.g., relocate their families to the project site?  
  (ii) Can they be targeted with specific HIV-preventive and curative services (e.g., condom promotion, STI testing, and treatment)? |            |   |    |                                                       |
| Are construction workers likely to come from the local community or from neighboring communities/countries? If not from the local community,  
  (i) Will there be a language barrier?  
  (ii) Can the same strategies work for multicultural target groups or should they be customized according to key cultural groups? |            |   |    |                                                       |

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### Types of Impacts (Social and Economic Risks)

<table>
<thead>
<tr>
<th>Potential for increasing HIV vulnerability</th>
<th>Not known</th>
<th>Yes</th>
<th>No</th>
<th>If yes, consider potential scope of HIV vulnerability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will some groups be disadvantaged by the (e.g., people who need to resettle)?</td>
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<td></td>
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<tr>
<td>If yes, can this be prevented?</td>
<td></td>
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<tr>
<td>If not, will there be processes to address the livelihood impact and will HIV vulnerability be considered?</td>
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<tr>
<td>Will the project affect the access to health care in the local population?</td>
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<tr>
<td>If it reduces access, can this be addressed?</td>
<td></td>
<td></td>
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<tr>
<td>If it increases access, can this alter the current scope of services to enhance HIV-related measures?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Will the project affect access to any type of education?</td>
<td></td>
<td></td>
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<tr>
<td>If yes, (i) Will this be addressed by the project?</td>
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<tr>
<td>(ii) Is there potential to enhance HIV-prevention measures in this process?</td>
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<tr>
<td>Will the project affect ethnic minority groups? Will the road traverse through their land and communities?</td>
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<tr>
<td>If yes, (i) Do they have cultural beliefs and traditions that make them extra vulnerable to HIV and other STI (e.g., premarital/courtship practices)?</td>
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<tr>
<td>(ii) Do you need ethnic- and linguistic-specific information, education, and communication methods and materials? Are there any available or do they need to be developed?</td>
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</tbody>
</table>

### Affected Persons

- Any estimate of construction workers and allied workers required for the project? No ( ) Yes ( )
  - If yes, approximately how many? ____
  - What is the gender ratio? ____

- Any estimate of the number of those in the local communities to be affected by the project? No ( ) Yes ( )
  - If yes, approximately how many? ____
  - What is the gender ratio? ____

- Are any of these people poor or vulnerable to poverty risks? No ( ) Yes ( )
  - If yes, how? ____
  - What is the gender ratio? ____

*Continued on next page...*
## Institutional Constraints

<table>
<thead>
<tr>
<th>Type</th>
<th>Not known</th>
<th>Yes</th>
<th>No</th>
<th>If yes, consider potential scale and scope of HIV activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are local health and HIV-related laws and regulations compatible with ADB policies (e.g., mandatory HIV testing for construction workforce)?</td>
<td></td>
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<tr>
<td>Will coordination and collaboration among several government entities be required? What will be the role and responsibility of the National AIDS Authority?</td>
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<tr>
<td>Is the executing agency willing to incorporate HIV considerations into their project?</td>
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<tr>
<td>Are there adequately skilled staff members in the executing agency who are available for planning and monitoring an HIV-prevention component?</td>
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<tr>
<td>Are training and capacity development interventions required prior to the implementation of the HIV intervention?</td>
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</tbody>
</table>

### Summary of Actions Required During the Predesign Phase

<table>
<thead>
<tr>
<th>Action Required</th>
<th>Not known</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is a full and separate HIV assessment required?</td>
<td></td>
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</tr>
<tr>
<td>Is an HIV/AIDS specialist required to design the HIV component for the initial poverty and social assessment? For the feasibility study?</td>
<td></td>
<td></td>
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<tr>
<td>What funding options are available?</td>
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<tr>
<td>Is further work necessary during the design stage to answer these questions?</td>
<td></td>
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</tbody>
</table>

Continued on next page...
<table>
<thead>
<tr>
<th>Action Required</th>
<th>Not known</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the HIV component design to be based on the feasibility study?</td>
<td></td>
<td></td>
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<tr>
<td>Is a stand-alone TA on HIV prevention warranted and/or possible?</td>
<td></td>
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<tr>
<td>Is the HIV component going to be blended into the loan?</td>
<td></td>
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<tr>
<td>Will further technical design be needed after Board approval?</td>
<td></td>
<td></td>
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<tr>
<td>Who will be the executing agency for the HIV component?</td>
<td></td>
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</tbody>
</table>

HIV = human immune deficiency, STI = sexually transmitted infection, TA = technical assistance.
### Attachment 1.2: Checklist on Gender-Responsive Design for HIV/AIDS Components in Transport Sector Projects

#### I. Project Planning

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the PPTA team include a member with gender expertise?</td>
<td></td>
<td></td>
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<tr>
<td>Are questions on gender relations and the socioeconomic situation of women included in the IPSA preliminary questionnaire?</td>
<td></td>
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</tr>
<tr>
<td>Is gender included in the team work plan for the fact-finding mission?</td>
<td></td>
<td></td>
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<tr>
<td>Is gender included in the TOR for any consultant involved?</td>
<td></td>
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</tr>
<tr>
<td>Are women’s and youth NGOs and government agencies included in the list of stakeholders consulted?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do the methods used for field consultations allow women, men, and youth to participate equally in culturally appropriate ways (e.g., separate consultations for men and women, and male and female youth, with same-sex facilitators)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are men and women key informants interviewed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are both men and women included in small sample surveys?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do the surveys cover the situation of women as well as men?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are sufficient data gathered on any local socioeconomic and cultural factors which discriminate against women and girls, or against men and boys?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are all data disaggregated by sex and by age group where relevant?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the IPSA report fully cover gender issues and the factors affecting the vulnerability of men, women, male and female youth and children, including the risk of trafficking?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### II. Project Design and Monitoring and Evaluation

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is gender analysis used in deciding what approaches and activities to include in the HIV/AIDS component?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the design include interventions to empower women?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are target groups sex-specific (e.g., men and women, male and female youth, male and female sex partners of male construction workers, female sex workers and their clients, MSM and their male and female sex partners, etc., instead of gender-blind groups such as “people,” “workers,” communities”)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Continued on next page...*
### II. Project Design and Monitoring and Evaluation

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are the spouses/regular sex partners (both sexes) of people in high-risk groups included in the target groups identified?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are component objectives and targets sex-specific (e.g., to reach 50% of male and female construction workers with peer education in Year 1; to train 80% of male and female youth aged 14–20 years in local communities in male and female condom use)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are there targets and quotas for the employment of women (especially female-headed households)?¹</td>
<td></td>
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<tr>
<td>Does the component address the risks of trafficking for women, men, girls, and boys?</td>
<td></td>
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<tr>
<td>Is there a Gender Action Plan for the component?</td>
<td></td>
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<tr>
<td>Does the design require sensitization on gender issues (e.g., to be included in HIV/AIDS-related trainings provided to project and component implementing agency staff and managers (senior as well as middle level) of both sexes, and to men, women, and youth in local communities)?</td>
<td></td>
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<tr>
<td>Does the component track project effects on girls and boys, and male and female adolescents, in the area of influence (e.g., on school attendance)?</td>
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<tr>
<td>Are strategic partnerships made with agencies assisting women and youth, sex workers, and MSM?</td>
<td></td>
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<tr>
<td>Does the M&amp;E framework use gender-sensitive indicators and sex disaggregated data to monitor and evaluate the different levels of involvement of women and men in the project and the impact on them of project activities?</td>
<td></td>
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<tr>
<td>Are gender results analyzed routinely to identify lessons learned and modify project implementation accordingly?</td>
<td></td>
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<tr>
<td>Does the budget provide specific allocations for activities needed to reach men and women separately, where necessary (e.g., separate consultations or trainings, different IEC materials, child care for village meetings, provision of female as well as male condoms, etc.)?</td>
<td></td>
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</tbody>
</table>

