RETA 6467: HIV Prevention and Infrastructure: Mitigating Risk in the Greater Mekong Subregion

Second AusAID Progress Report

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REGIONAL TECHNICAL ASSISTANCE (RETA) 6467:
HIV PREVENTION AND INFRASTRUCTURE: MITIGATING RISK IN THE GREATER MEKONG SUBREGION

2nd PROGRESS REPORT
JULY 2009

A. INTRODUCTION

1. In June 2008, the Asian Development Bank (ADB) approved a Regional Technical Assistance (RETA 6467) for HIV Prevention and Infrastructure: Mitigating Risk in the Greater Mekong Subregion (GMS) co-financed by the Government of Australia, represented by AusAID. The RETA was developed in close collaboration with AusAID and supports HIV prevention programs in ADB-supported infrastructure projects the pre-construction, construction and post-construction phases in the GMS. Under the RETA, a set of distinct subprojects on HIV prevention and mitigation associated with ADB-financed infrastructure projects in the GMS.

2. There had been significant progress in implementing the RETA since the first progress report in December 2008. The core of the RETA is the set of eight subprojects to be implemented in conjunction with ADB-financed road construction projects in the GMS. Since the RETA inception in 2008, work has commenced on seven of the eight subprojects which are at different stages of implementation. The following sections provide a brief summary and implementation progress of seven of the eight subprojects. The subproject documents (i.e., inception reports) are provided as supplementary appendices. A summary of subproject status is provided in Attachment 1. A summary of the contracting status of the four subprojects is provided in Attachment 2. A disbursement status and projection is included in Attachment 3.

B. IMPLEMENTATION STATUS

1. COMPONENT 1: Subproject Implementation

3. Six of the 8 subprojects (Subproject 1, 2, 3, 4, 5, 8) completed the process of contracting consultants, 4 in the first quarter, and 1 in the second quarter of 2009. The 4 subprojects contracted in the 1st quarter of the year entail field-based interventions, while 1 is for the conduct of an analytical study. In the four field-based subprojects (1, 2, 5 and 8) consultants have been fielded; inception missions conducted, and initial implementing activities have commenced. For the analytical study (Subproject 3) which delves on the general risk settings for HIV, human trafficking and gender in small-scale infrastructure projects compared with large-scale ones, field research is currently underway.

4. As to the three other subprojects (4, 9 and 10), considerable progress has been made on two of them. Subproject 4, which is a study on the impact of the Cross-Border Transport Agreement on HIV/AIDS risk factors, the Consultant final report was submitted in late December 2008. Subproject 9, the design mission was conducted in March 2009 and the process of contracting the consultant is currently underway. For Subproject 10, the design work will be conducted in the third quarter of 2009. The monitoring and evaluation of two other subprojects (6 & 7), financed under a separate TA, will be covered under the RETA.

a. Subproject 1: Northern Economic Corridor (LAO)

5. **Introduction.** This subproject intends to mitigate HIV related vulnerabilities in the post-construction phase along the completed Northern-Economic Corridor (Route 3), in the two northern provinces of Bokeo and Luang Namtha in Lao PDR. Key outputs of this sub-project are: i) Strengthened capacity of and partnerships with key stakeholders for HIV prevention; ii) Prevention awareness related to HIV; iii) HIV and STI related health services readily available to vulnerable communities along Route 3. The subproject will establish multi-sectoral project working teams, develop and implement behavioral change communication strategies together with key stakeholders, build partnerships with other agencies working on sexual health in the area, train and support provincial and district AIDS authorities to work with the private sector on workplace HIV intervention, involve key stakeholders in project monitoring and evaluation, and facilitate the establishment of local revolving funds of condoms and STI treatment kits.

6. The Burnett Institute was recruited on 3 March 2009 for 24 months as the consulting firm to implement the subproject. The Center for HIV/AIDS and STI (CHAS) under Department of Prevention and Hygiene of Ministry of Health is designated as a national coordinating agency while the Provincial Committee for the Control of AIDS (PCCA) in Bokeo and Luang Namtha are provincial coordinating agencies. PCCAs coordinate the implementation of subproject activities with the Committee for the Control of AIDS (DCCA) at district level in the two provinces. The total budget for this subproject is US$600,000.

7. **Implementation progress.** The consultants were fielded in early March 2009 and an inception mission was conducted from 31 March to 3 April 2009 in Vientiane to discuss and reach agreement on the subproject design, implementation arrangement, workplan and timeline with CHAS, the PCCAs and the Consultant. The inception mission culminated with the signing of the Aide Memoire between ADB and CHAS on 3 April 2009. The inception report was submitted to ADB on 10 April 2009. Provincial inception workshops for Luang Namtha and Bokeo were held on 5 and 6 May 2009, respectively. These provincial workshops served to level off understanding about the subproject, especially the roles of national and local implementing agencies, among the local authorities.

8. In preparation for the baseline assessment, a joint training of the Multi-sectoral Project Working Teams (MPWTs) from Bokeo and Luang Namtha on methodologies for qualitative data collection was held on 18 to 22 May 2009. The data collection was conducted by the provincial Project Working Teams, with support from the Burnet team, in the period of 22 to 29 May 2009. A training on qualitative data analysis for project working teams followed in 10 to 12 June 2009. The rest of the period from March to July 2009 has been spent, among others, on holding initial consultations with key stakeholders about potential areas of collaboration, preparing a project performance and management system (PPMS), developing a plan of action based on the information from the baseline assessment, compiling the draft provincial plan of action and translating these to a detailed quarterly activity plans, preparing the implementation report submitted to ADB on 24 June 2009, and conducting baseline situation assessment.

9. **Other issues.** A session on gender was held on 2 April 2009 by the Gender Consultant of RETA with 12 participants from Burnet Institute, and representatives from MPWT and PCCA from Bokeo and Luang Namtha provinces to ensure that all had a similar understanding on gender and how it should be mainstreamed into the project. The session concluded with agreements on next steps. Gender implications in the selected priorities for implementation will be integrated in the plans with the help of the national gender consultant who will be recruited.

In the training sessions that are planned for the provincial implementing agencies together with key partners, sessions on gender will be held.

10. The issue raised by the Consultant at this inception phase is the a*vailability of government stakeholders* for the subproject activities*.* Capacity building initiatives planned for this subproject are highly dependent on the availability of government counterparts. Delays may occur that are beyond the control of the Consultant team. Another concern is the *willingness of private sector actors to be involved.* The success of initiatives involving the private sector in this subproject will depend to a large degree on the buy-in and commitment of the companies and managers involved. Needless to say, advocacy messages aimed at the private sector should highlight the benefits of a workplace initiative on both labor and management.

b. Subproject 2: East West Economic Corridor (LAO/VIE)

11. **Introduction.** Subproject 2 aims to mitigate the HIV vulnerabilities in the post-construction phase along and near Route 9 in Lao PDR and Viet Nam. The outcome is to effectively address HIV vulnerabilities associated with Route 9 and to develop a set of effective mechanisms and strengthen the capacity of local AIDS authorities. The project will focus on 2 key issues: (i) vulnerability of ethnic minority communities near and along Route 9, and (ii) behavior change among targeted migrant and mobile populations living and working near and along Route 9. The subproject covers Savannakhet (Lao PDR) and Quang Tri (Vietnam) along Route 9. The project focuses on the four areas: (a) advocacy and capacity building; (b) promotion of information, education, and behavior change communication; (c) strengthening access to medical services, and (d) monitoring and evaluation

12. World Vision Australia was contracted by ADB as the Consultant, to undertake the subproject implementation. CHAS and VAAC are designated as government counterparts for TA implementation in Lao PDR and Viet Nam. CHAS coordinates implementation of subproject activities at national level, while PCCA coordinates subproject activities with the Committee for the Control of AIDS (DCCA) at district level in Savannakhet. A similar coordination mechanism and at national and provincial level in Viet Nam are proposed with VAAC and the Provincial AIDS Centre (PCA). The total budget for this subproject is US$693,500. The Consultant was mobilized in 23 March 2009 for a total period of engagement of 24 months.

13. **Implementation progress.** A field assessment was conducted along the Highway prior to the inception mission. This field assessment fed into the draft inception report in which significant changes to the scope of Subproject 2 were recommended by the Project Implementation Team. Due to limited timeframe and limited resources, the subproject refocused its geographic and population targets on the Bru/Van Kieu ethinic minorities and migrant and mobile population in Savannakhet and Quang Tri along Route 9. These changes were discussed with key stakeholders during the Inception Mission, fielded from 4 to 5 May 2009 in Hanoi, Viet Nam and from 6 to 8 May 2009 in Vientiane, Lao PDR. The changes were agreed on in the Aide Memoire. The official concurrence of the VAAC and CHAS with the proposed coordinating structure for TA implementation was obtained in June 2009. The Inception Report was finalized and submitted to ADB on 15 July 2009. The Team is currently undertaking a baseline survey, which is conducted over the month of July 2009; first in Vietnam then in Lao PDR.

14. **Other issues.** Based on the comments on the inception report, the following key issues will be defined more specifically following baseline research analysis: (a) improving access to medical services by ethnic minority peoples from affected communities along Route 9; and (b)

behavioral change communication to migrants and mobile population, including the clients of sex workers, based on findings from the forthcoming baseline study.

c. Subproject 3: Central Region Transport Networks (VIE)

15. **Introduction.** The ongoing CRTN project aims to rehabilitate 1,200 kilometers of provincial and district roads in 19 provinces across central Viet Nam and is expected to be completed by the end of 2010. The road project includes a Gender, HIV/AIDS and Human Trafficking Prevention Program funded through a grant of US$500,000. Following a site visit and consultations in November 2008, it was recommended that a study would be conducted to understand what HIV prevention strategies are better-suited for small-scale construction settings, such as those found in the CRTN project sites. The degree of vulnerability associated with large-scale construction projects may not be the same in small-scale infrastructure projects, such as the construction and/or rehabilitation of provincial and district roads. Civil works in these types of projects often require less time and generally use local labor with smaller number of workers. The demand and supply for paid and unpaid sexual services may not be high and the usual risk factors associated with infrastructure and HIV not significant.

16. **Implementation progress.** ADB recruited an international HIV/AIDS and Infrastructure Consultant[1] for a total of 120 days, intermittent, starting 23 March to 30 September 2009 to (a) conduct a comparative analysis of the general risk settings for HIV, human trafficking and gender in small-scale infrastructure projects; and (b) design and recommend a minimum standard package for small-scale infrastructure projects The total budget for this study is $27,000. A work plan was submitted in April 2009 which outlines the scope of the study, the research process, and the timelines. This was followed by preparatory activities for field work and the conduct of desk research. Field work is currently underway and a draft report is expected in early August. Follow-up field work is proposed to be undertaken in August to September after which a final report will be submitted on 30 September 2009. A key target group for the research is ethnic minority women. While there is no formal gender plan for research, gender issues will be part of recommendations for working with vulnerable populations.

d. Subproject 4: Cross-Border Transport Agreement

17. **Introduction.** The Cross Border Transport Agreement (CBTA) is a multilateral instrument for the facilitation of cross-border transport of goods and people in the GMS. It is a comprehensive document that addresses all the relevant aspects of cross-border transport facilitation, including: (i) single-stop/single-window customs inspection; (ii) transit traffic regimes, including exemptions from physical customs inspection, bond deposit, escort, and phytosanitary and veterinary inspection; (iii) eligibility requirements for cross-border traffic of road vehicles; (iv) exchange of commercial traffic rights; (v) infrastructure, including road and bridge design standards, road signs and signals; and (vi) cross-border movement of persons, including health inspection. ADB has been working with GMS Governments to prepare and endorse the various CBTA protocols.

18. Subproject 4 was proposed to facilitate an assessment of the likely HIV impact of the CBTA implementation and, if possible and appropriate, to design and implement an intervention package aimed to mitigate this risk. An International Consultant was engaged, starting 15 September until 31 December 2008. The total budget for the study is US$55,131.

[1] The Consultant, Allan Beesey, is also the Team Leader for Subproject 8 of RETA 6467.

19. **Summary of findings.** A consultant final report, which was submitted on 23 December 2008, contains the following findings and recommendations:

a. The CBTA contributes to the direct reduction of potential risks in the immediate zone of implementation at specific border-crossings. This is due to the reduction or removal of an array of risk factors, foremost of which is the reduction of waiting time at the border.

b. The Lao Cai-Hekou border zone between Viet Nam and China is the most complex, with factors such as ethnic diversity, population density, human development status, and the projected growth potentially overshadowing those at the other border crossings. Thus, rather than spread the activity funds from the subproject to different cross-border sites, the funds should be used to augment the resources for a careful baseline research in the Lao Cai-Hekou border crossing area.

c. The report also poses a caveat that while CBTA will remove or reduce risk factors within specific border crossings, there is the likelihood that these risk factors will shift to new urban centers of specialized production – not necessarily far from the border crossings - as the risk factors will follow the investments along with the migrants seeking work.

20. In view of these findings, Subproject 4 will no longer fund specific activities in cross-border sites, as originally considered. As to the Lao Cai-Hekou border zone, another ADB-supported HIV prevention project, RETA 6321-Subproject 12,[2] covers the Noi Bai-Lao Cai highway. Implementation of this subproject has not commenced due to delays in implementing the road project.

e. Subproject 5: Cambodia Road Improvement Project (CAM)

21. **Introduction.** The objective of this subproject is to reduce HIV risks among mobile and migrant populations in targeted areas in the provinces affected by the Cambodia Road Improvement Project (CRIP), namely, Oddar Meanchey and Banteay Meanchey in North-West Cambodia. The subproject will address post-construction HIV risks with the following outputs: (i) strengthened capacity of local communities to effectively address HIV, health and social risks and vulnerabilities; (ii) integration of HIV prevention into workplace or occupational safety and health programs, where they exist, and increased access to sexual and reproductive health services for mobile and migrant workers; (iii) strengthened capacity of key stakeholders for implementing effective HIV and STI prevention activities in the workplace, among migrant and mobile populations and in local communities; and (iv) high quality, timely information on HIV-related risks and behaviors, and on the project activities being implemented to address the risks for quality improvement purposes.

22. Family Health International (FHI) was contracted by ADB as the Consultant to undertake subproject implementation. The National AIDS Authority (NAA) is designated as a national

[2] The overall objective of this TA, with a total budget of US$1.0 M 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.

coordinating agency for TA implementation in Cambodia. NAA will coordinate TA activities at national level in close collaboration with the National Centre for HIV/AIDS, Dermatology and STI (NCHADS) and other relevant ministries. Provincial AIDS Secretariats (PAS) provide a primary secretariat role to coordinate activities, and Provincial AIDS Office will oversee the implementation at the provincial level. The subproject has a total budget of US$700,000 and will be implemented from 19 March 2009 to June 2011.

23. **Implementation progress**. The consultants were fielded in 19 March 2009 and conducted an Inception Mission from 27-30 April 2009 in Phnom Penh. The inception workshop was conducted on 30 April 2009 with 29 participants from government, NGOs and bilateral agencies. The inception mission culminated with the signing of the Aide Memoire between the ADB and the Deputy Secretary General of the NAA. A baseline assessment was conducted in May and the draft baseline report will be submitted by end of July 2009. Data collection was conducted in close collaboration with the NAA, PAS, local authorities of Banteay Meanchey and Oddar Meanchey, and FHI's partners, namely, the Social Environmental Agricultural Development Organization (SEADO), and Women Organization for Modern Economy and Nursing (WOMEN). A convenience sampling method was used among motor taxi drivers, car-taxi drivers, cart pullers, deported migrants, porter/truck drivers in the Poipet area. The information compiled during the assessment, along with some documents related to safe migration, anti-trafficking, drug use and HIV/AIDS from relevant stakeholders, will be used in developing the Risk Mitigation Package.

24. To contribute to cross-fertilization of ideas and experiences, FHI hosted on 1 June 2009 the visit of World Vision Australia (WVA) team that is implementing Subproject 8 (PP-HCMC Highway). FHI and WVA shared experiences to guide project implementation, refining coordinative structures, strategies and population targets. The deputy team leader of Subproject 5 also participated in the meeting of the Technical Working Group on Mobility and HIV (TWG-MH) on 19 June, 2009 wherein an overview of Subproject 5 was presented. The TWG-MH is a national working group that serves as Steering Committee of Subproject 5. It is coordinated by NAA with membership from relevant stakeholders, including government organizations, NGOs, and People living with HIV.

25. FHI will work with two local NGOs (i.e., SEADO and WOMEN) in the delivery of a risk mitigation package in selected districts and communes in Banteay Meanchey and Oddar Meanchey. FHI is now developing the subgrant mechanism with these two NGOs. FHI will also work with the Border Victim Support Team, Poor Family for Development, Population Services International, and Men's Health Cambodia, among others. The PPMS has been developed by FHI in collaboration with the International M&E Consultant of RETA 6467. The PPMS includes a Design and Monitoring Framework (DMF), highlighting key indicators against which the progress of the project will be measured. It also includes a description of the monitoring mechanisms that will be put in place for the project and the performance evaluation tools.

26. **Other issues.** One difficulty encountered by the team is in the conduct of the baseline assessment, specifically in reaching deported migrants. Due to the difficult administrative work and other barriers, the team reached only 26 deported migrants. The team is working with the Ministry of Interior (MoI) in the conduct of the assessment among this population group. FHI engaged mainly female Commune Councilors in the assessment. The Border Victim Support Team (BVST) was originally identified as a possible grantee. However, since it is not registered with MoI and owing to its loose consortium structure which further threatens the delivery, quality and sustainability of interventions, an alternative is identify one NGO member of BVST to subcontract with FHI.

f. Subproject 8: Phnom Penh-Ho Chi Minh Highway

27. **Introduction.** Subproject 8 focuses on post-construction HIV risks along the PP-HCMC Highway, particularly in the cross-border area. The Subproject will have five outputs: (i) community-based Risk Mitigation Program to increase awareness and promote positive behavior change among local communities; (ii) HIV prevention package in entertainment settings targeting migrant and mobile populations; (iv) HIV prevention package in the Workplace; (v) capacity building to strengthen partnerships with key stakeholders in HIV prevention activities; and (vi) improved Monitoring and Evaluation system. The output is the strengthened capacity and partnership of key stakeholders (i.e., national and local AIDS authorities, NGOs, private sectors) to implement effective HIV prevention activities at the cross-border area, in workplace, and in local communities.

28. World Vision Australia was engaged by ADB as the consulting firm to undertake subproject implementation starting 25 May 2009 until 27 July 2011. NAA and VAAC are designated as government counterparts for TA implementation in Cambodia and Viet Nam. In Cambodia, NAA will coordinate TA activities at the national level, while the Provincial AIDS Committees (PAC)/Provincial AIDS Secretariats (PAS) will provide overall coordination at the provincial level. In Viet Nam, VAAC will coordinate TA activities at the national level, while the Provincial Health Department (PHD) in Tay Ninh will provide overall coordination of subproject implementation in the province. The subproject has a total budget of US$700,000.

29. **Implementation progress**. ADB conducted an inception mission from 1 to 7 July 2009 to discuss and reach an agreement on the subproject scope, implementation arrangement, and workplan with the Governments of Cambodia and Viet Nam, and the Consultant. Prior to the Inception Mission, the Project Implementation Team spent considerable time identifying and consulting with many stakeholders, assessing the Project Design in light of what the Team was learning, and determining the best locations for project offices. A DMF is being prepared as part of the Project Performance Monitoring System (PPMS). The key indicators will follow national M&E frameworks of Vietnam and Cambodia. The Project has the benefit of Subproject 2 experience as well as Subproject 5, and the M&E consultant of the RETA visited Cambodia in mid-July 2009 to provide techinical support to the Consultant Team on finalizatin of PPMS.

31. **Other issues.** A Gender Action Plan has been drafted with inputs from the International Gender Consultant and included in the Subproject 8 Draft Inception Report. There are no outstanding issues at present as the subproject has only just commenced implementation.

g. Subproject 9: Northwest Road Improvement Project (CAM)

30. **Introduction.** The objective of the subproject is to mitigate HIV vulnerabilities associated with the pre-construction stage of infrastructure development. The desired outcome is strengthened community resilience to HIV and human trafficking vulnerabilities among communities along NR 56 and NR 68, including the O'smach border town. The subproject will focus on four outputs: (i) community-based risk mitigation package for HIV and safe migration along NR 56 and 68 to address HIV and human trafficking vulnerabilities associated with road construction; (ii) HIV interventions for entertainment workers and uniformed services personnel in selected project areas; (iii) improved Sexual and Reproductive Health (SRH) services at district-level for the distinct needs of men, women and youth in the community; and (iv) a rigorous M&E system. The component will be implemented in close collaboration with the provincial, district and commune AIDS committees.

31. A Steering Committee will be established, led by NAA and comprised of representatives from the Ministry of Interior, NCHADS of the Ministry of Health, provincial AIDS committees, and ADB. The implementation of the subproject is expected to commence in the third quarter of 2009 and completed in the second quarter of 2011. The total cost of the subproject is US$350,000.

32. **Implementation progress.** ADB is now in the process of recruiting Family Health International which is also currently engaged to implement Subproject 5: CRIP, which is a post-construction intervention in the same project areas, and with a similar timeframe. FHI has already established contacts and relationships with local institutions in the same project areas. The continuity in the technical approach and experiences acquired under Subproject 5 are essential for the implementation of Subproject 9.

33. **Other issues**. A Gender Strategy and Action Plan was prepared by the Gender Consultant of RETA. Among the gender issues and specific actions identified under the subproject are: a) capacity building for gender specific situation analysis, risk mapping and planning; b) the need to tackle gender in workplace initiatives; c) the need for gender-responsive service delivery; d) increasing the absorptive capacity of health centers for (temporary) increased demand by drawing from the results of the mapping of integrated HIV and SRH capacity in health clinics in the target area; e) improved M&E, which will include gender-responsive indicators and sex- and ethnic disaggregated data to be collected and reported.

2. COMPONENT 2: M&E, Knowledge Dissemination, and Regional Coordination

a. Monitoring and Evaluation

34. **Summary of outputs and activities.** In order to prepare the M&E framework, set the parameters for a common M&E process for all subprojects and set up a schedule for M&E processes through the life of the project, ADB engaged international M&E specialists[3] for 8 person-months for the period 23 November 2008 to 9 September 2009.

35. The overall project DMF was written in 2007 and requires some revisions. The current version does not reflect that most of the subprojects are working on HIV mitigation in a post-construction context. The DMF will be revised to include quantitative indicators on comprehensive knowledge of HIV/AIDS that will be measured by all subprojects. At completion, all subprojects will also measure exposure to their activities reported by the targeted populations. The overarching DMF will also include individual indicators collected by the subprojects where appropriate, so that the individual subproject DMFs are nested within the overall RETA DMF.

36. The previous M&E consultant prepared a final report that contains much useful material for preparing M&E guidelines for the RETA subprojects. This material is currently being reorganized and expanded for this purpose and the draft guidelines will be completed in the first week of August 2009. A literature review has been completed and much useful material has been gathered from the World Bank, UNAIDS and other international organizations who have worked on mitigating HIV/AIDS in the transport sector. Standard HIV/AIDS indicators have been gathered from two of three of the countries to clarify and update the information compiled by the

[3] An International M&E specialist, Andrea Mestrov, was initially engaged for three person-months to develop a M&E system for the overall RETA and subproject, and was replaced by Kerry Richter

previous consultant. In addition, a protocol has been developed for the PPMS which is currently under review by ADB. For Subprojects 1 and 5, baseline study protocols have been reviewed that can serve as models for the upcoming subprojects. The data analysis plan prepared for Subproject 5 may also serve the same purpose.

37. A summary of progress on the individual subproject DMFs is reported below.

Table 1. M&E Implementation Status by Subproject

Subproject 1 (NEC)
The M&E specialist traveled to Vientiane to work with the Burnet team from 20-24 April. The goal of the trip was to draft the DMF or PPMS and discuss the plans for the baseline assessment, a qualitative study investigating knowledge, attitude and behaviors of the target populations. Since the technical assistance trip in April, the consultant has commented on several revisions of the PPMS and DMF. However, Burnet would prefer to finalize these after considering the results of the baseline assessment. The subproject team and the M&E Consultant are now reviewing the results of the baseline assessment, after which the PPMS and DMF will be finalized.
Subproject 2 (EWEC)
The implementing agency, World Vision Australia, drafted a DMF in June which the consultant has provided comments on. The consultant has also provided comments on the quantitative questionnaire for the baseline survey and the outline of the qualitative study, and on the draft Inception Report The next step for Subproject 2 is to prepare the PPMS with a full monitoring and evaluation plan and to finalize the DMF.
Subproject 5 (CRIP)
The consultant travelled to Phnom Penh to work with FHI on monitoring and evaluation plans for Subproject 5 from 8-12 June. The DMF was already approved by ADB as part of the inception report and the project had already collected data for a quantitative baseline study; the next task was to draft the PPMS and to plan the analysis of the baseline data. The consultant drafted a template for the PPMS which the team followed, and also worked with the team to draft a report outline and analysis plan for the survey. FHI submitted the PPMS for ADB approval in June. The baseline study report will be submitted to the consultant for comments in early July and subsequently submitted to ADB.
Subproject 8 (PP-HCMC Highway)
A draft inception report was submitted for comments in late June. The next step is to draft a DMF and PPMS.

b. Gender

38. **Summary of outputs and activities.** ADB engaged an international gender consultant[4] starting 20 March to 30 May 2009 to contribute to preparing subproject gender action plans and ensuring these are relevant, technically-sound, and effectively implemented. A draft final report was submitted by the consultant on 2 June 2009 which contains the outputs and activities

[4] Madeleen Wegelin-Schuringa

during the period of her engagement, the follow-up actions and recommendations and the draft Gender Action Plan (GAP) of Subprojects 1, 2, 5, 8 and 9.

39. The following is a summary of outputs and activities of the consultant for five of the ten subprojects.

Table 2. Gender Activities and Outputs

Subproject 1 (NEC)
▪ Inception workshop attended and gender session conducted with Burnett team, Provincial Committee for the Control of AIDS (PCAA) and Ministry of Public Works and Transport (MPTW) focal persons
▪ GAP was drafted in line with inception report (April 4) to be translated and discussed during the Provincial Inception workshops.
▪ Comments received from Burnett (June 1)
▪ GAP discussed with international M&E consultant and draft PPMS plan reviewed for integration of gender aspects in the PPMS.
▪ Comments received from Burnett (June 1)
▪ GAP discussed with international M&E consultant and draft PPMS plan reviewed for integration of gender aspects in the PPMS.
Subproject 2 (EWEC)
▪ GAP was drafted after receipt of the inception report (May 25) and sent for comments
▪ Comments on the inception report submitted to ADB (May 26)
▪ Specific questions on implementation modalities sent to team leader (May 26)
Subproject 5 (CRIP)
▪ ADB draft GAP was reviewed and adapted (March 19)
▪ Comments on inception report submitted to ADB (April 24)
▪ GAP was adapted in line with inception report and sent for comments (April 24)
▪ Comments were given on baseline survey (May 25)
Subproject 8 (PP-HCMC)
▪ ADB draft GAP was reviewed and adapted (May 18)
▪ Draft GAP sent to team leader for comments and for implementation modalities as soon as the project started (May 29)
Subproject 9 (NRIP)
▪ Support to the design mission for subproject 9 and draft design for community based program and GAP (April 4)
▪ Adaptation of GAP to final version of subproject design (May 18), sent for comments to FHI

c. Knowledge Dissemination and Regional Coordination

40. **ICAAP 2009.** ADB will host a satellite session at in the 9th International Congress on AIDS in Asia and the Pacific, 9-13 August 2009 in Bali, Indonesia. The purpose of this satellite meeting is to share new experiences from ADB's infrastructure and HIV/AIDS programs, specifically prior to construction and after construction. The session includes the presentation of subproject implementation under this TA, in particular focusing on pre- and post- construction

initiatives in the GMS. The session will be co-chaired by Vice President Ursula Schafer-Preuss, ADB and Sam Beever, AusAID.

41. **GMS regional workshop.** The 3rd Workshop on HIV Prevention and the Infrastructure Sector in the GMS is planned in January 2010. This workshop will follow the 2nd workshop held in Bangkok on 24-26 November 2008 with the aim of sharing experiences and lessons learned during the design and implementation of subprojects, and discussing issues and challenges from the implementation, and areas of collaboration and coordination among the partners and stakeholders. Participants of the workshop will include representatives of the national AIDS authorities, ministries of health and transport, implementing consultants, NGOs, and other development partners.

42. **Partnerships and Coordination.** ADB and implementing consultants are strengthening partnerships with other agencies implementing similar activities in country and are closely coordinating project activities with partners during the preparation and implementation stages. Stakeholder meetings have been arranged for all the subprojects to inform the project activities to avoid any duplication of efforts and to identify synergies between the subproject and partner activities in the project area. In particular, ADB has been in close coordination with the World Bank which implements similar initiatives are in Cambodia and Viet Nam with funding support from AusAID. ADB held meetings with PACT Vietnam and PACT Cambodia, implementing HIV intervention in Viet Nam for the World Bank and shared information about ADB HIV prevention initiatives. ADB consultants are coordinating with World Bank consultants to further harmonize intervention activities in Cambodia and Viet Nam.

C. DISBURSEMENT STATUS AND PLANS FOR 2009/2010

1. Disbursement Status and Projections for 2009/2010

43. With the progress mentioned above, total disbursement is now at US$671,686 or 14 percent of the total TA amount of US$4.8 million (current equivalent of A$6 million). Current commitment amount is US$3,246,994 which amounts to 67 percent of the total budget. This leaves $1,573,006 amount remaining as uncommitted budget. Disbursement under Component 1 is US$579,643, which is 19 percent of the committed amount of US$3,119,631 for the component.[5] As for Component 2, disbursement is US$92,043, which is 12 percent of budget allocation of US$780,000. The remaining US$0.3 million consists of administrative and audit fees. The total disbursement is projected to increase to 36 percent by the end of 2009, 65 percent by end of 2010 (Please see Attachment 3).

2. Planned Activities

44. For the rest of 2009, the main priorities include completion of the contracting process for the implementation of Subproject 9, and the baseline assessment for Subprojects 1,2 and 5. Review missions of subprojects are also scheduled for this period. Preparation for the conduct of the 3rd Workshop on HIV Prevention in the Infrastructure Sector will also be made so that this workshop is held, as targeted, in January 2010.

45. The planned program of activities from August 2009 to January 2010 is summarized as follows:

[5] The committed amount of US$3.1 million includes the budget for Subproject 9 which amounts to US$350,000.

Timeline	Activities
August 2009	Baseline assessment for Subprojects 1, 2, 5 submitted; Finalize contracting of FHI for Subproject 9; Tentative M&E site visits for Subproject 1 and 2
September 2009	Submission of Subproject 3 Report Design missions for Subproject 10 Review mission for Subproject 1
October 2009	Inception mission for Subproject 9 Review missions for Subproject 2 and 5
November 2009	Review mission for Subproject 8
January 2010	The 3rd Workshop on HIV Prevention and the Infrastructure Sector The 3rd progress report prepared and submitted

3. Other Matters

46. Owing to the discrepancy in the TA amounts in the TA Paper (US$6 million) and the actual amount of the AusAID grant (A$6 million equivalent to US$4.8 million), the activities originally identified in the TA paper had to be revised and reduced without deviating from the RETA's goal and objectives. Subprojects 3 and 4, with original budgets of US$700,000 and US$500,000, respectively, were recast as analytical studies - instead of field intervention projects - that can guide and enhance current and future HIV prevention initiatives in the transportation sector. Subproject 9, which had an original allocation of US$600,000, was reduced to a budget of US$350,000. The amounts taken from the original budgets of these sub-projects will be realigned to augment the resources for Component 2 (M&E, Knowledge Dissemination, and Regional Coordination).