### III. Project Implementation

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>Are gender issues and women’s needs integrated into the HIV/AIDS IEC materials used, and into the HIV/AIDS topics covered in meetings, inductions, workplace safety trainings, etc.?</td>
<td></td>
<td></td>
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<tr>
<td>Are women effectively represented in project, component, and related workplace committees (less than 30% is usually not effective)?</td>
<td></td>
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</table>

¹ 30% female participation is a commonly accepted benchmark.
### III. Project Implementation

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Are women supported in taking leadership roles, both in the workplace and in local communities?</td>
<td></td>
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<tr>
<td>Are efforts being made to involve men and women in work or activities not traditionally linked to their gender?</td>
<td></td>
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<tr>
<td>Are women’s needs being addressed in the workplace (e.g., provision of segregated and secure latrines and ablution facilities, lighting, safe accommodation and transport)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is information provided to women in the workplace and in communities, on support services for victims of sexual or physical violence, especially where to get preventive treatment on STI, HIV, and pregnancy if they have been raped?</td>
<td></td>
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<tr>
<td>Do the implementing agency and the construction company have policy, procedures, and awareness on sexual harassment in the workplace?</td>
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<tr>
<td>Are the spouses of workers included in company health insurance covering HIV/AIDS?</td>
<td></td>
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<tr>
<td>Are workplace HIV/AIDS education sessions arranged so that male and female employees can benefit from them equally?</td>
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<tr>
<td>Do peer education and peer education programs reach women to the same extent as men?</td>
<td></td>
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<tr>
<td>Are efforts being made to raise awareness with men, women, and youth in the workplace and in local communities about violence against women and children, and trafficking of women and children?</td>
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<tr>
<td>Are local women’s organizations involved, and links made with provincial and/or national level agencies and advocates?</td>
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<tr>
<td>Are ADB standards for workplace equality being applied (e.g., equal pay for men and women doing similar work)?</td>
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<tr>
<td>Are savings schemes for men/women available through the workplace?</td>
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</table>

### Implementation: Capacity Development and Training

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Are gender issues included in the design of capacity development and training programs, and in the materials used?</td>
<td></td>
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<tr>
<td>Are gender-equitable targets included in the objectives for capacity development and training outputs?</td>
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<tr>
<td>Are safety issues for women considered in the logistics?</td>
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<tr>
<td>Are the capacity development needs of women, and women’s organizations, considered?</td>
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<tr>
<td>Is there a code of conduct for trainers that require them to role-model respectful relations between men and women?</td>
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*Continued on next page...*
### Implementation: Capacity Development and Training

<table>
<thead>
<tr>
<th>Yes</th>
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<tbody>
<tr>
<td>Is there gender balance in training of trainers, and are man–woman training teams used whenever possible?</td>
<td></td>
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<tr>
<td>Are trainers trained to facilitate women’s equal participation in training activities?</td>
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### Implementation: Behavior Change Communication

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Are sex-specific groups used for peer education and peer leadership?</td>
<td></td>
</tr>
<tr>
<td>Are efforts made to reach the spouses/regular sex partners of people in high-risk groups?</td>
<td></td>
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<tr>
<td>Do materials include gender issues (e.g., differences in vulnerability, VAW) and address different gender needs (e.g., different symptoms of STI for men and women)?</td>
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<tr>
<td>Is violence-free sex included as a safer sex behavior?</td>
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<tr>
<td>Is information given to men and women about women’s human rights, and the right to say “no” to sex?</td>
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<tr>
<td>Are appropriate IEC materials and methods used for each sex (e.g., adjusted for different literacy levels, access to mass media, etc.)?</td>
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<tr>
<td>Do materials avoid reinforcing negative gender stereotypes, or stigmatizing certain groups (e.g., female SW, MSM, or mothers who transmit the virus to their babies)?</td>
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<tr>
<td>Is there regular monitoring of dialogue-based methods (e.g., peer education, community theater) to ensure that local prejudices or beliefs do not distort the intended messages?</td>
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<tr>
<td>Does peer education with both sexes include demonstrating how to use a condom (male and female) and inform men and women how to get them?</td>
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### Implementation: Condoms Provision and Promotion

<table>
<thead>
<tr>
<th>Yes</th>
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<tbody>
<tr>
<td>Are female condoms promoted to men and women, as well as male condoms?</td>
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<tr>
<td>Are both sexes informed about how to use both types?</td>
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</tr>
<tr>
<td>Do IEC reduce stigma (e.g., by promoting condom use as the choice of “partners who care,” inside marriage not just outside it)?</td>
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<tr>
<td>Do distribution methods take account of the sexual double standard which makes it difficult for women to access condoms openly (e.g., not only placing condom distribution or vending machines in public areas such as hospital entrances, but also in more private areas accessed by women, or through woman-to-woman distribution)?</td>
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2 Male and female condoms must not be used together.
### Implementation: Services for STI and HIV Testing

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
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</thead>
<tbody>
<tr>
<td>Does the location of the service allow for privacy and confidentiality?</td>
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<tr>
<td>Is staff trained to give confidential nonjudgmental service, including with marginalized groups such as sex workers, MSM, and young or unmarried people?</td>
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<tr>
<td>Can clients be seen by a health worker/counselor of the same sex?³</td>
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<tr>
<td>Are couples encouraged to be tested at the same time (especially in antenatal HIV testing) to minimize woman-blaming?</td>
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<tr>
<td>Do staff demonstrate and provide male and female condoms to clients of both sexes, as part of prevention information?</td>
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<tr>
<td>Do protocols require counselors to always ask clients, particularly women, about their risk of violence when they reveal a positive test result to their partner?⁴</td>
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<tr>
<td>Are counselors trained to provide practical advice, support, and referrals to reduce the risk of violence when a client discloses a positive test result to partner?</td>
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<tr>
<td>Are treatment kits for rape victims available (prevention of STI, of HIV through PEP,⁵ and pregnancy prevention)?</td>
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<tr>
<td>Does the service make efforts to reach mobile groups (e.g., sex workers moving with work camps)?</td>
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<tr>
<td>Are cases recorded by sex and age group?</td>
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</table>

#### For STI Services Only

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
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<tbody>
<tr>
<td>Are staff trained to recognize the range of STI symptoms in women, and the oral and anal symptoms more common to sex workers and MSM?</td>
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<tr>
<td>Are syndromic management and presumptive periodic treatment methods used?</td>
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</table>

#### For VCT Services Only

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>Do staff explain to male and female clients about how HIV can be transmitted to babies through the mother if no preventive measures are taken, and refer pregnant women with an HIV+ test result to health services where they can access the necessary medications and support?</td>
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</table>

#### For Injecting Drug Users

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<thead>
<tr>
<th>Question</th>
<th>Yes</th>
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</thead>
<tbody>
<tr>
<td>Are programs tailored to the needs of male and female users?</td>
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</tr>
<tr>
<td>Are male and female users educated on how to prevent sexual transmission of HIV, including for MSM?</td>
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</table>

³ This is particularly important with STI services, which require a physical examination as well as a discussion of sexual behavior.
⁴ Depending on the country, there may be a legal requirement for a person receiving an HIV+ test result to inform their sexual partners about the diagnosis. Because of women's dependent situation, revealing an HIV+ diagnosis can often have serious consequences.
⁵ Postexposure prophylaxis.
### For Injecting Drug Users

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
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<tbody>
<tr>
<td>Does the component address safety issues for women/girls accessing harm-reduction facilities?</td>
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<tr>
<td>Does rehabilitation training avoid gender stereotyping?</td>
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</tbody>
</table>

AIDS = Acquired immune deficiency syndrome, HIV = Human immunodeficiency virus, IEC = information, education, and communication, IPSA = initial poverty and social assessment, M&E = monitoring and evaluation, MSM = men-who-have-sex-with-men, NGO = nongovernment organization, PPTA = project preparation technical assistance, STI = sexually transmitted infection, SW = sex worker, TOR = terms of reference, VAW = violence against women, VCT = voluntary counseling and testing.

Sources include:
Attachment 2:
Sample Terms of Reference

Attachment 2.1: Sample TOR—HIV/AIDS Specialist during the Project Design Phase

1. Introduction

The (executing agency) is entrusted to develop, operate, and maintain (what types of roads or highways) under (implementing agency) comprising of (affected sections). The Asian Development Bank (ADB) has provided a Technical Assistance (TA) to the (executing agency) for (name of proposed loan project). Under the TA, ADB appointed (number of consultants) consultants—(identify if international and/or local)—to prepare for resettlement management and social impact assessment for the sector project. The TA has provision for subcontracting special studies in resettlement, indigenous peoples, HIV and AIDS, and trafficking of women/children to facilitate project preparation activities.

<table>
<thead>
<tr>
<th>Package</th>
<th>Section</th>
<th>NH</th>
<th>Km</th>
<th>Length</th>
<th>Area</th>
<th>Firm</th>
</tr>
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</table>

2. Purpose/Objectives of the HIV and AIDS Study

It is now common knowledge that improved national/regional transportation networks have added to the rise of cross-border human trafficking, illegal drug, and sex trade, including the spread of HIV and sexually transmitted infections (STIs). Several studies indicate that the demand for commercial sex near construction sites and along major highway routes has facilitated the spread of HIV and other STIs. The essential purpose of the study is to assess the current situation, spatial/social dynamics of HIV and AIDS, and potential impact of highway development in transmitting HIV infection in the project influence areas.

2.1. Scope of Works

The HIV/AIDS specialist will carry out rapid assessments at selected settings in project packages to:

---

1 Adapted from: ADB. 2002. Technical Assistance to India for Preparing the National Highway Corridor (Sector) Project. Manila.
(i) Analyze the HIV/AIDS and STI situation in the project influence areas and respective project states (e.g., HIV/AIDS/STI prevalence, main routes of transmission, policy environment, presence of HIV/AIDS/STI-implementing agencies, alternate funding options, available services for prevention, testing, treatment, care and support, etc.);

(ii) Examine possibilities for collaboration among donors, UN agencies, government ministries, HIV-implementing organizations, private sector (construction and trucking companies), public/private health professionals, civil society, etc.

(iii) Examine the local context for why, where, when, how, and among whom high-risk behaviors for HIV transmission occur (or can potentially occur) in the project area and respective project states. Emphasis should be placed on HIV vulnerability associated with construction activities (e.g., labor migration, increased mobility and connectivity, subculture in construction labor camps, etc.);

(iv) Elaborate and model the intricate information and operational network (e.g., between truckers, sex workers, construction workers, construction supervisors, trafficking agents, etc.) in the project region that facilitates the spread of HIV; and

(v) Assess the scope of highway projects, based on the findings of the study, to effectively address the HIV issues and, if so, what specific measures and activities are to be taken to mitigate such impacts.

2.2. Structure and Length

The report should be a total of 40–45 pages in length [or as otherwise determined], excluding tables and other field level data/maps, which should be placed in an appendix as much as possible. It should be analytical in nature and provide an assessment of the potential impact and dynamics of HIV transmission, and integrating the findings for a socially inclusive highway project. The report should be prepared in English with a 4–5-page [or as otherwise determined] “executive summary” highlighting the findings and recommendations.

2.3. Methods and Timing

It is expected that the preparation of the report will rely both on existing information/reports and primary data. Therefore,
field visits to the project sites are required. A list of potential problematic locations/areas in the project region is included for possible consideration. The specialist shall, however, adopt their own methodology and approach to identify critical locations and issues in the project influence area. Based on an initial field visit, a draft copy of the report should be presented to the TA consultant by (date). The ADB consultant will provide feedback by (date) and the final report should be submitted on or before (date).

3. Sample Outline of the Report

The following is a recommended outline. The consultant can use his/her own outline; however, the following issues must be covered by the report.

*Executive Summary*
- (i) Project description,
- (ii) Methodology,
- (iii) Situation analysis of HIV and AIDS in the project region,
- (iv) Vulnerability of communities to HIV infection caused by external influences/road development activities,
- (v) Information and operational network that facilitates the spread of HIV and AIDS,
- (vi) List of organizations/agencies/firms operating in the project areas,
- (vii) Project impact, and
- (viii) Measures and strategies to address and integrate the HIV issue in the highway projects.

The report should contain a series of recommendations for integrating HIV issues in the highway project, including project management, implementation and funding arrangements, and monitoring and evaluation frameworks.

4. Payments to Personnel/Consultants

The specialist will be paid [amount] for the assignment that includes the following:

- (a) Travel (air and ground costs)\(^2\) - $ ___
- (b) Per diem for ___ days ($X ___)\(^3\) - $ ___
- (c) Research support - $ ___
- (d) Lump-sum fee for ___ days - $ ___
- Total - $ ___

\(^2\) Reimbursable at costs with supporting receipts/documents. Tickets required (including boarding passes).
\(^3\) Fixed rates, no receipts required.
5. General Notes

The study will become the property of ADB. The author does not retain ownership of the product. The author is responsible to the ADB TA team members in all matters related to this assignment.
Attachment 2.2: Sample TOR—HIV/AIDS Service Providers

1. The program implementation consultant will be responsible for the effective and efficient implementation of the following three components of the HIV, Illicit Drugs, and Human Trafficking Prevention Program (the program): (i) advocacy and capacity building; (ii) information, education, and behavior change campaign; and (iii) provision of medical packages. The project supervision consultant, who will be selected by the Vietnam Expressway Corporation (VEC) to supervise consulting services for the Greater Mekong Subregion: Kunming-Hai Phong Transport Corridor-Noi Bai-Lao Cai Highway Project (the project), will make a subcontract with the selected organization/consulting firm for the program implementation.

2. The selected program implementation consultant should have demonstrated competence and experience in implementing an HIV, drug, and human trafficking prevention programs in the infrastructure sector. The consultant team should consist of one international team leader (14 person-months), one national deputy team leader (40 person-months), and five national project officers (a total of 200 person-months). The team leader, the deputy team leader, and the project officer for Ha Noi should be based at the headquarters of the project management team (PMT) of VEC. The other project officers should be based in each of the four field offices of the PMT.