D. CONCLUSIONS

47. ADB have made good progress in implementation of RETA activities. The consultants have already been fielded for most of the subprojects except Subproject 8 and 9 which are currently underway. The subprojects have successfully completed the inception activities and are in the implementation phase. By the end of 2009, all subprojects will be underway with four of them completing the first performance review. The remaining Analytical Study (Subproject 3) will be completed by end of September 2009. By 2010, five subprojects (Subprojects 1, 2, 5, 8 and 9) will undergo a mid-term review. Knowledge dissemination will also be given priority in 2010, and this will include the conduct of the 3rd GMS Workshop on HIV/AIDS and Infrastructure.

Attachments:

Attachment 1. Summary of Subproject Status
Attachment 2: Summary of Subproject Implementation Schedule
Attachment 3: Disbursement Status and Projections

Supplementary Appendices (distributed under separate cover):

1. Inception report for Subproject 1
2. Inception report for Subproject 2
3. Inception report for Subproject 5
4. Inception report for Subproject 8
5. Design document for Subproject 9

Attachment 1. Summary of Subproject Status

No.	Sub-Project Title	Estimated cost	Notes
1.	LAO: Northern Economic Corridor (Route 3) (post construction)	600,000	Consultants fielded in early March 2009; Baseline Report, Implementation Report and revised scope of work submitted in July. Peer education and outreach has commenced.
2.	LAO/VIE: East West Corridor (post construction)	693,500	Consultants fielded in late March 2009; Baseline survey underway.
3.	VIE: Central Region Transport Networks (construction phase)	27,000	International HIV/AIDS and Infrastructure Consultant engaged from 23 March to 30 Sept 2009. Desk research and preparatory work for field research completed; field work is underway.
4.	GMS: Cross Border Transport Agreement	55,131	International Consultant engaged, starting 15 September until 31 December 2008; Consultant final report submitted 23 December 2008.
5.	CAM: Road Improvement Project (during and post construction)	700,000	Consultants fielded 19 March 2009; Draft baseline report finalized and submitted end of July 2009.
6	CAM/VIE: Southern Coastal Corridor	0.0	The HIV intervention package associated with this road construction is financed by AusAID under a separate agreement. M&E of the HIV activity is included in the overall M&E framework under the TA
7.	LAO: Northern GMS Transport Network Improvement Project	0.0	Same as above.
8.	PP-HCMC Highway (post construction)	700,000	Consulting firm contracted 25 May 2009; Inception workshop conducted and Aide Memoire signed; Design and Monitoring Framework currently being prepared.
9.	CAM: NW Provincial Roads (pre and during construction)	350,000	Design Mission has been completed in March 2009. Contracting of Consultant is underway.
10.	VIE/GMS: Second Northern GMS Transport Network (pre and during construction)	TBD	Design Mission is planned in September 2009

APPENDIX 2: Summary of Subproject Implementation Schedule

Subproject	Design Mission	Consultant Recruited	Consultants Fielding	Inception Mission	Supervisory Review Mission	Mid-Term Review	Final Review
Subproject 1. Northern Economic Corridor (Lao)	Oct 2007	23 Feb 09	3 March 09	31 Mar-3 Apr 09	Sep 2009		
Subproject 2. East-West Corridor (LAO/VIE)	Oct 2007	27 Feb 09	2 March 09	4-8 May 09	Oct 2009		
Subproject 5. Road Improvement Project (CAM)	1-17 Oct 2008	16 March 09	19 Mar 09	27-30 Apr 09	Oct 2009		
Subproject 8. PP-HCMC Highway (CAM/VIE)	Jan 2009	15 May 09	27 May 09	1-7 July 09	Nov 2009		
Subproject 3 Central Region Transport Networks (VIE)			23 Mar 09 (completion 30 Sep 09)				
Subproject 4 Cross Border Transport Agreement (GMS)			15 Sep 08 (completion 31 Dec 08)				
Subproject 6 Southern Coastal Corridor (CAM/VIE)	xx	xx	xx	xx	xx	xx	xx
Subproject 7 Northern GMS Transport Network Improvement (LAO)	xx	xx	xx	xx	xx	xx	xx
Subproject 9 NW Provincial Roads (CAM)	23-31 Mar 09	xx	xx	xx	xx	xx	xx
Subproject 10 Second Northern GMS Transport Network	Sep 2009	xx	xx	xx	xx	xx	xx

APPENDIX 3: Disbursement Status and Projections

No.	Component/Activities	Original Budget (per approved TA Paper)	Proposed Amount (adjusted)	Actual Committed Amount (as of 20July09)	Disbursed (as of 20 July 2009)	Projected Disbursement, 3rd-4th Qtr, 2009			Projected Disbursement, 2010-2011		Total
						Q3 '2009	Q4 '2009	Total	2010	2011	
Component 1: Subproject Implementation											
1	LAO: Northern Economic Corridor	600,000	600,000	600,000	138,477	130,023	33,866	163,889	178,810	118,824	600,000
2	LAO/VIE: East -West Economic Corridor	700,000	700,000	693,500	155,118	146,313	36,313	182,625	213,750	148,507	700,000
3	VIE: Central Region Transport Network	700,000	30,000	27,000	0	0	30,000	30,000			30,000
4	GMS: Cross Border Transport Agreement	500,000	60,000	55,131	49,454	10,546	0	10,546			60,000
5	CAM: Road Improvement Project	700,000	700,000	700,000	109,034	127,753	58,591	186,343	228,402	176,221	700,000
6	CAM/VIE: Southern Coastal Corridor	0	0	0				0			0
7	LAO: Northern GMS Transport Network Improvement	0	0	0				0			0
8	PP-HCMC Highway	600,000	700,000	694,000	127,560	102,230	54,230	156,460	210,800	205,180	700,000
9	CAM: North-West Road Improvement Project	600,000	350,000	350,000	0	0	82,400	82,400	267,600	0	350,000
10	VIE/GMS: Second Northern GMS Transport Network	600,000	600,000		0		120,000	120,000	240,000	240,000	600,000
	Total (Component 1)	**5,000,000**	**3,740,000**	**3,119,631**	**579,643**	**516,864**	**415,399**	**932,263**	**1,339,362**	**888,732**	**3,740,000**
Component 2: M&E, Knowledge Dissemination, and Regional Coordination											
1	Project Coordination (consultants)	380,000	200,000	45,249	34,674		25,326	25,326	80,000	60,000	200,000
2	Monitoring and Evaluation (consultant)	120,000	120,000	69,000	47,681		24,319	24,319	24,000	24,000	120,000
3	Gender and development (consultants)	120,000	120,000	12,114	9,675		14,325	14,325	48,000	48,000	120,000
4	Surveys and other field studies (Projected amount)	70,000	70,000	0	0		35,000	35,000	21,000	14,000	70,000
5	Publications and reports (inc production, dissemination)	70,000	70,000		0			0	35,000	35,000	70,000
6	Workshops and consultations for knowledge dissemination	140,000	100,000			21,000	9,000	30,000	40,000	30,000	100,000
7	Contingency (Projected amount)	100,000	100,000					0		100,000	100,000
	Total (Component 2)	**1,000,000**	**780,000**	**127,363**	**92,043**	**21,000**	**107,970**	**128,970**	**248,000**	**311,000**	**780,000**
	Project Administration		**300,000**			50,000	50,000	100,000	100,000	100,000	300,000
	TOTAL (USD)	**6,000,000**	**4,820,000**	**3,246,994**	**671,686**	**587,864**	**573,369**	**1,161,233**	**1,687,362**	**1,199,732**	**4,820,000**

Supplementary Appendix 1

Sub-Project 1:

Expanded HIV Prevention Programs on Lao Northern Economic Corridor

TA-6467 (REG): HIV PREVENTION AND INFRASTRUCTURE; MITIGATING RISK IN THE GREAT MEKONG SUBREGION

SUB-PROJECT 1: EXPANDED HIV PREVENTION PROGRAMS ON LAO NORTHERN ECONOMIC CORRIDOR (ROUTE 3)

Table of Contents

1. Introduction

The present implementation report serves two purposes:

1) It provides an update on technical assistance provided by the Burnet Institute under TA-6467 Sub-Project 1 from the project's commencement to date (3 March – 23 June 2009).

2) It provides details of the revised scope of work that was developed in consultation with provincial stakeholders, as flagged during the sub-project's inception workshop.

Luang Namtha Province Project Working Team participating in the data analysis training hosted by Bokeo PCCA and facilitated by Burnet (June 2009).The team drafted a plan of activities based on the baseline data they had collected.

2. Key Events to Date

The table below summaries key events in the life of the project to date. Additional detail is provided in the narrative that follows the table.

Table 1: Summary of Key Events to Date

Date (2009)	***Event***	***Comment***
3 March	Contract signed between Burnet Institute and ADB for Sub-Project 1.	
1 April	Inception workshop in Vientiane	Participants included representatives of CHAS, Bokeo and Luang Namtha PCCAs, ADB, MPWT, MoH and the Burnet Institute.
3 April	Tripartite meeting between CHAS, ADB and Burnet Institute	Agreement between CHAS, ADB and Burnet on the overall Technical Assistance to be provided by Burnet.
3 April	Signing of Aide Memoire	First step of a two step process related to official documentation required before implementation could start in the provinces.
13-17 April	Lao New Year	National holidays.
28 April	Muti-sector Provincial Working Team (PWT) initially nominated In Bokeo by Dr Phengsy Viengsavanh	Dr Phengsy is the Director of Bokeo Provincial Health Service Department, as well as the chair of the Bokeo PCCA.
5 May	Provincial authorities receive copy of Aide Memoire	Official copy of Aide Memoire received by provincial authorities, providing the necessary documentation for work to commence in the provinces.
5-6 May	Deputy Team Leader met with Luang Namtha Director and Bokeo Vice Director of Health Services Department	Orientation for Health Services Department prior to inception workshops
5 May	Inception workshop in Luang Namtha	Orientation for authorities in Luang Namtha
6 May	Inception workshop in Bokeo	Orientation for authorities in Bokeo

Date (2009)	*Event*	*Comment*
18-22 May	Joint training for muti-sectoral Project Working Teams from Bokeo and Luang Namtha on methodologies for qualitative data collection	Hosted by Luang Namtha PCCA.
22-29 May	Data collection for baseline situation assessment	Provincial implementing agencies (Project Working Teams) conduct data collection, supported by Burnet project team.
10-12 June	Training by Burnet Institute staff on qualitative data analysis for Project Working Teams from Bokeo and Luang Namtha	Hosted by Bokeo PCCA.
12 June	Draft plan of action compiled by the two provincial Project Working Teams	Plans were developed based on the information gleaned through the baseline situation assessment.
15 June	Burnet team provide CHAS with a project update	Burnet met with the two CHAS focal points for this project as well as with Dr Chantone.
22 June	Muti-sector Provincial Working Team nominations officially approved in Luang Namtha	Until this time, nominees were working on project activities 'informally' while awaiting official approval of their nominations.

i) Official Approval and Documentation

Project work was able to progress after the signing of an Aide Memoire between CHAS and ADB on 3 April. This document provided the necessary official approval for implementation to begin. Following the Lao New Year holidays, copies of the Aide Memoire were sent by CHAS to the provinces, as agreed with ADB.

The provincial authorities received this documentation on 5 May. Burnet was able to initiate work in Bokeo and Luang Namtha, starting with the planned provincial inception workshops, following this date.

ii) Provincial Inception Workshops and Establishment of Project Working Teams

The provincial inception workshops provided an opportunity to advocate for the proposed project activities and to ensure local ownership and development of the processes and strategies involved. This was a particularly important step as it was the first opportunity that the provincial authorities had to review the proposed scope of work and to fully understand the intent of the initiative. Given that this project originated from a regional perspective, the local authorities were able to provide the necessary detail to transform the proposal into a workable plan for their provinces.

The provincial inception workshops afforded the project team an opportunity to highlight the project's goals and objectives. Both sets of provincial authorities registered great interest in having their staff implement project activities with the technical support of the Burnet Institute.

In Luang Namtha, Mr Aloun Lokhamloy, Provincial Vice Governor, advised the PCCA to coordinate the broadening of implementation capacity and available expertise by including other relevant sectors to assist with the activities.

In Bokeo, Dr Nouchanh, Vice Director of the Bokeo Health Services Department, reported at the inception workshop that HIV remains a problem in Lao PDR and urged the group to ensure an effective response. He referred to the numerous construction and infrastructure development projects underway in the region, and requested that the team work hard to respond to the challenges that these pose for communities.

The Burnet Institute team described to the provinces the nature and value of working through a settings approach, and sought their feedback. Dr Niramonh, the Deputy Team Leader, drew on examples of similar successful activities that Burnet has facilitated in the past in other parts of Laos.

Burnet also raised the idea of establishing mulit-sectoral provincial Project Working Teams (PWT) to be responsible for the implementation and oversight of project activities. It was clarified that coordination of these teams would occur through the existing structure of the Provincial Committees for the Control of AIDS (PCCA), who in turn would report to the Centre for HIV, AIDS and STI (CHAS) on developments and achievements. These teams were endorsed by the provincial authorities and team members were nominated. The PWTs include representation from various sectors including from district level. The Ministry of Public Works and Transport (MPWT), the Lao Youth Union, the Lao Women's Union, the Ministry of Education, the Ministry of Information and Culture, the Ministry of Tourism, the Lao Trade Union, and the Military Hospital all expressed their support and offered to provide a representative to assist in project implementation.

iii) Baseline Situation Analysis

Following the establishment of the multi-sectoral PWTs, the Burnet team was requested to facilitate technical assistance and training in qualitative methods for conducting a baseline situation assessment.

The baseline situation assessment was conducted in May and June and served three purposes:

1. To provide an analysis of HIV vulnerability in the project area including those people most vulnerable and the sites to be prioritised to maximise impact. This included mapping of services to provide detail for the intervention design.
2. To provide data on significant HIV vulnerabilities prior to the commencement of project activities.
3. To contribute to baseline data against which the project can be measured during monitoring and evaluation

Initially, a core group of Project Working Team members attended a training on qualitative data collection. Lao language question guides were developed for use during focus group discussions. The guides were field tested and modified during qualitative research training.

Following the qualitative research training, the assessment team split into groups to collect data simultaneously at selected sites in 3 previously identified districts located along Route 3 (one in Bokeo and two in Luang Namtha province). During the data collection process, Focus Group Discussions were conducted with various groups of men and women at a number of sites along Route 3. Burnet supported the PWTs throughout the data collection by providing on-the-job training and monitoring the integrity of the process.

Finally, Burnet staff facilitated a data analysis training for the data collection teams, guiding them as they drew out common findings and developed appropriate recommendations. The findings and recommendations of the baseline situation assessment will be documented and shared for the reference of all stakeholders. A formal report is due July 7 2009. This will serve as a valuable future reference in both provinces. The report will also include a complete list of the team members who participated in the assessment.

In addition to providing valuable qualitative data to inform the development of a detailed project plan, the baseline situational assessment process was also an important capacity building exercise for the provincial authorities. Although this was the first time that many of the PWT had ever engaged in this kind of activity, their enthusiasm and commitment to produce a quality outcome was evident from the outset.

Young women along Route 3 discuss the issues facing them by drawing a village map and referring to more sensitive issues using the 10 Seed activity

iv) Development of Provincial Plans of Action

Building on the information collected during the baseline situation assessment, and the data analysis process that was undertaken, each of the two Project Working Teams were supported to develop a detailed plan of action for their province. Full details are provided in the following section of this report.

v) Coordination with ADB RETA Initiatives

To date, the Burnet Institute team has coordinated with two successive ADB International Monitoring and Evaluation consultants, and met for a half day with the Regional Gender Consultant. These consultations were important as Burnet is committed to feedback into the regional coordination being undertaken by ADB.

Burnet also took the initiative to request a seat at the Sub-Project 2 (East-West Corridor) inception workshop. Where possible, Burnet is attempting to facilitate dialogue with the Sub-Project 2 consultants, including the exchange of lessons learnt and mutual assistance with the coordination and streamlining of the two ADB sub-projects that have sites in Lao. This is proving a valuable exchange.