A. Team Leader (14 person-months, international)

3. The team leader will have at least 15 years of public health experience, including at least 5 years in Asia, in prevention programs for HIV, illicit drugs, and human trafficking, and as team leader of projects. Some experience in Viet Nam along with HIV-prevention programs in non-health sectors would be beneficial. The team leader will be responsible for overall coordination, implementation, and report preparation for the program. In coordination with VEC’s focal person for the program, the team leader will undertake the following tasks but will not be limited to them:

(i) Report to the team leader of the project supervision consultant, VEC’s focal person for the program, and the Asian Development Bank (ADB).
(ii) Manage the administration and implementation of the program.
(iii) Lead consultations on HIV, drug and human trafficking prevention in the project area.
(iv) Guide the consultant team members, ensure that the program is implemented according to the TOR for the consultant and
any subsequent instructions or guidance from VEC and ADB, and be responsible for the collective work of the consultant team.

(v) Ensure regular liaison with VEC, the Viet Nam’s Administration of HIV/AIDS Control (VAAC), provincial people’s committees (PPCs) in the project area, other ministries, development partners, and civil society. Ensure collaboration with the resettlement and social development team of the project supervision consultant, and the project performance monitoring system (PPMS) consultant.

(vi) Take responsibility for preparing a detailed implementation and budget for the above three components of the program through a participatory planning process (including consultations, task forces, field visits, and workshops) with the PPCs and VAAC. The plan should comprise the five sets of plan of action, budget, and a performance monitoring system from each PPC. The plan must be approved by the PMT and ADB not later than 1.5 months after civil works commence.

(vii) Develop and ensure the overall implementation of an effective system for internal monitoring of the program implementation and outcomes, in collaboration with the PMT, PPCs, and the PPMS consultant. The scope of the internal monitoring system will include (a) maintaining baseline data for benefit evaluation purposes as developed by the PPMS team, and (b) tracking of resources, activities, and schedules related to the program.

(viii) Support the PPMS consultant in developing indicators and targets that are adequate for detailed planning, monitoring, and evaluation of the program using updated information on HIV/AIDS, sexually transmitted infections (STIs), illicit drug use, alcohol use, sex work, transport settings, commercial and entertainment settings, mobility and migration patterns, ethnic minority settings, health systems, among others.

(ix) Ensure that extensive consultation with the representatives of civil works contractors and subcontractors, transport companies, commercial and entertainment establishments, local communities, and PPCs about the program is conducted.

(x) Take responsibility for facilitating the steering committee and provincial steering committees, and ensuring that regular monitoring meetings are conducted with the PMT, construction and transport companies, and local community representatives. Provide guidance to the PPCs and the steering committees in the execution of their specific responsibilities.

(xi) Prepare memorandum of understanding/contracts required to implement the approved program design, and financial and reporting requirements and to ensure formal and documented approval of the program at provincial and district levels.
(xii) Ensure complete and on-time submission of formal written reports, including the inception report, implementation report, annual reports, and completion report.

B. Deputy Team Leader (40 person-months, national)

4. The deputy team leader will have relevant postgraduate qualification and at least 10 years of HIV-prevention experience, including 5 years in project planning and management. The deputy team leader will undertake the following tasks but will not be limited to them:

(i) Report to the team leader, and support the team leader in managing the consultant team and other consultants and making all arrangements for the smooth implementation and administration of the consultant’s work.

(ii) Arrange and support the establishment of close working relationships with the VEC, VAAC, PPCs, civil works contractors, as well as with nongovernment/community groups and other donors. Support and coordinate with the resettlement and social development team of the project supervision consultant and the PPMS consultant.

(iii) Work with the team leader to prepare a detailed implementation and budget for the above three components of the program through a participative approach.

(iv) Ensure that systems and procedures including reporting for overall management and implementation of the components are conducted smoothly. Conduct quality internal monitoring of the program implementation and outcomes, in collaboration with the PPCs and the program officers of the consultant team.

(v) Ensure and maintain close working relationships with the PPCs through the program officers. Provide guidance and support to the provincial steering committees.

(vi) Ensure that each PPC undertakes appropriate consultations at provincial, district, and village levels to obtain consensus on the program and to ensure that agencies/organizations involved understand, endorse, and are able to comply with the objectives, principles, and procedures for the implementation of the program.

(vii) Support the PPMS consultant in establishing and maintaining the PPMS.

(viii) Organize regular monitoring meetings with the representatives of civil works contractors and subcontractors, transport companies, commercial and entertainment establishments, local communities, PPCs, and others related to the project.
Draft memorandum of understanding/contracts required to implement the program, including designs, and financial and reporting requirements. Facilitate in getting formal and documented approval of the program at provincial and district levels.

Liaise with the PMT to ensure proper and timely disbursement of the TA funds to the PPCs.

Provide the team leader with quarterly progress reports, including detailing achievements, implementation issues, and recommendations for remedial measures.

Assist the team leader in preparing formal written reports, including the inception report, implementation report, annual reports, and completion report.

Provide support and TA to the PPCs for the preparation of a detailed action plan, and financial and monitoring requirements. Ensure that these are congruent with ADB policies, protocols, and regulations.

C. Program Officers (200 person-months, national)

The program officers will have a bachelor’s degree in public health, social service, or related field and at least 5 years of work experience in project implementation and/or coordination. Experience in HIV prevention, drug and/or human trafficking prevention in Viet Nam is highly desirable. The program officers will undertake the following tasks but will not be limited to them:

Report to the deputy team leader and work as a member of the team.

Perform liaison work with, and ensure close working relationships among, the PMT field offices, PPCs, civil works contractors, and nongovernment/community groups in the project area.

Provide support and technical assistance to the PPCs for preparing a detailed action plan, and financial and monitoring requirements.

Assist in ensuring that the PPCs undertake appropriate consultations at provincial, district, and village levels to obtain consensus on the program and to ensure that agencies/organizations involved understand, endorse, and are able to comply with the objectives, principles, and procedures for program implementation.

Take responsibility for the smooth implementation and monitoring of the provincial plans of action and financial and reporting mechanisms.
(vi) Liaise between the PPCs, the PMT field offices, and civil work contractors.

(vii) Provide the deputy team leader with monthly progress reports based on the implementation plan and budget of the program and the PPCs, including detailing achievements, implementation issues, and recommendations for remedial measures.

(viii) Provide coordination and secretariat work to the provincial steering committees.

(ix) Conduct regular monitoring meetings with the PPCs, civil works contractors and subcontractors, transport companies, commercial and entertainment establishments, local communities, nongovernment/civic organizations in each designated project area.

(x) Assist the PPMS consultant in arranging meetings and logistics to conduct the PPMS surveys and other tasks when required.
Attachment 2.3: Sample TOR—Monitoring and Evaluation Consultant

1. The objectives of the consulting services are to develop and implement a program performance monitoring system (PPMS) to (i) assess the progress of the HIV, Illicit Drugs, and Human Trafficking Prevention Program (the program) associated with the Greater Mekong Subregion: Kunming-Hai Phong Transport Corridor-Noi Bai-Lao Cai Highway Project (the project) in a timely fashion, (ii) enable appropriate adjustment of the program activities during the highway construction through monitoring performance indicators, and (iii) evaluate the impacts of the program. The PPMS is aimed at improving the knowledge of the HIV issue and its dynamics in relation with the implementation of large infrastructure projects to help fine-tune prevention programs associated with such projects in the future.

2. The PPMS consultant team will consist of one international and two national specialists. The international specialist will be required for a total input of 7 person-months, while the two national specialists will be required for a total of 20 person-months. The consulting firm/organization will be highly qualified in PPMS, with recognized experience in monitoring and evaluating HIV/AIDS, drug and human trafficking prevention programs in Viet Nam. The consulting services will be intermittently conducted over a period of about 4 years from the third quarter of 2008 until 2 months after civil works finishes (estimated to be the second quarter of 2012).

3. The PPMS consultant will undertake the following tasks but will not necessarily be limited to them:

   (i) Develop a PPMS including establishment of data sources and a set of performance indicators based on the targets and anticipated outputs of the program, and the detailed prevention program prepared by the program implementation consultant; in addition to the program performance indicators, the PPMS will report on a set of data including (a) HIV prevalence in the project areas disaggregated by gender and group, e.g., construction workers, sex workers, and local communities; (b) incidence of STI among the same vulnerable groups and accessibility of quality STI testing and treatment services; (c) behavior change; and (d) availability of condoms in project areas.

   (ii) Prepare appropriate procedures and mechanisms for the participation of key stakeholders and periodic collection and processing of data.
(iii) Design a baseline survey that considers the high turnover of employees in the construction companies and among migrant and mobile workers for the follow-up surveys. Complete the baseline survey 1 month after the start of civil works.

(iv) Review and assess the current HIV-prevention measures, and HIV and STI testing and treatment protocols, and costs including clinic monitoring and record system.

(v) Undertake annual evaluations/surveys, analyze the outcomes, compare them with those anticipated, and recommend corrective measures; in evaluating the program’s impacts, the PPMS should focus on those benefiting the vulnerable populations (construction workforce, local communities affected by the construction of the highway and subsequent feeder roads, and sex workers); these impacts will be further analyzed upon completion of the program to evaluate the cost-effectiveness of each behavior change communication method adopted, health systems intervention and condom social marketing.

(vi) Provide inputs to the meetings and seminars organized by the program implementation consultant.

(vii) Train VEC staff in PPMS to evaluate and monitor the spread of HIV, STI, and drug and human trafficking in the project area.

(viii) Prepare a PPMS manual for use by relevant government agencies for HIV, drug and human trafficking prevention in similar road construction projects.
Attachment 3:
Bidding Documents

Attachment 3.1: Draft HIV Clause for Inclusion in Construction Contracts

1. For the Purpose of this Clause:

“Service Provider” means a person or entity approved to provide the HIV-Awareness and Prevention Program;

“the Contractor’s Employees” means, without prejudice to any other definition contained in the Contract, any workers who are under the Contractor’s control and on the Site in connection with the Contract, including any workers who are under the control of any person or entity to whom the Contractor has subcontracted any its obligations under the Contract other than those responsibilities set out in this Clause);

“the HIV Prevention Program” means an HIV-prevention program that will use the Tool Kits for HIV/AIDS prevention among construction workers developed by ADB/UNDP in 2002;

1.2. It shall be a Condition of the Contract that the Contractor:

1.2.1 subcontracts with a Service Provider to implement an HIV-prevention program among the Contractor’s Employees for the duration of the Contractor’s contract and commencing as soon as practicable after the Contractor’s Employees arrive at the Site/s;

1.2.2 gives any representative of the Service Provider, and the Employer all reasonable access to the Site in connection with the HIV-prevention program;

1.2.3 instructs the Contractor’s Employees to participate in the HIV-Prevention Program in the course of their employment and during their normal working hours or any period of overtime provided for in the relevant employment contracts and uses all reasonable endeavors to ensure this instruction is followed;

1.2.4 does nothing to dissuade the Contractor’s Employees from participating in the HIV-Awareness and Prevention Program.
1.3 The Contractor shall be entitled to be reimbursed by the Employer for any payments made under a subcontract made for the purpose of Clause 1.2.1 in accordance with the relevant provisions in the Contract.

1.4 Where the Contract does not provide for reimbursement of named costs, the amount paid by the Contractor to the Service Provider shall be added to any lump sum to be paid by the Employer to the Contractor under the Contract and, before such lump sum is paid, the Contractor shall provide to the Employer evidence of:

1.4.1 payment of the amount claimed to the Service Provider; and
1.4.2 provision of the HIV-Prevention Program (e.g., a certificate issued by the Service Provider).

1.5 Where a clinic is provided on behalf of the Contractor on Site, the Contractor shall ensure that such clinic provides to the Contractor’s Employees, on request and without charge:

1.5.1 confidential counseling and advice on HIV/AIDS and
1.5.2 condoms that comply with the WHO/UNAIDS Specification and for Condoms 1998 or any more recent equivalent publication to a maximum of [number] per member of the Contractor’s Employees per year.

1.6 Where the Contractor subcontracts any of its obligations under the Contract, it shall require any subcontractor to comply with sub clauses [1.2.2–1.2.6] of the Contract as if it were the Contractor.
Clause [ ] requires the Contractor to arrange for its employees, its subcontractor’s employees, and others to attend an HIV-prevention program provided in accordance with the National HIV/AIDS Authority strategy.

The program will be provided at the Employer’s cost, though the Contractor will make the initial payment to the program provider before claiming reimbursement from the Employer in the usual way. The program will take place during its employees’ normal working hours. In pricing his bid, the Contractor should therefore take into account the “down time” during which employees attend the program.

Further information on the HIV-Prevention Program using the ADB/UNDP tool kit for construction workers; please refer to www.hivmekong.net/ or www.hiv-development.org (a UNDP website).
## Attachment 4.1: Comparative Analysis of HIV/AIDS Components in ADB Transport Projects

<table>
<thead>
<tr>
<th>Project Title</th>
<th>Country</th>
<th>Loan Status/No.</th>
<th>Sector</th>
<th>Total ADB Financing ($'000,000)</th>
<th>Type of Loan</th>
<th>Cost of HIV/AIDS Comp. ($'000)</th>
<th>Type of Financing</th>
<th>Executing Agency</th>
<th>Implementing Arrangement</th>
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<td>Loan</td>
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<td>GMS: Cambodia Road Improvement</td>
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<td>Chhattisgarh State Roads Development Sector</td>
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<td>National Highways Authority of India</td>
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<td>National Highways Authority of India</td>
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<tr>
<td>Project Title</td>
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<td>Sector</td>
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<td>Type of Loan</td>
<td>Cost of HIV/AIDS Comp. ($'000)</td>
<td>Type of Financing</td>
<td>Executing Agency</td>
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<td>7 East-West Corridor</td>
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<td>National Highways Authority of India</td>
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<td>8 West Bengal Corridor Development</td>
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<td>1870 T&amp;C</td>
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<td>Public Works Road Department</td>
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<td>9 Roads for Rural Development</td>
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<td>T&amp;C</td>
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<td>National and Provincial Committees for Control of AIDS</td>
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<td>10 GMS: East-West Corridor</td>
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<td>Ministry of Communications, Transport, Post &amp; Construction</td>
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<td>National and Provincial Committees for Control of AIDS</td>
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<td>13 Subregional Transport Facilitation</td>
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<td>Department of Roads</td>
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<td>2094 T&amp;C</td>
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<td></td>
<td>Ministry of Transport</td>
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</tr>
</tbody>
</table>


Source: ADB Database.
### Attachment 4.3: Example—Design and Monitoring Framework