Burnet has also made contact with the ADB sub-project in Yunnan Province in China. Tentative plans have been made to organise exchange visits between the two sites, and for Burnet to source available HIV related information and communications materials that have been developed in Chinese language (useful for mobile Chinese populations in Lao PDR). This is particularly pertinent in relation to the Luang Namtha activities, as one of the selected settings is a Chinese owned and run casino in Boten. Although plans remain in their infancy at this stage, there is substantial potential and good will on both sides to foster this collaboration.

3. Revised Scope of Work

i) Background

As highlighted at the inception workshop and in the inception report, the original Terms of Reference for this project are comprehensive yet ambitious. Through the establishment of the Project Working Teams, the project was provided with an opportunity to review what is feasible within the local context. A facilitated consultation process was built into the inception phase and work plan development.

The resulting revised scope of work reflects and acknowledges two realities:

a) Appropriate infrastructure and capacity must be in place to effectively implement the different components of a comprehensive approach – not everything needs to be or can be done at once.

b) Short term projects cannot cover all aspects of a comprehensive HIV response. By establishing a phased approach, work can build and gain momentum as appropriate to match existing capacity. This approach increases the potential for a sustainable and positive long term impact [1]

It is important to acknowledge that one of the challenges for the Project Working Teams in the implementation of this sub-project is the timeline of less than two years. It is therefore imperative to prioritise and focus on strategies which are deemed to have the greatest potential for long term impact. The question of sustainable investment in local authorities also needs to be addressed.

This was an issue raised by both ADB and the Bokeo PCCA at the inception workshop based on previous lessons learnt. It is not enough to bring in international implementing agencies with large budgets who exit after a couple of years. The approach that was agreed upon was an investment in the skills and capacities of local implementing agencies, including the PCCAs, the District Committees for the Control of AIDS (DCCA), and the multi-sectoral Project Working Teams.

Through consultations with the provincial authorities and other key stakeholders it has been possible to modify the components outlined in the original Terms of Reference without compromising the integrity or the intent of the sub-project goals and objectives. In fact, the modifications, made following suggestions from the PWTs and coupled with a review of existing provincial capacity, have contributed to a more focused implementation plan. The increase in local ownership also provides greater potential for long term impact.

It is of note that the provincial authorities in Bokeo and Luang Namtha recognise that responding to HIV and STI requires a long term commitment to increasing their understanding of complex and inter-related issues. The teams have made requests for training to review basic HIV/STI knowledge. As part of and effort to build their own skills and capacities to implement an effective and responsive prevention program, the PWTs recognised the need to have a better understanding of the basics themselves.

[1] UNAIDS (2007) A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-at-Risk Populations

The Burnet team is in fully supportive of this self assessment, and in response, additional basic technical support and training programs for the PWTs have been included in the implementation phase. This underscores an important guiding principle in the overall implementation process - the need to take a strategic yet practical and phased approach.

The revised activity plans also aim to reflect an HIV and STI prevention project that is focused on communities at higher risk but with the participation of whole communities. Interventions will be tailored according to existing available data on epidemiology and the socio-cultural context of Bokeo and Luang Namtha.

Burnet provided the Provincial Working Teams with background on the global research that identifies behaviours which are known to contribute to people being at greater risk of HIV infection. This includes people who have higher rates of unprotected sex, unprotected anal sex particularly with multiple partners, and injecting drugs with shared equipment. Population groups at higher risk include:

- Female sex workers
- Clients of female sex workers
- Injecting drug users
- Men who have sex with men

Combining local knowledge and expertise with international research provided a framework for prioritising interventions.''[2]

The PWTs applied the settings approach in developing their implementation plans. These were based on:

a) Their own detailed understanding of their communities and what is appropriate;
b) The qualitative data collection and analysis they engaged in;
c) The technical advice offered through experienced HIV resource people from Burnet;
d) The priorities of the PCCAs;
e) Available epidemiological information;
f) Existing capacity of the PWT members;
g) Available funds and resources;
h) The project mplementation period;
i) A balance between capacity building and an implementation rate that would lead to the greatest potential long term impact;
j) Long term investment in skills building of local community representatives who could be called upon to assist in HIV and STI responses in the future;
k) Existing activities of other stakeholders already responding to HIV in the area.

It is evident that many issues need to be addressed in a response to HIV and STI. However, it was determined that the key to a successful plan rests on the ability to prioritise – considering available capacity, time and resources.

More detail about the proposed changes to the project components is provided in the sections below.

[2] UNAIDS (2007) A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-at-Risk Populations

ii) Confirmed Activities and Coverage:

.

The following key decisions have been made to date during the implementation period with regard to the project's activities and coverage:

1. The process of facilitating the PWTs to identify and prioritise the most at risk populations within their particular context was an integral part of implementation process. The provincial authorities prioritised the following groups:

    a) ***Bokeo*** prioritised work with the truck drivers and mini van operators that ply Road 3. In addition, they will focus on strategies for reaching specific ethnic communities who interact with the mobile populations along the road.
    b) ***Luang Nam Tha*** prioritised two settings: i) the casino located in Boten on the Chinese border; ii) the coal mine and adjacent village of Ban Nam Ngeun where the mine workers seek entertainment and services.

Chinese owned and managed casino in Boten, Luang Namtha

2. Consultations with LNP+ at central and provincial levels have resulted in an agreement for the participation of their representatives in project activities. The emphasis will be on ensuring mutual benefit, recognising the needs and concerns of their members, and focusing on reducing stigma within the concerned communities. LNP+ is particularly keen to work with the PWTs on the development of advocacy strategies.

3. The project has negotiated with Population Services International (PSI) to use their existing condom social marketing pipelines. There is no need to establish parallel systems where these exist already. Where the PSI pipelines have not yet been established, the project will provide data to PSI regarding potential new venues and opportunities that might exist. The establishment of a revolving fund for condoms and STI treatment will also be supported through PSI procurement.

4. The PCCA of Bokeo has specifically requested technical assistance in developing responses appropriate for working with men who have sex with men. This request reflects this significant and growing component of the HIV epidemic in the Asia Pacific region and in Laos specifically. Effective responses in addressing risks faced by men who have sex with men will have a direct and significant impact on the epidemic.[3]

[3] AusAID (2009) Intensifying the response: Halting the spread of HIV

iii) Component Updates

The original Terms of Reference outlined four component parts to this project.

In some, the revision of the scope of work has meant broadening these out to include additional issues. In other cases, the provincial authorities determined that there were already enough stakeholders supporting the interventions outlined in the original Terms of Reference, and alternative approaches to support the same objectives were proposed. For example, the PCCA in Bokeo reported that female sex workers in Bokeo are already being supported other NGOs. As such, they have proposed that instead Burnet work with them to develop their skills to work with men who have sex with men. This is an area of work for which Burnet is known to have significant expertise.

An update on each of the four original components is provided below. This includes the original objective identified by ADB, together with a brief description of what has taken place to date, and an updated list of priority activities that was decided together with Government of Laos stakeholders. The listed activities will be conducted over the remainder of the project implementation period.

A. Advocacy and Capacity Building

Objective: To build the capacity of a wide-range of stakeholders to advocate for, and implement, effective community based HIV and STI prevention activities.

ADB gave clear direction in the inception phase of this subproject that this is a technical assistance initiative as opposed to a 'big budget' project implemented by an international agency. The project implementing agencies were identified at the time as the Provincial and District Committees for the Control of AIDS (PCCA and DCCA). Burnet is providing support and technical assistance to these organizations, using as a starting point their existing capacity level and their absorptive capacity. The multi-sectoral Project Working Teams (PWTs) will draw from lessons learned in previous ADB supported projects in these provinces. These lessons were raised and discussed during the original central level sub-project inception workshop. Key issues that emerged included the necessity to focus on strategic areas of implementation rather than falling into the trap of spreading the implementation too broadly and diluting the effectiveness of the response.

Prioritised Activities:

1. Facilitation of consultative implementation planning.
2. Capacity building of multi sectoral teams in using qualitative methods to collect and analyse data in order to prioritise the development of HIV and STI interventions for those most at risk
3. Cross-border collaboration between the health authorities of Yunnan in the People's Republic of China and those in Laos to address safe migration and sexual health issues among mobile and migrant populations in the border region.
4. The development of practical strategies for working with the private sector, and specifically the casino in Boten (Luang Namtha), the coal mine located along Route 3 (Luang Namtha), and the trucking and minivan companies that ply the road (Bokeo).
5. Provision of technical assistance to PCCAs in the development of advocacy strategies for HIV prevention activities to be integrated into the work sites of the private sector.

6. Specific training for PCCAs in effective ways of developing responses to address HIV vulnerabilities among men who have sex with men.
7. Mid- and end-of-project workshops bringing together all key stakeholders to discuss lessons learned and recommendations for mid-term remedial measures and strategies for improving future interventions aimed at responding to HIV and STIs.

B. Information, Education and Behavior Change Communications

Objective: To support the PCCA and DCCA to develop IEC and BCC materials designed with communities to reduce the vulnerability of those at higher risk of HIV and STI along route 3

Following the baseline assessment and analysis conducted by the designated multi-sectoral Project Working Teams, a clearer picture of the situation emerged that allowed the PCCAs to decide where to focus their implementation and what strategies to develop for communities at higher risk. Burnet was able to work with the provincial teams to highlight those behaviors that characterize higher risk.

Prioritised Activities:

1. Provision of training sessions for the PWTs on effective IEC and BCC development for communities identified in the selected settings
2. Development of awareness raising strategies with ethnic minority populations using IEC and BCC materials and methods that are culturally- and linguistically-appropriate in the selected project sites (e.g. radio programs focussed on HIV prevention in at least two languages appropriate to the prioritised sites
3. Development of focused interventions employing strategies such as peer education for work with sex workers, truck drivers and mini van operators, mine workers living away from their families in dormitories on site, and young ethnic community members.
4. Development of capacities within the provincial authorities to increase access to and availability of condoms in the commercial market by working with existing organizations and supporting the effective monitoring of existing social marketing infrastructure.
5. Strengthening collaboration between the implementing agencies and any potential partners engaged in sexual and reproductive health, child and maternal health services, harm reduction or drug and human trafficking in the project areas.

C. Provision of medical packages

Objective: To develop existing capacities of the PCCAs to improve access to condoms and STI treatment for communities at higher risk of STI and HIV infections

In discussions with the provincial authorities regarding the effectiveness of previously conducted workshops for pharmacists, it became clear that this was problematic, complex and not the most cost efficient approach to responding to STIs. Training of pharmacists in the past has shown to have limited impact as they are frequently not in attendance in the pharmacies. They are supported by their families and friends to staff their shops. Moreover, other agencies have previously invested in the training of

pharmacists in these provinces, and the PCCAs will also be supported through the Global Fund to conduct future training for pharmacists. As such, it was decided that this element will be dropped from the list of project activities.

The PCCA from Luang Namtha requested a very practical alternative. The new strategy is thuis to provide their existing mobile health teams with the means to initiate a revolving fund of condoms and 'one stop' STI treatment kits that could service the more difficult to reach populations such as communities and settings that do not have access to pharmacies at all.

The long term plan would be to develop an action research model that provided the evidence of a market for the supply of condoms and STI treatment. This could then be used as a feasibility study to entice commercial operation or pharmacy to establish themselves.

CHAS and the PCCAs have also reported that STI protocols are already currently being revised. Although it is not yet clear when this would be finalized, this project will not try to interfere in the existing process.

Prioritised Activities:

1. Support for PCCAs to work with LNP+ in developing practical strategies to improve access to treatment, care and support.
2. Supporting for PCCAs to develop a revolving fund of STI treatment and condoms through mobile health teams (where appropriate).
3. Collaboration with the condom social marketing system that PSI has already established in both provinces.

D. Monitoring and Evaluation

The project monitoring and evaluation strategy has been discussed at length with ADB's international consultant, as well as with the Project Working Teams. These discussions have resulted in a draft project performance and management system, that will be finalised now that the baseline situation assessment has been conducted.

A partnership has been established between the PCCAs of Luang Namtha and Bokeo to design, implement, monitor and evaluate the project. It was agreed at the inception workshop that the PCCAs would review the comprehensive list of possible activities and prioritise them to ensure that the focus of the implementation is achievable and appropriately targeted. This prioritisation has been completed and the resultant modifications are presented in this report.

Prioritised Activities:

1. Finalisation of a project performance and management system (PPMS) to be applied throughout the project duration (baseline, monthly, mid-term and end-term). To the extent possible this will be streamlined with the (Draft) National Monitoring and Evaluation Framework.
2. Program monitoring in accordance with the work plan.
3. Twice yearly meetings of the full Project Working Teams to review progress. A specific action plan, budget, and monitoring scheme is being developed with each province. Joint meetings on lessons learnt are incorporated into the plan.

iv) Outcomes of the Revised Scope of Work

Following the revision of the project scope of work in consultation with the provincial authorities, the project now reflects more accurately the priorities as identified by the PCCAs and their multi-sectoral Project Working Teams. In accordance with the Technical Assistance role of Burnet as outlined by ADB and discussed at the Inception workshop there is a priority on local capacity building and investment in provincial authorities as implementing agencies. The PCCAs in Bokeo have presented their concerns over previous implementation strategies funded by ADB and others. This included the dispersal of the limited funds over too great an area and involving too many community groups including schools and resulting in few measurable outcomes and being assess as having no impact. With the revised scope of work, it is hoped that such challenges can be avoided in the current project.

This implementation for this project has also drawn on these lessons and those of other ADB projects in southern Yunnan. The ultimate aim of this investment in local communities is to encourage sustainable and replicable interventions that will result in outcomes and an impact beyond the timeline for which the project is funded.

4. Detailed Project Activity Plans

i) Quarterly Activity Plan (July-September 2009)

Detailed quarterly activity planning was conducted together with the provincial Project Working Teams (PWT) in both Luang Namtha and Bokeo. Please see Annex 1 for the summarised activity schedules.

In July, activities in both provinces begin with a three day joint training for the PWTS. As previously reported the PWTs have specifically requested this additional training. this training will focus on providing updated and basic information about HIV/AIDS and STIs, especially relating to the context in Laos. The training will also lay out the steps to conduct an effective Peer Education approach including the skills development required and useful tools that have been trialled in a Lao context already. Existing Burnet trained Peer Educator trainers from Vientiane will join Burnet staff to co-facilitate this training.

Specific activities will follow with each of the identified project sites. In Luang Namtha these sites are the Boten casino, the coal mine company and nearby Nam Ngeun village. In Bokeo these sites are Pangsalao village and the headquarters of the trucking company. During the mini-van transportation companies.

Pangsalao village has been chosen as a pilot village. It is a comparatively larger village than others along the route in Bokeo. It has a pharmacy and is a popular rest stop for truck drivers and other transport drivers. The village is made up primarily of Lao Theung, and are specifically from the Lamaed group. The village will be a focus for more intense work such as peer education, BCC development and work with the pharmacy. The Bokeo PWT will also work on IEC development such as the radio programming that will have far greater reach but less impact. Burnet will provide advice and technical assistance on the benefits and challenges of ‘’broadcasting’’ as compared to the more labour intensive and more time consuming work with smaller

groups such as peer education. The difference between impact potential and ''coverage'' will be highlighted through on the job training and mentoring.

In the villages of Nam Ngeun and Pangsalao, training will be conducted for potential peer educators. These trainings will be split into 3 separate sessions phased into a three month period: 3 day session followed later by a two day refresher and debrief and a final I day debrief and support.

The sessions will focus on basic information about HIV/AIDS and STIs, including modes of transmission, modes of prevention, and elements of safe and risky behaviour. They will also focus on communication skills and how key messages about safe behaviour can be communicated to peers. It is anticipated that a total of 20 peer educators will be trained in each village, although it is of note that the village of Pangsalao is smaller than Nam Ngeun so numbers may vary. Peer educators will commence activities after the second phase, with the support and mentoring of the PWT members where necessary.

Two forms of peer education will be undertaken:

i) informal one-on-one discussions conducted as and when possible with peers during the course of normal day to day activities;
ii) organised discussions conducted on a monthly basis with groups of 8-10 peers.