<table>
<thead>
<tr>
<th>Design Summary</th>
<th>Performance Targets/Indicators</th>
<th>Data Sources/Reporting Mechanisms</th>
<th>Assumptions and Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Impact</strong></td>
<td>Preventing the spread of HIV and halting drug and human trafficking in Viet Nam.</td>
<td>On completion of the project, Viet Nam will have already reached the 2015 MDG targets for halting and beginning to reversing the spread of HIV, achieved its goals in the National Drug Control Master Plan (2001–2010), and halted human trafficking.</td>
<td>Assume. Data are available.</td>
</tr>
<tr>
<td></td>
<td>Viet Nam HIV sentinel surveillance survey</td>
<td>UNODC report</td>
<td></td>
</tr>
<tr>
<td><strong>Outcome</strong></td>
<td>Mitigated the spread of HIV and drug and human trafficking associated along the Lao Cai–Hai Phong Transport Corridor.</td>
<td>30% increase in HIV and STI testing at provincial level.</td>
<td>Assume. Data are available.</td>
</tr>
<tr>
<td></td>
<td>60% increase in positive behavior change among construction workforce and local communities affected by the road project.</td>
<td>60% increase in positive behavior change among construction workforce and local communities affected by the road project.</td>
<td>Efficient implementation of the HIV, drug and human trafficking prevention program.</td>
</tr>
<tr>
<td></td>
<td>10% decrease in cases of illegal drug use and human trafficking at provincial level.</td>
<td>10% decrease in cases of illegal drug use and human trafficking at provincial level.</td>
<td>Commitment of the national and provincial governments.</td>
</tr>
<tr>
<td></td>
<td>Provincial HIV and STI sentinel surveillance survey</td>
<td>Provincial HIV and STI sentinel surveillance survey</td>
<td>Assume. Quality HIV and STI diagnostic and treatment services are not available.</td>
</tr>
<tr>
<td></td>
<td>TA final report</td>
<td>TA final report</td>
<td>Assume. Quality HIV and STI diagnostic and treatment services are not available.</td>
</tr>
<tr>
<td></td>
<td>Reports from the provincial people’s committees</td>
<td>Reports from the provincial people’s committees</td>
<td>Assume. Quality HIV and STI diagnostic and treatment services are not available.</td>
</tr>
</tbody>
</table>

*Continued on next page...*
### Design Summary

**Outputs**

1. Increased awareness about, and capacity to address, HIV, drug and human trafficking issues among key partners in the infrastructure sector.

2. Increased awareness and positive behavior change among construction workforce, local communities, and sex workers affected by the road project.

3. Increased access to quality HIV, STI, and other health services.

<table>
<thead>
<tr>
<th>Performance Targets/Indicators</th>
<th>Data Sources/Reporting Mechanisms</th>
<th>Assumptions and Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Development of HIV and AIDS policies in VEC and construction companies.</td>
<td>TA midterm report</td>
<td><strong>Assumptions</strong></td>
</tr>
<tr>
<td>Workshops and on-the-job training have improved capacity of MOT and VEC to design and monitor HIV, drug and human trafficking prevention programs.</td>
<td>PPMS report</td>
<td>- MOT counterparts participate in workshops.</td>
</tr>
<tr>
<td>100% coverage of construction workforce and local communities affected by the road project.</td>
<td>TA progress reports</td>
<td>- VEC and counterparts participate in on-the-job training.</td>
</tr>
<tr>
<td>60% increase in positive behavior change among construction workforce and local communities affected by the road project.</td>
<td>PPMS report</td>
<td>- Condom social marketing in the project areas is feasible and sustainable.</td>
</tr>
<tr>
<td>50% increase in condom availability outside the government’s family planning program.</td>
<td>PPMS report</td>
<td>- HIV testing is only available at provincial center and STI testing and treatment is allowed at district level.</td>
</tr>
</tbody>
</table>

**Risks**

- Quality HIV and STI diagnostic and treatment services are not available.
- Change in current pattern for drug and human trafficking in the project area.
- Change in government policy on the commercial retail of condoms.
### Design Summary

<table>
<thead>
<tr>
<th>Performance Targets/Indicators</th>
<th>Data Sources/Reporting Mechanisms</th>
<th>Assumptions and Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>50% increase in reported capacity among provincial and district health workers to diagnose and treat STI and to conduct HIV counseling and testing.</td>
<td>PPMS report</td>
<td>• High turnover of construction workforce and mobile sex workers to capture in PPMS surveys</td>
</tr>
<tr>
<td>50% increase in district health centers providing STI testing and treatment services.</td>
<td>PPMS report</td>
<td></td>
</tr>
<tr>
<td>Updated protocols on HIV and STI voluntary counseling and testing, treatment, care, and support in the provinces.</td>
<td>PPMS report</td>
<td></td>
</tr>
</tbody>
</table>

### Activities with Milestones

1. Consultant selection
   1.1 Program implementation consultant is selected by June 2008.
   1.2 PPMS consultant is selected by July 2008.
2. Advocacy and Capacity Building
   2.1 Advocacy workshops are completed by May 2009.
   2.2 HIV and AIDS policy in the construction workplace is completed by May 2011.
   2.3 Mid- and end-of-project dissemination workshops are completed by May 2010 and May 2012, respectively.
3. Information, Education, and Behavior Changes Campaign
   3.1 Inclusion of HIV prevention in contractors’ occupation health and safety program is completed by July 2009.
   3.2 Production of customized IEC and BCC materials completed by May 2009.
   3.3 Weekly education and training sessions in construction camps/sites are conducted until project completion.

### Inputs

- ADB: $1,000,000

*Continued on next page...*
3.4 Mechanism for sustained condom delivery is established by May 2012.
3.5 Confidential HIV referral and counseling system is established by December 2009.

4. Provision of Medical Packages
   4.1 Updated protocols on HIV and STI services for migrant and mobile populations completed for each province by December 2011.
   4.2 Training of health implementers is completed by December 2009.

5. Monitoring and Evaluation
   5.1 Baseline survey report is completed by October 2008.
   5.2 PPMS is completed by November 2008.
   5.4 Final report is completed by May 2012.

Where you are at the project cycle: DESIGN PHASE

### Attachment 4.4: Example—Cost Estimates for the Program

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost (’000)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Asian Development Bank Financing</strong>(^1)</td>
<td></td>
</tr>
<tr>
<td>1. Consultants for Program Implementation</td>
<td>470.0</td>
</tr>
<tr>
<td>a. Remuneration and Per Diem</td>
<td></td>
</tr>
<tr>
<td>i. International Consultants</td>
<td>140.0</td>
</tr>
<tr>
<td>ii. National Consultants</td>
<td>300.0</td>
</tr>
<tr>
<td>b. International and Local Travel</td>
<td>30.0</td>
</tr>
<tr>
<td>2. Consultants for Program Performance Monitoring System</td>
<td>105.0</td>
</tr>
<tr>
<td>a. Remuneration and Per Diem</td>
<td></td>
</tr>
<tr>
<td>i. International Consultants</td>
<td>50.0</td>
</tr>
<tr>
<td>ii. National Consultants</td>
<td>40.0</td>
</tr>
<tr>
<td>b. International and Local Travel</td>
<td>15.0</td>
</tr>
<tr>
<td>3. IEC Materials, Medical Supplies, and Office Equipment</td>
<td>265.0</td>
</tr>
<tr>
<td>a. Print and audiovisual materials and equipment</td>
<td>80.0</td>
</tr>
<tr>
<td>b. Condoms</td>
<td>140.0</td>
</tr>
<tr>
<td>c. STI treatment kits</td>
<td>30.0</td>
</tr>
<tr>
<td>d. Office equipment</td>
<td>15.0</td>
</tr>
<tr>
<td>4. Training, Seminars, and Conferences</td>
<td>30.0</td>
</tr>
<tr>
<td>5. Surveys</td>
<td>30.0</td>
</tr>
<tr>
<td>6. Contingencies</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,000.0</strong></td>
</tr>
</tbody>
</table>