As their skills and confidence levels increase, peer educators will be encouraged to support activities with the other target populations as resource people for PWT coordinated activities.

In addition the team of peer educators will meet on a monthly basis with the Project Working Teams to discuss the progress of their activities to date, to collectively debrief and troubleshoot any problems that may have arisen. The plan for upcoming activities will evolve from the discussions with Burnet resource people on hand to provide some guidance.

Within the context of the private sector (the Boten casino, the coal mine, and the truck and mini-van companies), a slightly different approach will be taken. Burnet's experience has shown that some peer education programs can be difficult to implement within a commercial setting, as staff or workers of private companies rarely have sufficient free time. This is especially true of highly mobile staff bodies such as truck drivers.

Burnet will work with the PWTs to set up a meeting with the company managers to discuss potential strategies for undertaken HIV/AIDS awareness raising activities that are relevant to each particular setting. Where the managers and workers deem it possible, peer educators will be trained using a similar model to those in the villages. Burnet staff and the PWTs will brainstorm other approaches with the employees and establish plans to conduct appropriate HIV/AIDS and STI training and outreach activities.

Activities with sex workers in the area surrounding Boten casino in Luang Namtha province will be initiated this quarter. In early July, additional information will be collected in an attempt to provide an approximation:

a) the number of sex workers
b) what proportion are men and what proportion are women
c) the proportion of Chinese nationals compared to Lao national
d) how mobile they are

These discussions will serve to provide the foundation for developing an appropriate response.

The quantitative component of the baseline assessment will also be undertaken this quarter. The trained peer educators will assist with the process. This quantitative study will use standard techniques developed for behavioural surveillance surveys, collecting information using a brief survey that will be designed and field tested by Burnet's national Monitoring and Evaluation focal point in consultation with ADB's International Monitoring and Evaluation Consultant.

The Project Working Teams will meet monthly in each province bringing together the 'implementing group' - approximately 5 people from the local authorities who have accepted the responsibility based on availability and capacity. In addition, quarterly meetings in each province will bring together a wider 'coordinating group'. These people make up the entire PWT and consist of about 20 government representatives who have officially been accepted to be part of the Project Working Team. they will lay a pivotal role in the monitoring of the project activities whilst being exposed to strategies related to systematic coordination.

On a quarterly basis, the PWTs will plan and conduct one large 'outreach activity' at a given project site. These activities will consist of larger awareness raising events that promote information about HIV/AIDS and STIs using a range of games, quizzes, and activities. In the settings approach this strategy works to reinforce the value of the community working together and is designed to reduce the potential for stigmatising the most vulnerable groups. Build into these larger events will be appropriate messages about supporting people who have already become infected. Where appropriate LNP+ representatives may chose to participate.

To supplement the training, peer education and awareness raising activities, a range of information education and communication (IEC) materials and behavioural change communication (BCC) materials will be developed. Initially, a training of BCC will be conducted for Project Working Teams in each province, after which a consultative process will be undertaken through which existing materials will be adapted to the local context and/or new materials will be designed. These materials might include brochures, billboards, a series of announcements on village public speakers, condom access points and STI referral information.

It is of note that in Bokeo province, the PWT has already begun to develop the concept of a radio program to reach a broad based audience. This will be designed and developed in consultation with local experts who are experienced in this field and are resident in Bokeo. They will make use of existing material previously developed by Burnet where relevant. Once finalised, the radio program will be broadcast as widely as possible and if appropriate it will be shared with other provinces..

PWT in each province will be provided with training on how to engage private sector company managers in HIV prevention and mitigation initiatives. This training will be supplemented by on-the-job mentoring as PWT members join Burnet staff to meet with the managers of the identified companies and discuss and negotiate HIV prevention activities that could be conducted on each site to support the company and its workers. Regular follow up 'advocacy' meetings will also be arranged with relevant company managers to ensure that they remain informed and part of the decision making processes.

An important addition is the establishment of revolving funds for both condoms and 'one-stop' STI treatment kits. An idea posed by the PCCA in Luang Namtha. This is being negotiated in collaboration with Population Services International (PSI). These will then be sold at PSI standard rate through already active mobile health teams who visit key sites on a regular basis. Revenue raised through the sale of these items will go back into the revolving fund and will be used to replenish the stocks through PSI pipelines.

It is anticipated that the revolving funds will increase the availability and access to condoms and STI treatment within the identified project sites as well as provide valuable lessons in social marketing for the PWTs. The strategy of using the mobile health teams will serve several purposes, including:

a) Providing some action research data on the market for condoms and STI treatments in sites that are currently not serviced by pharmacies. This information could provide the feasibility study for advocating for an entrepreneurial pharmacist to establish an outlet if the ''demand' exists in the market place.
b) Providing the PCCAs with an opportunity to work through a problem solving model and come up with potentially creative solutions to some of the existing problems that face them in responding to HIV and STIs along Route 3
c) Providing an opportunity to demonstrate the benefits of engaging in these responses to selected of the private sector companies and potentially ''opens'' the door for more collaborative work.

ii) Two Year Activity Plan and Reporting Schedule

For a summary of the full two year activity plan, please see Annex 2. For an updated reporting schedule, see Annex 3.

The eventual signing of the Aide Memoire between the ADB and CHAS assisted with appropriate endorsements to permit the project to initiate consultations and implementation in the provinces. In light of these delays, and other issues that required further consultation with ADB, the following revised reporting dates were agreed by ADB and are included here for reference.

(i) The draft Inception Report was submitted to the inception workshop on 1 April 2009, with the final English language version of the report submitted to ADB on 10 April as agreed. The English version of the report was then translated into Lao following the Lao New Year Holiday, and both versions submitted to CHAS and the PCCA in Bokeo and Luang Namtha.

(ii) After consultation with ADB and the monitoring and evaluation consultant, it was agreed that the baseline situation assessment report will be submitted by 7July.

(iii) The present Implementation Report constitutes a combination of the first quarterly report and the Implementation Report, detailing activities after consultations with the PCCA that were only possible following the signing of the Aide Memoire. As agreed with ADB at that time of the inception workshop, the present report reflects the agreed and updated work plan. Proposed annual budgets to accompany this plan will be submitted by 7 July.

(iv) Quarterly progress reports highlighting the component achievements over the period under review, the issues, and proposed responses will be submitted on or

before 18 September and 18 December 2009, and 18 March (combined with the mid-term report), 18 June, 18 September and 18 December 2010.

(v) A mid-term report detailing achievements, implementation issues, and lessons learnt will be submitted by 18 March 2010.

(vi) A draft final completion report will be submitted by 04 April 2011. A final completion report will then be due within 3 months of any comments being received by relevant parties on the draft report.

Three copies of these reports in the English language will be submitted to CHAS and ADB. An additional copy of these reports in the Lao language will be submitted to CHAS and the PCCAs.

5. Gender Action Plan (GAP)

Please find the updated Gender Action Plan (GAP) in Annex 4.

6. Organisational Chart

Please find an organisation chart in Annex 5.

ANNEX 1: Quarterly Activity Schedules

Luang Namtha Province

No.	Activities	July				August				September			
		1	2	3	4	1	2	3	4	1	2	3	4
Activities in Boten Casino													
	Burnet and PCCA meeting with human resource manager of casino												
	Background information collection by PWT at casino site												
	HIV/STI training for casino staff												
	Develop outreach strategy for reaching service women working around casino												
	Outreach work with service women working around casino												
Activities in Nam Nguen Village													
	Training of 20 Peer Educators in Nam Ngeun village												
	Village Peer Educators conduct monthly focus group discussions with young villagers												
	Village Peer Educators conduct one-on-one peer discussions												
	Monthly discussion meetings between PWT and Village Peer Educators												
Activities in coal mine company													
	Burnet and district team meeting with management of coal mine												
	Background information collection by PWT at coal mine company												
	Training of 20 coal mine workers as Peer Educators												
	Coal mine Peer Educators conduct one-on-one peer discussions												
Province wide activities													
	Basic training on HIV/STI and peer education processes for PWT												
	Design of quantitative assessment tools												
	Quantitative assessment data collection using Peer Educators												
	Monthly meeting of PWT implementing group												

	Quarterly meeting of larger PWT coordinating group												
	PWT conduct awareness raising events in Namngeun village and at coal mine												
	Monitoring and observation visits by PWT implementing group to project sites												
	Advocacy strategy workshop												
	Training of PCCAs on how to work with company managers												
	Follow up meetings with casino and coal mine managers (Burnet and PCCA)												
	Training on Behavioural Change Communication (BCC) for PWTs												
	Design/production of new BCC materials												
	Establishment of revolving fund of STI kits and condoms in casino and coal mine												
	Submission of quarterly report to ADB and CHAS												

Bokeo Province

No.	Activities	July				August				September			
		1	2	3	4	1	2	3	4	1	2	3	4
Activities in Pangsalao Village													
	Training of 20 Peer Educators in Pangsalao village												
	Village Peer Educators conduct monthly focus group discussions with young villagers												
	Village Peer Educators conduct one-on-one peer discussions												
	Monthly discussion meetings between PWT and Village Peer Educators												
Activities with trucking and mini-van companies													
	Burnet and PCCA meeting with managers of two companies												
	HIV/STI training for truck drivers												
	HIV/STI training for mini-van drivers												
	Truck drivers and mini-van drivers conduct one-on-one peer discussions												
	Review approach for working with truck drivers and mini-van drivers												
Province wide activities													
	Basic training on HIV/STI and peer education processes for PWT												
	Design of quantitative assessment tools												
	Quantitative assessment data collection using Peer Educators												
	Monthly meeting of PWT implementing group												
	Quarterly meeting of larger PWT coordinating group												
	PWT conduct awareness raising events in Pongsalao village												
	Monitoring and observation visits by PWT implementing group to project sites												
	Advocacy strategy workshop												
	Training of PCCAs on how to work with company managers												
	Follow up meetings with trucking and mini-van company (Burnet and PCCA)												
	Training on Behavioural Change Communication (BCC) for PWTs												

	Design/production of new BCC materials, including radio program												
	Broadcast radio program												
	Establishment of revolving fund of STI kits and condoms with truck drivers												
	Submission of quarterly report to ADB and CHAS												

ANNEX 2: Updated Two Year Activity Schedule

No	Activity	Year 1												Year 2											
		M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F
1	Basic training for PWT on HIV/STI and peer education processes																								
	Private Sector																								
2	Advocacy monitoring meetings with private sector (BI & PCCA)																								
3	Information collection by PWT at selected private company																								
4	Work with PCCAs on approaches to working with company managers																								
	Data Collection																								
5	Design of quantitative assessment tools																								
6	Quantitative data collection conducted with peer educators																								
7	Design and implementation of mid-term survey																								
	Peer Education and Outreach																								
8	Develop outreach strategy for reaching service women working in and around the casino																								
9	Outreach work with service women working around casino																								
10	Training of potential Peer Educators (PEs) at Pangsalao and NamNgeun villages (M=10; F=10 each village), with refresher training in year 2																								

11	Training of Peer Educators for truck and mini-van drivers (20), Coal mine workers (20) and Casino workers (20) refresher training in year 2																									
12	PEs conduct group discussions (1 per month)																									
13	PE conduct One on one informal peer discussion on HIV/STI																									
14	Monthly debrief and monitoring meeting between PWT and PEs																									
15	Exchange meeting for LNT and Bokeo village PEs																									
16	Monthly meeting of core PWT implementing group																									
	International Exchanges																									
17	Exchange from Yunnan Project Site																									
18	Exchange to Yunnan																									
	IEC BCC and Awareness Raising																									
19	Develop radio broadcast schedule																									
20	Training on Behaviour Change Communication BCC) for PWTs																									
21	Design/produce new BCC materials, including radio program																									
22	Broadcast radio program																									
23	Development of collaboration with PSI re social marketing of condoms and STI treatment (one stop kit)																									
24	Development of revolving fund of STI kits and condoms																									

	Monitoring and Evaluation																								
25	Monitoring visits by PWT implementing group to project sites																								
26	Quarterly meeting of PWT coordinating group																								
27	Annual CHAS/MPWT monitoring visits to Bokeo and Luang Namtha																								
28	Submission of quarterly reports																								
29	Draft final report																								

ANNEX 3: Updated Reporting Schedule

Report	*Due Date*	*Submitted*	*Requirements*
Personnel schedule	10th of each month	*	
Inception Report	10 April 2009	*	▪ 3 copies in English to ADB ▪ 2 copies in English and 1 copy in Lao to Govt.
Baseline Survey Report	7 July 2009		
ADB Update for AusAID	10 July 2009		
Implementation Report	23 June 2009	*	
Quarterly Progress Report	18 Sept 2009		
Quarterly Progress Report	18 December 2009		
Midterm report	18 March 2010		
Quarterly Progress Report	18 June 2010		
Quarterly Progress Report	18 September 2010		
Quarterly Progress Report	18 December 2010		
Draft Final Report	04 May 2011		
Final report	after receipt of all comments on draft final report and within 3 months of the end of the project		▪ 3 copies in English to ADB ▪ 3 copies in English and 3 copies in Lao to Govt. ▪ CD with report + 500 word knowledge summary

ANNEX 4: Updated Gender Action Plan

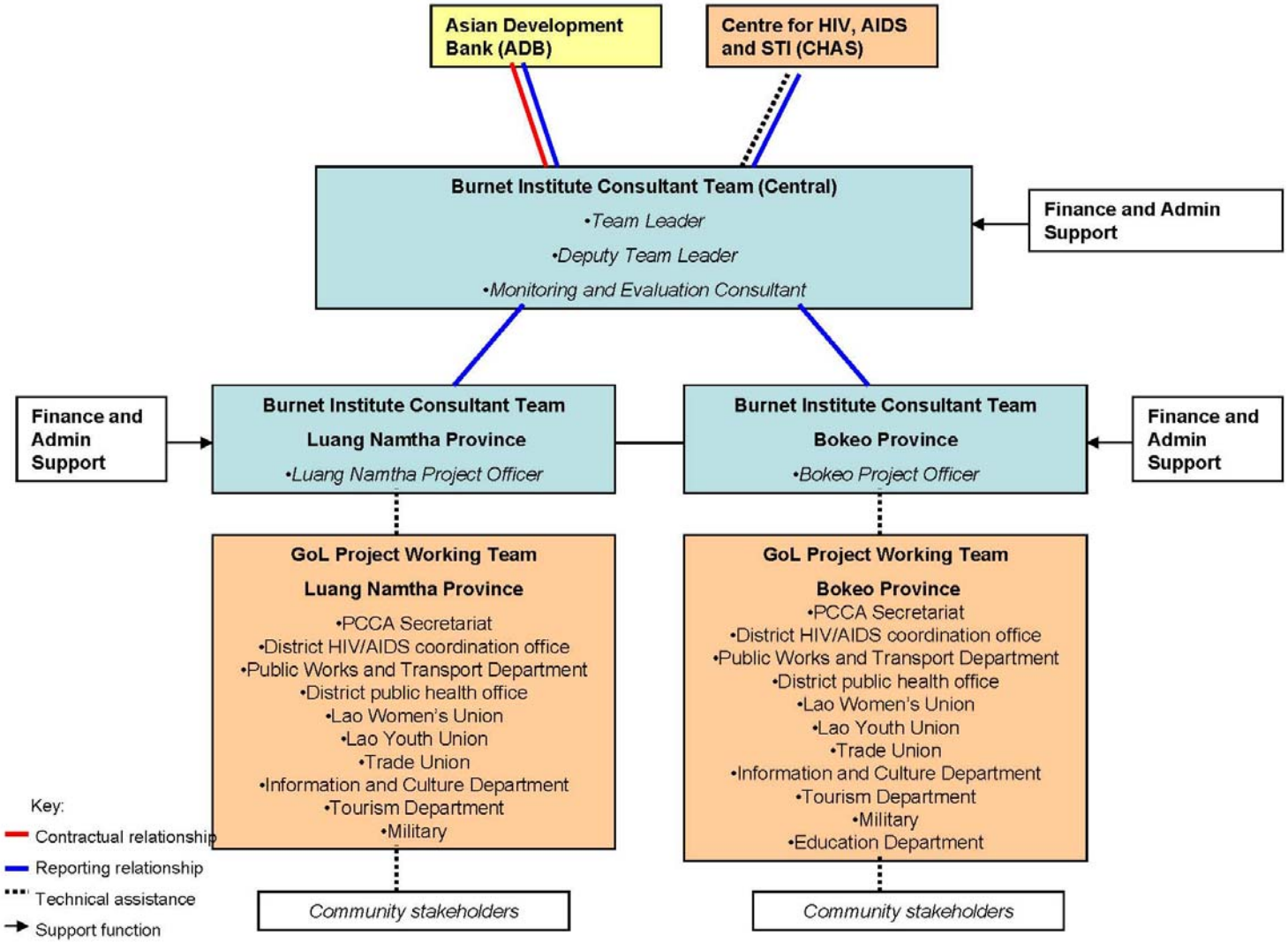
General principles:

- Work towards a gender balance in all activities related to capacity building
- Ensure gender of facilitators is appropriate
- Include technical assistance on men who have sex with men
- Encourage discussion on socio-cultural norms and values that increase vulnerabilities of men and women
- Develop interventions with participation of the men and women of affected groups
- Interventions will aim to strengthen the lifeskills, knowledge and capacities for all participants
- Address any stigma and discrimination as an integral part of all interventions

Advocacy and Capacity Building	**Gender Responses**
(a) Cross border collaboration to address issues related to the safe migration and sexual health issues of mobile and migrant populations.	• efforts will be taken to develop understanding with the different stakeholders on the factors that facilitate or hinder safe migration and sexual health as they relate to gender and age.
(b) capacity building and technical advice targeting the private sector, along and near Route 3	• Activities will include highlights for managers on the vulnerabilities and risks of their workforce, male and female • Advocacy materials will illustrate the benefits of workplace management structures for both men and women employees as well as managers
(c) capacity building of provincial and district government authorities in addressing HIV along the road and in border areas, including among migrant and mobile populations and ethnic minority communities	• Make use of existing materials as much as possible and adapt - to include gender dimensions if appropriate • Create understanding on the factors that facilitate or hinder safe migration and sexual health in relation to participating groups and gender
(d) mid- and end-of-project workshops among key stakeholders to discuss lessons learned and recommendations for mid-term remedial measures and improving strategies for future interventions in infrastructure sector, border areas and along Route 3.	• Mid- and end-of-project workshops to include discussion on lessons learned and recommendations for a gender-sensitive approach to HIV prevention • The strategy to contribute to the development of effective and sustainable implementation of interventions after project completion will contribute to gender equality and empowerment
Information, Education and Behavior Change Communications	
(a) ensuring that education and training sessions are provided for migrant and mobile population and communities along the road and in the border area	• Where appropriate conduct separate sessions with men, women, boys and girls to better understand different knowledge levels, risks, norms, values, impact, access and socio-economic issues of all groups

	• Make presentations of any outcomes of these or other sessions to contribute to a greater understanding of the relationship between gender and interventions
(b) conducting HIV awareness and prevention sessions with ethnic populations using IEC and BCC materials and methods that are culturally appropriate	• Challenge gender stereotypes, double standards and perceptions that compromise any group • Include participatory activities within the peer education sessions • BCC package to address factors that facilitate safe behaviour • Ensure that dissemination of materials reaches places of greatest impact with due consideration to gender
(c) supporting focused interventions for sex workers and their clients, considering the groups' high mobility, legal status, racial and ethnic backgrounds, language,	• Use existing materials adapting where necessary to include appropriate attention to gender • Skills building including consideration of the context of working environment
(d) increasing access to condoms available in the commercial market	• Work with PSI to maintain or develop easy access to condoms for both men and women
(e) Supporting PCCAs in advocacy to integrate HIV prevention in any occupational health and safety programs of companies under their area of influence.	• Support PCCAs to develop an advocacy package that includes a gender dimension
Monitoring and Evaluation	
(a) develop a project performance and management system (PPMS) to be applied throughout the project duration (baseline, monthly, mid-term and end-term)	• PPMS to include gender-specific indicators and disaggregated data to be collected and reported where possible • Mid- and end-of-project workshops to include discussion on lessons learned and recommendations for gender-sensitivity
(b) undertake program monitoring at regular intervals and share with ADB and relevant Lao authorities.	• Include any lessons on gender in reports, including any relevant specific activities taken in relation to gender • The plan/strategy making recommendations to maximise effective and sustainable implementation of interventions after project completion to contribute to gender equity and empowerment

ANNEX 5: Organisational Chart



Supplementary Appendix 2

Sub-Project 2:
Post Construction HIV Prevention on the East West Corridor

TA-6467 (REG):
HIV Prevention and Infrastructure
Mitigating Risk in the Greater Mekong Subregion

Subproject 2 – Post Construction HIV Prevention on the East West Corridor

World Vision Australia

In association with
Research Communications Group

Inception Report – May 2009

Acronyms and Abbreviations

ADB	Asian Development Bank
AIDS	Acquired Immune Deficiency Syndrome
BCC	Behaviour Change Communication
CHAS	Center for HIV/AIDS/STI (Lao PDR)
CSO	Civil Society Organisation
EWEC	East West Economic Corridor
GMS	Greater Mekong Sub-region
HCM	Ho Chi Minh
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
M&E	Monitoring and Evaluation
MMP	Migrants and Mobile Populations
MOT	Ministry of Transport (Vietnam)
MPWT	Ministry of Public Works and Transport (Lao PDR)
NGO	Non-Government Organisation
PAC	Provincial AIDS Committee (Vietnam)
PCCA	Provincial Committee for the Control of AIDS (Lao PDR)
PPMS	Project Performance Monitoring System
STI	Sexually Transmitted Infection
TAP	Technical Advisory Panel
ToR	Terms of Reference
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organisation
VAAC	Vietnam AIDS Administration and Control
WVA	World Vision Australia

Table of Contents

Appendices

1. BACKGROUND AND RATIONALE

The ADB HIV and Infrastructure Program is a focused series of interventions to identify and reduce social risks emergent from the massive investments being made into the Asian Highway Network. Highway 9 of the East-West Economic Corridor (EWEC) serves as a key segment of the Network. The entire EWEC spans four countries, running from Mawlamyaing Port in Myanmar, across Thailand and southern Lao PDR to intersect with Vietnam's Highway 1 at Dong Ha, in Quang Tri Province.

An evaluation on the social and health impacts of the EWC project was conducted by ADB and the Executing Agency in 2006. One of the key findings included in the evaluation report was that the number of new HIV cases in Savannakhet and Quang Tri Provinces doubled compared to rates before the EWEC project commenced. To follow up on this finding, ADB conducted a case study review in June 2007 to assess the design and implementation issues, as well as impact (where data were available), of the HIV-related measures incorporated into the project implementation. A number of recommendations were made, including the need for post-construction HIV prevention initiatives. On 14-24 October 2007, a joint inception mission was conducted by ADB and AusAID to develop a detailed implementation plan for a follow-on project.

TA-6467 (REG): Subproject 2 – Post-Construction HIV Prevention on the East-West Corridor (Lao PDR/VIE – 2008-2011) responds to the linkages between migration, mobility, and the spread of HIV. The ADB has recognised and supported incorporating HIV prevention programs targeting post-construction workers and the local communities affected by infrastructure Projects.

This document, prepared following the initial weeks of fielding the response team in April 2009, represents: a more detailed rationale for Subproject 2; a profile of the characteristics of the ethnic minority and mobile populations that the project seeks to reach; an update of progress made in respect to Inception phase formative research findings, partner and stakeholder meetings and consultations (including an Inception Workshop); proposed revisions to the project's objectives, geographical focus, and technical advisory inputs; and an illustrative work plan and timeline for activities (for the interim period - prior to a comprehensive plan and timeline being submitted as part of the first Project Progress Report). The Project Implementation Team will finalize the work plan, personnel schedule, etc. prior to the first Progress report – based on the outcomes of the ADB's Inception Mission and the Tripartite Aide Memoire (ADB, Lao PDR and Vietnam) (see Appendix) has been agreed upon and signed.

2. PROJECT UPDATE: THE INCEPTION PHASE

Official project mobilization was delayed by several weeks as a result of ongoing negotiations between the Asian Development Bank (ADB) and the National Governments of Lao PDR and Vietnam. Despite the delay, the Project Implementation Team took the opportunity to travel along Highway 9 to make observations, undertake unofficial consultations and conduct informal studies with several significant stakeholders.

One of the key beneficial outcomes of the Inception Phase has been the opportunity it has afforded the team to consult with a broad range of Governmental and non-governmental stakeholders and partners, as well as ADB, in reviewing the Terms of Reference (ToR) for Subproject 2, particularly with regard to the scope of work and the outputs, given the time and resources provided. In light of what has been learned, a number of proposed changes to the ToR are presented in this Inception Report. Each

of the proposed changes is justified and supported by primary and secondary research activities and/or consultations with key stakeholders.

The proposed revisions of the Project's terms and the structure for delivery of technical assistance include:

(a) Activities undertaken to mitigate vulnerability of communities affected by Highway 9 will focus on the vulnerabilities and consequent needs of the dominant ethnic minority population – the Bru/Van Kieu (both names apply to the same group, either side of the Lao-Vietnam border);

(b) Establish skill sets and local capacity to design and manage local language communication and materials – to be applied to HIV and safe mobility as well as to broader social and health sector issues beyond the mandate of this project.

(c) Revise the geographic scope of Subproject 2 so that the focus is on the two provinces through which Highway 9 passes – Savannakhet in Lao PDR and Quang Tri in Vietnam;

(d) Improve access to, and use of, medical services by ethnic minorities and migrant and mobile populations through expanded awareness campaigns, including health service promotion and referral information. That said, medical service strengthening will not be an outcome of the project, per se, and emphasis will instead be placed on the HIV prevention components and key activities: i. Advocacy and Capacity building; ii. Information, Education and Behaviour Change Communication; and iii. Monitoring and Evaluation.

(e) Services for mobile and migrant populations are expanding rapidly in the areas around Savannakhet city, as such, this project will focus primarily on the districts closest to the border and consequently target community members (specifically members of the dominant ethnic minority group, 'Bru') and migrant and mobile populations (MMP) in those districts.

(f) The baseline study will consider both the extent to which populations passing through these areas represent risks or vulnerabilities (that should be addressed by this project) and the key risks and vulnerability of affected ethnic minorities, who, by and large, have not been exposed to national or local communication projects or activities due to numerous linguistic and cultural barriers, but are (as formative research clearly indicates) underserved with information and services. That said, communication methods, approaches and materials and messages will be informed by baseline data analysis. As such, the Inception Report outlines 'suggested' communication activities determined by a round of consultation that has taken place, during Inception, with community members and stakeholders.

g) Scaling-up the role and responsibilities of the Project Implementation Team's Technical Advisory Panel. The Inception phase indicates that Subproject 2 will clearly benefit from increased involvement of advisors with complementary regional experience and knowledge on HIV, mobility, transport and minority to assist with advocacy, capacity building, operational research, gender mainstreaming, social mobilization and communications responses - as well as ensuring a streamlined quality assurance mechanism.

An *Inception Workshop* was held in Vientiane, Lao PDR, on May 7, 2009. The agenda included introductions to RETA 6467, an outline of the HIV situation and previous responses along Highway 9 (from Savannakhet and Quang Tri Provincial AIDS Councils respectively), an outline of project scope

and timeline, proposed activities and inputs. A discussion took place after the presentations, the resulting decisions and project direction of which was summarized by ADB on May 10. An ADB team, the Project Implementation Team for Subproject 2, Vietnam and Lao PDR officials from Ministry of Public Works and Transport, National and Provincial AIDS Centre's and Councils and key stakeholders from the relevant public health authorities attended. Burnett Institute, UNAIDS, and World Vision Lao Representatives observed proceedings.

Consensus and decisions resulting from the workshop will be presented at appropriate points through this Inception Report.

The Aide Memoire arising from the Inception Workshop – including full agenda, participants' names and titles, and the workshop discussion notes - is presented as an appendix to this document.

3. PROJECT CONTEXT

(i) The East-West Economic Corridor

Given that the Myanmar segment of this highway will not be completed for many years to come, the dreams of the EWEC as a four-country growth corridor will remain somewhere in the future. For now, the primary utility of this corridor is for traffic from Southern China to the Thai port of Laem Chabang, and for east-to-west migrants. In the absence of a traffic analysis, it appears that only very modest commercial traffic is moving eastward along the highway, or that it contributes to any measureable increased shipping traffic from either Hue or Da Nang ports at this time.

Moreover, with the new bridge across the Mekong River under construction at Nakorn Panom, Thailand, Highway Routes #8 and #12, which run parallel to Route #9 to the north, may very significantly reduce the transport traffic using Highway Route 9.

What remains are more localized impacts from the upgrading of the highway, with socio-economic changes being witnessed in areas long considered 'under-developed'. Nearly all social or risk-related studies conducted along Highway 9 to date clearly state that human movement on this segment of the EWEC (Highway 9) is from east to west. Lowland Vietnamese are moving into the highlands or into Laos. The highlanders are moving into Laos or Thailand, and the Lao migrants are moving west to Savannakhet township or on into Thailand, all in search of economic opportunities.

What this also suggests is that migrant and mobile populations are NOT risk factors in the transit zones, but represent at-risk and vulnerable populations primarily at the destinations. For the most part, the destination of these migrant and mobile populations is either Savannakhet city or Thailand.

The East-West Economic Corridor (EWEC) project was one of the ADB's first large infrastructure projects in the GMS to address HIV vulnerabilities associated with construction work specifically. The project supported rehabilitation of 78kms of Road 9 in Quang Tri Province in Viet Nam and 83kms of Road 9 in Savannakhet Province in the Lao People's Democratic Republic (Lao PDR), affecting an estimated 353,000 people. Of these, an estimated 47% are poor and 39% are from ethnic minority groups, although these rates are much higher in areas closer to the border crossings between the two countries.

The project aimed to promote economic activities and facilitate trade between the Lao PDR, Thailand and Vietnam; and to increase the prospects of poverty reduction among communities along the

transport corridor. However, it was recognized that along with economic development came the risk of potentially exacerbating the AIDS epidemic in the project-affected areas. At the start of project implementation, HIV prevalence in Quang Tri Province was low, but Savannakhet Province had the highest HIV prevalence in Lao PDR. To address possible vulnerabilities associated with road construction, mitigation measures for HIV and other sexually transmitted infections (STI) were incorporated into the project design that were focused on construction employees. The HIV mitigation efforts ran in parallel with the road construction from 2000 to 2006.

(ii) Cultural and Ethnic Characteristics

In the areas encompassed by Highway 9, the dominant ethnic minority population is the Bru or Van Kieu people, a Mon-Khymer language group. In some areas of the cultural catchment area along Highway 9, this minority group comprises approximately 80% of the resident population. A smaller group, the Pahco (Paco, Pako), also a Mon-Khymer language group, represent approximately 5% of the population. The remaining populations are from the dominant groups of either side of the respective borders of Vietnam and Lao PDR.

The Bru/Van Kieu peoples are effectively without written language. Although foreign linguists, notably the Summer Institute of Languages and several individual academics, have produced written scripts for this language, none has apparently ever been put into use on either side of the border. This means that the majority of this language group is non-literate, or has very low literacy in the dominant national language of either side. All previous studies have indicated the inability of this language group to understand or make use of health education or other behavioral change and IEC materials due to this lack of basic literacy.

Numerous myths exist regarding the social relations and behaviors of this minority group, particularly regarding courtship traditions and sexual relationships. Generally, these are the usual condescending, salacious and patronizing views of dominant outsiders. Unfortunately, these are often used to justify exploitations that do occur as a "natural" outcome of the backward nature of the ethnic minority.