IEC = information, education, and communication; STI = sexually transmitted infection; TA = technical assistance.
\(^1\) ADB. 2007. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to Viet Nam for the GMS: Kunming-Hai Phong Transport Corridor–Noi Bai-Lao Cai Highway Project*. Manila. [Project Number 33307])
Attachment 4.2: Example—Technical Assistance for HIV, Illicit Drugs, and Human Trafficking Prevention Program

I. INTRODUCTION

1. The Greater Mekong Subregion: Kunming-Hai Phong Transport Corridor—Noi Bai-Lao Cai Highway Project (the project) has potential social risks for the increase of HIV infection, and the trafficking of drugs and humans. After discussions with Asian Development Bank (ADB), the Government of Viet Nam requested additional technical assistance (TA) to implement a prevention program against HIV, and the trafficking of drugs and humans in the project area to help mitigate the potential social risks. The need for such a program was identified during ADB’s Review Mission that visited the project area in March 2007. Further discussions on the program objectives, scope, cost, and implementation arrangements were held with key stakeholders in June 2007. A major change in the scope of the ongoing regional TA for Fighting HIV/AIDS in Asia and the Pacific with additional grant fund of $1 million is proposed to undertake the proposed HIV, Illicit Drugs, and Human Trafficking Prevention Program (the program) associated with the project.

II. ISSUES

2. The linkages between migration, mobility, and the spread of HIV are well documented. Increases in HIV prevalence have been observed along major transport routes, cross-border areas, and in regions experiencing high seasonal and long-term population mobility. In many developing countries, large infrastructure projects offer economic opportunities that attract migrant workers, commercial retailers, and entertainment industries to previously remote and isolated communities. The interaction among the construction workforce, local communities, and sex workers can create a potentially high-risk environment for the spread of HIV and other sexually transmitted infections (STIs) through unprotected sex and/or injecting drug use (IDU). Mobile and migrant

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workers, including construction workers, are highly vulnerable since their prolonged separation from family and communities, access to disposable income, and lack of alternative sources for rest and recreation can lead them to adopt high-risk behaviors. Other vulnerable groups include truck drivers and their helpers, commercial retailers, and border police.

3. ADB has been incorporating HIV-prevention programs targeting construction workers and the local communities they interact with into the design of its transport projects for some years. In August 2006, ADB signed a joint initiative together with five other donor agencies to commit to reducing HIV vulnerabilities associated with infrastructure projects through targeted interventions and supporting the HIV and AIDS response of partner countries. The proposed program is consistent with the recommendations of the joint initiative as well as lessons learned from ADB’s experience with similar activities.

4. **Situation in Viet Nam.** The HIV epidemic in Viet Nam continues to rise and HIV has been detected in all 64 provinces and cities. The number of people living with HIV has doubled since 2000, with an estimated 260,000 cases by the end of 2005. Around 40,000 Vietnamese are believed to be infected with HIV each year, mostly through the sharing of contaminated needles during the use of illicit drugs and unsafe sex between a female sex worker and her client. IDUs are the most affected, accounting for 53% of the total reported HIV cases in the country. While female sex workers are the second most vulnerable group with a prevalence of 6.5% among those tested in 2004.

5. Trafficking of women and children in Viet Nam is reported to be on the rise. It is thought that thousands of Vietnamese women are trafficked through the Viet Nam–People’s Republic of China (PRC) border by illegal organizers who take them to Cambodia and other neighboring countries for sexual exploitation. Reports also indicate that women are trafficked to Europe and Macau for prostitution and arranged marriages.

6. **Situation in the Project Area.** The Noi Bai-Lao Cai Highway will connect Kunming in Yunnan province in the PRC to the Hai Phong and Cai Lan ports in Viet Nam via the major city of Ha Noi. These cities and provinces have some of the worst HIV epidemics in their respective countries and the region. More than 1% of the adult population in Yunnan is HIV positive, mainly transmitted through IDU. In 2005, HIV prevalence among IDUs in Yunnan was estimated to have exceeded 50%. The epidemic has also affected truck routes and border towns, particularly near the Myanmar border. Likewise, Ha Noi and Hai Phong have some of Viet Nam’s worst HIV epidemics. More than 1% of the
adult population in Hai Phong is HIV positive, while it is estimated to be 0.9% in Ha Noi. Viet Nam’s epidemic has mostly been driven by IDU and its association with sex work.

7. The proposed highway cuts across the northern plateau of Viet Nam through Ha Noi, Vinh Phuc, Pho Tho, Yen Bai, and Lao Cai provinces. In 2005, this region (excluding Ha Noi) was estimated to have a total of 6,000 HIV cases. Lao Cai, the international border town with Yunnan Province, has the worst HIV situation among the cluster with 181 reported cases in 2003, of which 75% were associated with IDU. Lao Cai has 1,000–1,500 travelers passing through its international border gate daily; among them are traders, long-distance truckers, construction/transportation workers, and porters.

8. IDU, commercial sex, and trafficking of women and children are rapidly increasing in Lao Cai. With improved transportation and infrastructure, enabling 1-day travel time between Kunming and Hai Phong, the existing risks and vulnerabilities for HIV transmission, drug use, and human trafficking along the Noi Bai-Lao Cai Highway will significantly increase if targeted risk mitigation initiatives are not implemented.

III. THE TECHNICAL ASSISTANCE

A. Impact and Outcome

9. The overall objective of the additional scope of the TA is to prevent the spread of HIV along the Noi Bai-Lao Cai Highway during and after the construction stage and to mitigate the increased risk of illicit drug use and human trafficking that may result from the project. The specific objective is to raise public awareness, address the risks, and highlight multi-sectoral roles and responsibilities for the project management staff, consultants and workers, IDUs, local residents, transport service providers, local police and border officials, commercial and entertainment establishments, and other groups affected by the project. Key outputs will include (i) increased awareness about HIV, AIDS, and STI, drug and human trafficking among local communities, road contractors and workers, and local authorities; (ii) behavior change among construction workforce, local communities, and sex workers and their clients; (iii) improved access to affordable, high-quality condoms, and HIV/STI-related and other health services and products in project area; (iv) increased collaboration among key players for drug and trafficking prevention; and (v) an improved monitoring and evaluation system. The design and monitoring framework for the program is shown in Attachment 4.3.
B. Methodology and Key Activities

10. The additional scope of the TA will comprise four components:

(i) **Advocacy and Capacity Building.** To ensure commitment and cooperation across a wide range of stakeholders, awareness will be raised to prevent HIV and drug and human trafficking in a sustainable way through: (a) workshops targeting the construction workforce (management, consultants, contractors, subcontractors, and workers), provincial and district government authorities, border police, local communities, health providers (private and public clinics and pharmacies), commercial and entertainment establishment owners and staff, and other groups located in the project area; (b) development of HIV/AIDS policies in the construction workplace including preemployment screening, confidentiality of medical status and worker’s rights to ongoing employment if found positive for HIV and other STIs; (c) strengthening cross-border cooperation for prevention of HIV, drug and human trafficking between the Lao Cai and Yunnan provincial authorities; and (d) mid- and end-of-project workshops among key stakeholders to discuss lessons learned and recommendations for midterm remedial measures and improving strategies for future prevention programs in the infrastructure sector.