There is little doubt that substantial socio-economic pressures are coming to bear on these minorities as in-migrants bring capital and investment, pushing the native populations aside. Labor exploitation, as well as asset deprivation, represents the first line of vulnerability. Dissatisfaction and alienation of youth from traditional lifestyles is rapidly accelerated by the influx of media (TV, video, karaoke, etc.), leading to higher risk behavior by youth unprepared for these changes or through seeking of wider experiences suggested by these media.

Community Risk Behaviour and Vulnerability:

Risk behaviors and vulnerabilities to human trafficking, sexual exploitation and HIV infection are a direct outcome of the changing dynamics of socio-economic development occurring following the expansion of Highway 9. The dynamics of these risks, again for emphasis, are either local or uni-directional from east to west. Program responses must acknowledge these unique features of emergent changes and the attendant risks and vulnerabilities. In essence, these source communities have been left unaddressed by any previous service programs, including the construction phase of Route 9. The baseline study for this project will better illuminate the particularities on both sides of the Vietnam/Lao border.

The Bru or Van Kieu ethnic group, essentially non-literate in the national languages of either country, represent the largest segment of those most vulnerable to the emergent risks of increasing socio-economic changes occurring with the expansion of the EWEC infrastructure. They are at risk as the receiving communities of in-migrants with skills and resources for which they have no match, as well as those being pushed or pulled into positions of manual and/or migrant labor. Across each of the various risk and vulnerability factors, the Bru/Van Kieu represent the most disenfranchised. Moreover, individuals from these communities are the least likely to have access to or understand public health and safety information or services. Thus, a strategy that undertakes a methodology to increase the capacity of officials to provide such communication and promote such services represents the best strategic use of resources.

Unfortunately, the Bru and Van Kieu are "boring" as an ethnic minority for purposes either of tourism or ethnographic interests. They are not colorful, nor do they dress in elaborate identifying costumes. To an untrained eye, the peoples of this ethnic and linguistic minority look mostly like the in-migrating peoples of the dominant populations – except they are generally smaller and much poorer. Overlooked, even among tribal minorities, they have received little attention from either anthropologists or authorities in earlier periods. That said, current officials on both sides of the border clearly recognized the needs and expressed serious concern and willingness to support improved access and programming.

Regardless of the topic or issues at hand – be it HIV/AIDS, human trafficking, illicit drug use, migrant work risks, general public health or education – officials on both sides of the border are quick to acknowledge that little depth in services nor even basic information has been delivered to the ethnic minorities in the target / catchment area.

(iii) Geographic Coverage

As noted above, the cultural catchment of socio-economic changes emerging from the construction and upgrade of Highway 9 is almost entirely restricted to the upper ranges of Highway 9 in Vietnam and across southern Laos to Savannakhet and Mukdahan, Thailand. While the usual range of various human risk and vulnerability factors may be found anywhere along the entire range of the projected EWEC (Mawlamyaing, Myanmar, to Da Nang, Vietnam), those that can be ascribed to the ADB infrastructure investment are, at this phase, more highly restricted to this limited portion of the corridor.

The geographic area of Dahong, Quang Tri province, where Highway 9 intersects with the north-south backbone Highway 1, down to Da Nang, for example, may exhibit some risks and vulnerabilities found elsewhere in the country. Yet it would be difficult to suggest that any significant changes or increases of these have occurred because of the improvements made to Highway 9.

While there are on-going needs for support to general HIV and human trafficking prevention programs, the purpose of this project is to respond to emergent issues specifically tied to the post-construction phase of the EWEC.

Likewise, the inclusion of Hue Province in the original TORs as an area of concern for this project has no basis in reality. The province lies far to the south of the EWEC, and the valid issues identified by the Hue Provincial AIDS officials are unrelated to the ADB funded construction.

The Project Implementation Team, following the meeting with the Hue Provincial AIDS authorities, drove across Highway 49 to A. Luoi, where it intersects with the Ho Chi Minh (HCM) Highway. From there the team drove north to reconnect with Highway 9, in the northern half of Quang Tri Province. The HCM Highway is an excellent road, yet traffic is relatively light through this area. While the immediate areas, well into Quang Tri province, where the HCM Highway does intersect with Highway 9, will be of interest to the project, the direct relationship with Hue Province as a source for emergent risks or vulnerabilities does not seem to exist beyond the most vague and tangential.

This is not to say that needs of Hue Province are unworthy of financial support. The project team was very positively impressed by the professionalism and real concern expressed by the Hue Province officials. Without doubt, there are very real grounds to justify funding of several if not all of their proposed programs and activities. Nevertheless, it was essentially impossible to see how any were directly related to the EWEC and should not be included in the geographic scope of this project.

This project has very strongly recommended that activities in Vietnam be concentrated in Quang Tri Province, and that Hue Province be removed from the geographic scope of interest. Fortunately, the VAAC have given their approval of removing Hue Province from the project.

The primary implication of this change includes the abolishing of the Hue Project Officer position. The intent of the project is to reprogram these funds into the Training line item. Field assistants, native Bru and Van Kieu speakers, will be hired to assist each Project Officer in the conduct of training activities.

4. PROJECT OUTLINE

(i) Objectives and Outcomes

This Project aims to mitigate the HIV vulnerabilities found along and near Route 9 in Lao PDR and Viet Nam. The outcome is to develop a set of effective mechanisms and strengthen the capacity of communities and institutions to effectively address HIV vulnerabilities associated with the rehabilitation of Route 9. The specific objectives of the Project are to: raise public awareness; address the risk of vulnerability by empowering the vulnerable to protect themselves; and empower stakeholders to protect the vulnerable. Per the Terms of Reference (ToR), the primary focus of the Project will be HIV and AIDS and STI prevention. However, the project management also recognise the potential for increased vulnerability to human trafficking and illicit drug use, and have, through the composition of the team and the Project TAP, ensured that such technical advice can be provided to the Project Implementation Team and partners.

The principal counterparts for this project are Provincial and District AIDS authorities along the EWEC, with supervision and coordination support from VAAC and CHAS. The Project Implementation Team will work with the authorities to mitigate the HIV vulnerabilities found along the EWEC (Route 9) by developing a set of practical approaches to strengthen capacities of local AIDS authorities to address immediate and emergent risks of HIV transmission associated with the use of Route 9 and the expansion and renovation of the highway in the immediate future. In response to the limited timeframe and limited resources, the Project Implementation Team intends to focus on the following key issues (each of which will be defined more specifically following baseline research analysis):

- Addressing the vulnerability of Bru/Van Kieu ethnic minority communities near and long Route 9,
- Improving access to medical services by ethnic minority peoples from affected communities along Route 9,
- Behavioral change communication to migrants and mobile population, including the clients of sex workers, based on findings from the forthcoming baseline study.

The following outcomes will be achieved:

- Increased capacity of individuals, groups and communities to protect themselves against the transmission of STIs and HIV, and trafficking in humans and illicit drugs;
- Enhanced capability of Provincial and District level agencies to engage communities and collaborate in building knowledge, attitudes and practices that will enable communities to address their vulnerability;
- Sustainable change and a measurable impact on the behaviour of vulnerable groups and communities.

(ii) Target Populations and Geographic Coverage

The original ADB assessment took note of any known and every possible emergent risk factor for HIV/AIDS, human trafficking or illicit drug use that might be found in the geographic region through which Highway 9 runs. The current project assessment and work-planning mission has sought to corroborate a triage of interests and actual concerns particularly related to the seen and projected impacts of Highway 9. A rapid consensus among a wide range of stakeholders and officials – on both sides of the border – agree that a specific focus on materials for and delivery to this largely underserved linguistic minority group will be the single most beneficial delivery of Subproject 2.

Migrants and mobile populations, as uniformly described in multiple studies as an East-to-West-only progression, both represent and are vulnerable to emergent risks. A number of existing, as well as new, programs directly address these mobile populations, particularly at prime destinations, such as Savannakhet. None of these programs are addressing source communities. In the dominant Bru/Van Kieu areas, these mobile populations represent invasion, displacement, opportunity and exploitation. The baseline study to come will take cognizance of possible intervention options currently overlooked.

The Inception Workshop resulted in a consensus that Subproject 2 will:

- Focus of ethnic minority populations and mobile and migrant populations on the Lao side of the border. Geographically the subproject will take place in Sepone and Phine Districts in Laos. The baseline research in Laos will include a sample of in-migrants and out-migrants on Highway 9.
- In Vietnam, from Quang Tri, target Huong Hoa and Dakrong ethnic minority populations but will await findings from the baseline research before determining the inclusion and participation of MMPs in the province. MMP issues will be researched in Dong Ha, and there was agreement that the baseline would include Huong-Hao migrant workers.

(iii) Key Activities

The initial assessment provided for a methodology and key activities that acknowledged the primary issues as (1) vulnerability of ethnic minority communities along or near Route 9, and (2) behavioral change among those identified as most at risk among those living and/or working along Route 9.

The Subproject will comprise of four components: (i) advocacy and capacity building; (ii) information, education and behavior change communications; (iii) the strengthening of access to medical services; and (iv) monitoring and evaluation.

The Subproject's approach and methodology is presented under each of those component headings. Please note that the Subproject Implementation Team is committed to an evidence-informed project design. As such, the activities presented in this section represent initial thoughts and directions that the team consider feasible and potentially effective based on what has been learned through the Inception period. Final activities and initiatives will be based on the complete formative research base of knowledge, including findings from the baseline research.

1. Advocacy and Capacity Building

At the time of writing, the Project Implementation Team were in the process of outlining and defining advocacy and capacity building in terms of Subproject 2. The original plans to hold regular workshops with public and private sector participation, with border authority and Ministry of Transport (MOT) involvement and with a cross-section of provincial stakeholders on a regular basis is being refined according to recent discussions held at the Inception Workshop and as a result of numerous other stakeholder consultations. The team has agreed to undertake an informal training needs assessment to determine what trainings and workshops will be most efficient to hold, given the time and resources allocated for this subproject. Until the Subproject team begin activities in the Provinces it will be difficult to gauge just how frequent such workshops and trainings should be held, with whose involvement, and which topics should be covered.

With this in mind the planned activities in this area will be revised. They may include (based on original and current thinking on this component):

Training: A week of training every six months – each week comprising a series of distinct but related workshops - engaging health authorities (such as district and provincial AIDS organisations), other government organisations (such as border police), NGOs, CSOs (such as social marketing groups), the private sector (such as manufacturing and mining companies), and non-traditional points of delivery for condoms (such as bars and tobacconists) working in Savannakhet and Quang Tri.

Workshops: To bring stakeholders together in awareness raising and capacity building – fostering improved private-public partnerships to help ensure a more comprehensive and sustainable response. The workshops will be comprised of general sessions of relevance to all stakeholders. Additional sessions will be tailored for specific target groups, taking into account ethnicity, gender and other issues of vulnerability. Workshops will be held in appropriate venues determined by participants and subject matter.

At this point it is clear that the iterative communications development process pursued by the Subproject (see ii) Information, Education and Behaviour Change Communications) will result in improved capacity among key community agents that will take part in developing, delivering and

monitoring radio dramas and complementary information, education and communication (IEC) materials and messages (through channels to be determined post-baseline research). Alongside these individuals the Subproject will build the capacity of local and community radio, with the assistance of UNESCO, in developing drama scripts, and in pre-testing, broadcasting and monitoring of radio messages.

In general the approach the subproject will adopt will be one that ensures that the focus of activities is on enabling individuals and communities to be self-determining and capable of advocating on their own behalf.

Other advocacy and capacity building activities will include dissemination workshops that that will highlight key issues and research findings. These will be conducted utilizing the Project Performance Monitoring System (PPMS) and their timing will be determined by the subproject baseline and end-line evaluations.

2. Information, Education and Behaviour Change Communication (IEC/BCC)

The project team will explore and review HIV prevention activities, operational research that has been done and is being done by other stakeholders, IEC materials that have been developed for mobile populations especially for ethnic minority communities, including, if possible, the Bru/Van Kieu. This information will be used for capacity building and evidence-based advocacy. The IEC and BCC activities will mainly focus on positive behavioral change for HIV prevention issues and for facilitating the creation of an enabling environment.

The Subproject will apply a comprehensive methodology for reaching, motivating, and strengthening opportunities for the relevant ethnic minority communities and for MMPs. While the primary focus will be on reducing risk of HIV and STI infection, the Project's communications component will also include elements relating to safe mobility, human trafficking and drug use. An outcome will be the development of a post-construction communications model, which could be presented for further consideration for future development Projects within the GMS. The Project's approach will include incorporating safe mobility messages into all activities and creating linkages with other organisations working on these issues.

Materials and follow-up among the Bru/Van Kieu language communities have been clearly identified as the least addressed and most important arenas of socio-economic change resulting from the Highway 9 upgrade and construction.

This Subproject will focus on technical assistance and collaboration with local stakeholders and officials to develop audio-based, scripted materials with an intention to broadcast via indigenous language radio broadcast programs in the respective countries. Depending on the findings of the formative and baseline research, the Subproject will also consider other forms of interpersonal-communication responses, deemed successful in similar contexts and environments. The Project Implementation Team and Project Technical Advisory Panel (TAP) have discussed the benefits of complementing radio narratives, drama or announcements with community mobilization techniques used successfully in similar non-literate cultures to reduce vulnerability and/or improve health status.

Baseline research will include an examination of the current media exposure and access to communications that exist within the Bru communities *and* within the MMP groups (ie. truck drivers,

migrant labourers, factory workers, seasonal migrant and traders etc.). Radio and television ownership data, media channel exposure and access, optimal messages and times for broadcasting, recollection and response to previous campaigns targeting the group and the appeal and recall of such campaigns, as well as information regarding traditional community channels of communications and group meetings etc. will be collected and gauged through the baseline research process. Essentially the Project Implementation Team will begin to build a communications exposure profile of their target populations in order to tailor the Subproject response. The Project Implementation Team intends to perform informal communications monitoring through the lifetime of the Subproject in order to inform decisions on message, channel, tone, appeal and degree of audience engagement.

The baseline research will determine the specific sub-groups to be targeted with the behaviour change component of the Subproject. Having said this, a key communication channel proposed at this point (following consultation with local stakeholders, Government counterparts and regional agencies) to target the largely illiterate Bru community members is minority-developed community radio drama and radio announcements.

Ethnic Minority Radio Drama Development and Broadcasting

Bright and young Bru Community members are introduced and provided basic training in field interviews and techniques in the collections of narratives. (Due to non-literacy, a number of small pocket field recorders will be required.) These community members may, tentatively, be selected from existing Handicap International teams working in the area and from the Hanoi Drama group, that the Project Implementation Team has explored involving.

UNESCO, with their wealth of experience from the region on reaching ethnic minorities with community developed radio drama, has agreed to deliver training to these community 'agents' during the last week of September 2009. Those selected for training will include the best and brightest from both the HI selected villages and those working with the Hanoi drama troupe. Other candidates will also be considered in a collaborative and transparent process among stakeholders.

Focus groups and narrative teams will be formed for the development of stories and plot lines. Materials will be constantly pre-tested and field-tested for clarity, content, veracity and entertainment response.

These groups will also serve to develop messages for other IEC materials or communication activities deemed appropriate following baseline data analysis. These teams/groups become a corps of pre-trainers, future trainer-of-trainers, yet still in their own learning stages.

As field partners will include NGO and local district groups focused on various subject matters (livelihood, micro-credit, wat-san, etc.), cross-cutting issues can be more easily addressed through the feedback process.

Pilot radio broadcasts will be part of an audience testing procedure. With refinement, different radio drama series can be broadcast concentrating on different aspects of socio-economic changes and risks confronting everyday people of these (their own) ethnic and linguistic communities.

Several different organizations are fielding teams of staff members, only some of them directly concerning HIV/AIDS or human trafficking. Nevertheless, their penetration into native Bru/Van Kieu

speaking communities will allow "listening groups" to be formed, from whom feedback shall be gained with regard to understandings and appreciations by the intended audience(s).

Such programs would represent only the mid-point of programming, as coordinated listening and discussion groups in villages throughout the area would conduct follow-up exercises, with a primary goal of refined and expanding the materials production capacities.