(ii) **Information, Education, and Behavior Change Campaign.** Awareness on HIV, drug use, and human trafficking will be raised and positive behavior changes will be created through: (a) integrating HIV and drug prevention activities into the occupation health and safety program of consultants, contractors, and subcontractors; (b) developing and using customized information, IEC materials, and behavior change communication (BCC) methods for construction sites and camps, commercial and entertainment settings, transport corridors and hubs including border area, local communities affected by the road project including from the construction of access roads, and health service delivery; (c) ensuring that education and training sessions in the construction sites/camps are conducted; (d) considering the difference in women’s issues, duties, and work schedules; (e) using IEC and BCC materials and methods for ethnic minority groups that are culturally and linguistically appropriate, participative and consider low literacy and education levels; (f) providing condoms throughout the project duration and ensuring the availability of condoms after project ends (e.g., through condom social marketing); (g) supporting, strengthening, and/or partnering with agencies/organizations working on drug and human trafficking in the
project areas; (h) supporting, coordinating, and collaborating with the resettlement and social development team of the project supervision consultant for the project in implementing HIV, drug and human trafficking prevention activities; and (i) ensuring that a confidential referral system is in place for construction workers who want to be tested and treated for HIV.

(iii) **Provision of Medical Packages.** In collaboration with the Department of Health in each province, it will be ensured that the construction workforce, transport workers, local communities, and entertainment workers have access to quality HIV, STI, and other health services through: (a) preparing and/or updating protocols on HIV and STI voluntary counseling and testing, treatment, and care and support, especially for migrant and mobile clients; (b) designing and implementing training sessions for health workers at the construction work sites and health centers and pharmacies serving the local communities in the project area; (c) ensuring the availability of STI diagnostic tools and drugs at project-affected districts; and (d) establishing a system to ensure that those diagnosed with HIV are provided with or referred to counseling and support services, information about clinical support services and treatment options, and information about rights to employment and protection from discrimination.

(iv) **Monitoring and Evaluation.** In close collaboration with the Vietnam’s Administration of HIV/AIDS Control (VAAC), independent program monitoring will be undertaken to: (a) develop a PPMS to be applied throughout the project duration (baseline, mid-term, and end-term) that is streamlined with the National Monitoring and Evaluation Framework for HIV Prevention and Control programs of VAAC; and (b) undertake program monitoring at regular intervals and report to the executing agency, ADB, HIV and drug and human trafficking steering committees, and local AIDS authorities.

C. **Cost and Financing**

11. The total cost of the additional scope of the TA is estimated at $1,000,000. The cost estimates are shown in Attachment 4.4. The cost will be financed through the Cooperation Fund for Fighting HIV/AIDS in Asia and the Pacific.

D. **Implementation Arrangements**

12. The Vietnam Expressway Corporation (VEC) will be the executing agency for the Program and will be responsible for overall coordination with the steering committee (to be established) and other partners. In
the project management team (PMT) of VEC, a focal person responsible for overseeing the implementation of the program will be nominated. This focal person will convene a steering committee that will provide technical advice in the design and evaluation of the TA activities, chaired by VEC and VAAC. The co-chairs will include representatives from the project supervision consultant and provincial steering committees (to be established).

E. Consulting Services

1. Program Implementation Consultant

13. ADB will select a program implementation consultant following the quality- and cost-based selection and simplified technical proposal according to ADB’s Guideline on Use of Consultants (2007, as amended from time to time). Quality-cost ratio is 80:20. The program implementation services are expected to start in the second quarter of 2008 and to be completed when civil works are completed (estimated to be in the second quarter of 2012). The office equipment and supplies required for the program implementation will be procured by the consultants in accordance with ADB’s Procurement Guidelines (2007, as amended from time to time).

14. The program implementation consultant will be responsible for the effective and efficient implementation of the program. The consultant should have demonstrated competence and experience in implementing HIV and drug and human trafficking prevention programs in the infrastructure sector. The consultant team should consist of one international team leader (14 person-months), one national deputy team leader (40 person-months), and five national project officers (a total of 200 person months). The team leader, the deputy team leader, and the program officer for Ha Noi should be based at the PMT headquarters of VEC. The other program officers should be based in each of the four field offices of the PMT. This is detailed in the terms of reference (TOR) of the project supervision consultant (Appendix 7 of the RRP). The indicative TOR for the program implementation consultant is found as Attachment 2.2. Civil works contractors for the project need to be involved in the program. In ADB’s experiences on other road projects, civil works contractors do not collaboratively work with consultants for the similar program engaged by ADB, as there is no direct contract between the contractors and the consultants. Therefore, the program implementation consultant should work with the construction supervision consultant, which has the power to supervise the contractors. Work with the program implementation consultant is included in the TOR for the project supervision consultant.

15. The consultant team will establish a partnership with the provincial people’s committees (PPCs) of Ha Noi, Vinh Phuc, Pho Tho, Yen Bai,
and Lao Cai to design and implement the prevention activities in their respective provinces. Each PPC will convene a provincial steering committee consisting of representatives from the Department of Health, the Department of Labor Invalids and Social Affairs, the Department of Education, Women’s Union, Public Security, Ethnic Minority and Religion Committee, and Youth Union. The team leader will be responsible for facilitating the provincial steering committees, which will meet at least twice a year. A specific action plan, budget, and monitoring scheme should be developed for each province. The consultant team will be allowed to subcontract other specialized institutions and/or government agencies for condom social marketing and activities specifically targeted to prevent drug use and human trafficking.

2. PPMS Consultant

16. ADB will recruit another consulting firm to develop and implement the PPMS according to ADB’s Guidelines on the Use of Consultants. The quality- and cost-based selection and biodata technical proposal will be used. Quality-cost ratio is 80:20. The inputs required for the PPMS consulting services will be one international consultant (7 person-months) and two national consultants (20 person-months total). The PPMS consulting services are expected to start in the third quarter of 2008 and to be completed 2 months after civil works are completed (estimated in the second quarter of 2012), intermittently. The indicative TOR is found as Attachment 2.3.

F. Reporting

17. The program implementation consultant will prepare the following reports: (i) an inception report, 4 weeks after commencement of the services; (ii) baseline study report, 1 month after civil works commence; (iii) an implementation report detailing activities and annual budgets, 1 month after completing the baseline study; (iv) quarterly progress reports highlighting the component achievements over the period under review, the issues, and proposed remedial actions at the end of each quarter; (v) four annual reports detailing achievements, implementation issues, and remedial measures, at the end of each year; and (vi) a completion report, 3 months after completion of the project. Two copies of these reports in the English language will be submitted to VEC, VAAC, and ADB. Also, two copies of these reports in the Vietnamese language will be submitted to VEC and the program partners.

18. The PPMS consultant will prepare (i) a PPMS report detailing indicators, targets, source of data, and PPMS methodology, 4 months prior to the start of the civil works; (ii) a baseline report, 1 month after commencement of the services; (iii) annual reports including results of the annual survey, analysis of the same, and recommended correctives measures if required, 1 month after completion of the annual survey; and (iv) a final report providing a detailed analysis of the program
impacts, lessons learned, and recommendations for improving future similar programs associated with infrastructure projects. Two copies of these reports in the English language will be submitted to VEC, VAAC, and ADB. Also, two copies of these reports in the Vietnamese language will be submitted to VEC and the program partners.

Attachment 5: Case Studies

Attachment 5.1: Case Study Review of HIV Prevention in Four ADB Transport Projects in the Greater Mekong Subregion

(ADB. 2007. HIV and Infrastructure: ADB Experience. Manila.)

www.adb.org/Documents/Reports/GMS-Case-Studies-HIV/default.asp