IEC and Interpersonal Communication Approach for MMPs

Community radio, developed by ethnic minorities for ethnic minorities will not meet the informational and motivational goals of a campaign targeting MMPs. The characteristics of this group are extremely different, not only in terms of linguistics and culture, but also in terms of access to information, their media exposure, access to services, literacy, risk behaviours, knowledge and awareness, risk perception, social support, and socio-economic status ie. their willingness-to-pay for condoms, for example. Baseline research and specifically the communications exposure component of the research tools will best inform how the Subproject will reach the MMPs identified for attention.

Both Vietnam and Laos has produced mobile population brochures, posters and other such IEC materials that could be drawn upon. However, until the baseline is complete, and a vulnerability assessment has been undertaken to assess which MMPs are most appropriate for the subproject to target, the subproject is unable to suggest particular approaches and materials (from a wealth of options) at this point.

3. Strengthening Access to Medical Services

Road users, MMPs and local communities need access to quality STI, HIV and other health services. The Subproject intends to collaborate with the relevant AIDS Councils/Committees/Centres, PHDs and other health sector stakeholders, to strengthen and support access to health services by promoting health service use via communication campaigns and by modeling 'preferred' health seeking behaviour practices through radio drama scripts – for example: modeling the 'best practice/behaviour' of a young man who believes he may have an STI and seeks advice and diagnosis; or, modeling how a community member can access the nearest Voluntary Counseling and Testing) VCT facility, including providing listeners with information regarding where that facility may be and what it offers.

It is important to note, at Inception stage, that the availability of health services and products is evidently significantly different for the ethnic minority communities the project will work with, in comparison to the access of many MMPs. Mobile populations often frequent larger towns and cities on a more frequent basis, and therefore, their health seeking behaviour opportunities are very different from an ethnic community member who rarely leaves the village. Messages promoting health services will need to take into account these clear delineations in access, availability, affordability and appeal of health services between the two target populations.

The Inception phase of the subproject, and previous ADB studies and anecdotal evidence, finds a clear need to improve coverage and quality of health care services in the areas within which this subproject operates. Indeed, the border districts and more remote stretches of Highway 9 have extremely limited access to any health services.

The Subproject includes availability of quality affordable condoms as a component of strengthening medical services. Condom promotion messages will be included within the campaigns conducted on

the Subproject and the national condom social marketing entities (Population Services International in Laos, and the GoV and PSI in Vietnam) will be approached. The project would like to explore the possibilities of community agents and team members assisting social marketing bodies in expanding coverage along Highway 9. At the time of writing, PSI/Vietnam has no project in Quang Tri province. PSI/Laos has a project in Savannakhet city only, not in the Eastern districts of Sepone and Phine. That said, this should be something of interest to both PSI and Subproject 9. Access to affordable quality condoms will be essential, as the subproject campaigns will promote risk-reduction practices and responsible sexual behaviour.

The Inception Workshop (May 7-8) participants agreed that the subproject would be charged with conducting a training needs assessment for STI/HIV medical services, focusing on Sepone and Phinh Districts of Savannakhet. The PCCA has agreed to provide resources to address findings and it was re-iterated that Subproject 2 will promote services but not provide medical trainings per se.

4. Monitoring and Evaluation

In line with the TOR, the M&E Specialist will develop a Project Performance Monitoring System (PPMS) in close collaboration with other team members. The PPMS will aim to develop practical and concise indicators with an appropriate balance between process and outcome. These will be harmonised with national and provincial M&E frameworks in both countries, and also draw on the regional M&E framework currently being developed by ADB – with the assistance of TA Dr Kerry Richter. In addition to indicators on HIV/AIDS and STIs, a key aspect of PPMS design will be to work with Project partners to articulate the specific Project targets with respect to HIV/AIDS and illicit drug use.

This project will conduct a baseline study along the Highway 9 route of the EWEC in the initial three (3) months of the project – with the draft and final reports due at the end of August, 2009. Project staff members are already in the field along the route in Vietnam, and have conducted a brief visit on the Lao PDR side. Initial field missions and interviews with provincial and district officials, as well as potential partners, have already brought significant focus to a widely disparate array of concerns.

The baseline survey will be designed in collaboration with Public Health Departments and other stakeholders, disaggregated by ethnicity, sex and other background socio-economic characteristics (occupation, income, education levels, literacy, etc.). Further baseline attention will be given to migrant and mobile populations passing into and through the area. Preliminary investigations suggest most migrants are westward bound towards Savannakhet or beyond, and are being addressed by other projects. The survey will be undertaken following agreement on sampling methods, fieldwork training and pre-testing of survey instruments. On completion of data analysis and reporting, a baseline survey dissemination workshop will be held. The relevant member of the Subproject's TAP, Dr Jacques Lemoine, will assist the Project Implementation Team in conducting the baseline and analyzing data.

The End-Term Survey will follow a similar process to that of the Baseline Survey. The Mid-Term Survey will be more limited in scope, recognizing that assessing behavioural impact at that point may be premature. It will thus focus on selected key indicators, as well as process indicators such as Project reach and recall. The End-Term Survey will combine assessment of these indicators with measurement of progress against the baseline, focusing in particular on behaviour.

The PPMS also has provision for a training programme for stakeholders on M&E. This will involves a series of training workshops for relevant PHD staff, provincial authorities, etc. Topics will include

sampling methodologies, fieldwork techniques, survey design and statistical analysis, complemented by practical fieldwork exercises.

The inception period, as well as the baseline studies, is taking a close look at emergent issues along the EWEC route to better determine their relative significance and which merit direct attention. Some of these behaviors, groups and vulnerability factors include:

- Ethnic minorities;
- Migrant populations, including migrant workers, in-migrants and out-migrants;
- Sex workers;
- Clients of Sex workers;
- Trafficked people, and those considered most at risk of being trafficked;
- Factory and warehouse workers, particularly at the border industrial zones;
- Officials, police, customs and border officials;
- Local communities.

Cross-cutting factors include:

- Low to zero literacy
- Lack of condoms and weak social marketing presence
- Inadequate awareness of Safe Migration issues
- Needs for Improved access to medical services for poor and ethnic minority populations

5. IMPLEMENTATION ARRANGEMENTS

(i) Project Management and Organization

The Technical Assistance Team consists of a Project Implementation Team, supported by WVA Staff:

Position	Name	Date Started
International Team Leader	Dr Owen Wrigley	1 April 2009
International Monitoring and Evaluation Consultant	Dr Kyi Minn	2 April 2009
Deputy Team Leader	Dr Nguyen Viet My Ngoc	24 March 2009
Project Officer – Savannakhet Province	Mr Southa Chanthalangsy	24 March 2009
Project Officer – Quang Tri Province	Ms Tran Thi Yen	24 March 2009
Administration Officer	Ms Tran Thi Thanh Yen	24 March 2009
WVA Innovative Partnerships	Natalie Craig-Vassiliadis	
WVA Innovative Partnerships	Andrew Binns	

The initial working arrangements for National Project officers are still being arranged. In Laos, the Project Officer will initially work directly with the Provincial AIDS office in Savannakhet, moving later to the eastern part of the province.

(ii) Implementation Schedule to August 2009

Subproject 2 Work Plan		Personnel	2009				
			April	May	June	July	August
i. Inception							
i.i	Finalise ToR - Agree on Implementation Roles and Deliverables	TL, M&E, DTL					
i.ii	Establish communication channels with ADB, CHAS, VAAC & PHD	TL. DTL					
i.iii	Establish country Network and Stakeholder lists	Entire Team					
i.iv	Review similar initiative experiences (in GMS)	TL, M&E, DTL					
i.v	Establish Project Steering Committee	TL, DTL					
i.vi	Harmonization Paper	TL, DTL					®
i.vii	Inception Report	TL, DTL		®			
Component 1 Advocacy and Capacity Building							
1.1	Review existing cross-border policies and collaboration between PHDs	TL, DTL					
1.2	Paper on Best Practices and Policy Components	TL, M&E, DTL					
1.3	Capacity Building/Training Workshops (2 days/6 months	Entire Team					
1.4	Sub-Project 2 Launch (Laos & Viet Nam Events)	TL, DTL, POs					
1.5	Private Sector Workshops	TL, DTL, POs					
1.6	Public Sector Workshops	TL, DTL, POs					
1.7	Route 9 Lessons Learnt/Research dissemination events (baseline, mid-term, end-term)	Entire Team					

Subproject 2 Work Plan		Personnel	2009				
			April	May	June	July	August
Component 2 Information, Education and Behaviour Change Communication							
2.1	IEC Needs Assessment – Communications Surveillance (profiling)	TL, DTL					
2.2	Campaign Design: Delivery Model – Channels & Messages & Implementation Report (including budget and work plan)	TL, DTL, POs					
2.3	Ethnic Minority Awareness Sessions – Participatory/Dialogue Group Learning	DTL, Pos					
2.4	IEC Materials Production	DTL, Pos					
2.5	IEC Material Dissemination	All Pos					
2.6	Condom Distribution Survey (standard social marketing [SM] methodology)	M&E, DTL, PO1, PO2					
2.7	Recommendations to PHDs and SM organisations for opening condom delivery points in underserved settings	M&E, DTL					
2.8	Advocacy Plans for PHDs (integrating HIV in Private and Public sector partners)	TL, DTL					
Component 3 Strengthening of Medical Services							
3.1	Review existing protocols on VCT for mobile and migrant populations	TL, DTL					
3.2	Develop standardized protocol for PHDs	TL, DTL					
3.3	(Through Activity 2.2) Build in VCT referral information and social support messages	TL, DTL					
3.4	Training sessions with PHDs and pharmacists on the Route 9 package for response	DTL, POs					

Subproject 2 Work Plan		Personnel	2009				
			April	May	June	July	August
Component 4 Monitoring and Evaluation							
4.1	Develop PPMS	TL, M&E, DTL				®	
4.2	Baseline Survey Design	M&E,DTL,POs					
4.3	Baseline Survey Sampling and Fieldwork Training/Preparation	M&E, DTL, All Pos					
4.4	Baseline Fieldwork	M&E,DTL,POs					
4.5	Baseline Analysis & Report	M&E, DTL					®
4.6	Baseline Survey Dissemination Workshop	M&E, DTL					
4.7	Review - Provincial Prevention, Testing and Counselling activities and protocols	TL, DTL					
4.8	Mid-Term Survey Sampling & Fieldwork Training/ Preparation	M&E, All POs					
4.9	Mid-term Survey Fieldwork, Data Entry and Analysis & Mid-Term Report	M&E, All POs					
4.1	End-Term Survey Sampling & Fieldwork Training/ Preparation	M&E, All POs					
4.11	End-term Survey Fieldwork, Data Entry and Analysis & End-Term Report and Final Project Report	M&E, All POs					
4.12	PPMS Training Programme provision (see 1.7 Dissemination Event)	M&E,DTL,POs					
Component 5 Reporting							
5.1	1st Quarterly Report	TL, DTL, M&E			®		
5.2	Baseline Survey Report	M&E, DTL, Pos					®

(iii) Personnel Schedule

Number of Personnel	Position	*Expert input*	2009					
			March	**April**	**May**	**June**	**July**	**August**
International								
1	Team Leader	*Home*					*	*
		Field			*			
1	M&E Consultant	*Home*						*
		Field			*		*	
							Subtotal	4 months
National								
1	Deputy Team Leader	*Field*						
2	Program Officer	*Field*						
							Subtotal	18 months

* Only part of these months was used by the International Consultants
Full time input
Part time input

(iv) Implementation Arrangements

- *Provincial Steering Committee:*

The Provincial Steering Committee will include

- Savannakhet PCCA (Dr. Panom, Head of Health Dept and Mr. Thongthiang, Head of Lao Youth Union), Heads of DCCA of Sepone and Pinh
- Quang Tri PCA, Representatives from Preventive Medicine Center of Huong Hoa, Dakrong, (Dong Ha-TBD)
- Project Implementation Team: Deputy Team Leader, Project Officers

Meetings will be conducted every 6 months
The Provincial AIDS Committees will submit to CHAS and VAAC for approval.

- *Stakeholder Meeting:* frequency and participants will be determined by the Steering Committee. Provincial representatives of MOT and MPWT will be invited to Stakeholder Meetings, which will be organized by the Project Implementation Team.
- *Focal Persons:*
  - In Quang Tri, Vietnam, Dr. Hieu of the Provincial AIDS Committee (PAC) will be the coordinator for WV and HI and will assign staff as needed.
  - In Savannakhet, Lao PDR, Dr. Ketshaphone of the Provincial Committee for the Control of AIDS (PCCA), will coordinate with the Project Implementation Team.

- *Progress Reports:* The Project Implementation Team will submit quarterly progress reports to ADB, VAAC, CHAS (translated), Savannakhet PCCA, and Quang Tri PCA. ADB will share reports with MOT/MPWT upon request.

1. The Technical Advisory Panel

During the proposal development stage of the response by World Vision and RCG, a Technical Advisory Panel (TAP) was established for Subproject 2. TAP members cut across a wide range of disciplines and organizations across the Greater Mekong and each possesses experience of working with HIV, ethnic minority and transport sector projects in the region. The TAP functions as both a resource and backstop for all stages of program development and delivery.

Dr. Jim Chamberlain has been consulted in several meetings to date. Phil Marshall, as RCG Asia and Pacific Director, has been consulted throughout the design and inception periods. The TAP also includes gender, HIV and transport advisor Dr Leenah Hsu. During the Inception Phase the TAP was expanded to include, Robb Butler, Managing Director of RCG, Dr David Feingold (UNESCO) and Dr Jacques Lemoine (UNESCO). Each of the five member panel has already contributed to the planning and design of the project and will, to varying degrees, be involved in providing on-the-ground or remote assistance and quality assurance over the lifetime of the project. A brief outline of each TAP member's contribution is outlined below:

Subproject 2: TAP Roles and Responsibilities

Name	Key Responsibility	Expected Inputs
Dr James Chamberlain	Ethnic Minorities	Advisor: characteristics and content of relevant ethnic minority groups
Dr David Feingold	Community Radio	Advisor: ethnic minority issues, community radio development and evaluation, radio drama design and broadcasting
Dr Jacques Lemoine	Operational Research	Baseline research assistance, advisor on 'Bru' community characteristics
Mr Phil Marshall	Trafficking, HIV & Transport, Quality Assurance	Trafficking, safe mobility, HIV and transport responses, quality assurance
Dr Leenah Hsu	Gender, HIV and Transport	Gender mainstreaming, HIV and transport advisor
Robb Butler	Transport and HIV Communications, Quality Assurance	Communications approach, HIV and transport, Q&A

One of the major benefits of the TAP is that it permits people to contribute to the project without necessarily having to travel. This offers the opportunity to greatly expand the pool of available experts. The approach of providing inputs remotely is of course more realistic than in the past, due to modern communications - Skype in particular.[1]

[1] RCG is in the process of developing a 'remote mentoring system for project TAPs. This will incorporate an accountable system to establish a TAP for all RCG projects and will include a client validation function.

The TAP for Subproject 2 sits in various locations of the world and provides the project team remote assistance via email and Skype (and face-to-face support where it is possible). The project is thus provided additional expertise and experience that is not immediately available through the project team or through immediate project partners. In turn, the TAP enhances information and knowledge exchange across projects – thanks to members (in this case such as Feingold, Marshall and Butler - who each work on other ADB and World Bank projects in the region of relevance to this project) sharing information and lessons learned from other regional ethnic minority, transport, HIV, safe mobility and trafficking responses. As a quality assurance mechanism the TAP allows the project team to focus and maximize efforts in designing and managing activities, in the knowledge that they are supported, monitored and assisted by this broader range of 'stakeholders'/technical advisors.

The Inception Phase has clearly identified a need for the increased involvement of the TAP. (see Section 6: Issues.)

2. Key Partners

Alongside National and Provincial Ministries of Public Works and Transport, AIDS Councils and Committees (6 Centres), Public Health authorities and other governmental and quasi-Governmental bodies, Subproject 2 has been fortunate to secure the support (and a willingness to assist) from several stakeholders, including UNESCO, World Vision and Handicap International/France. These stakeholders are, however, committed to other activities and facing their own resource and time challenges. The timing of some Project Implementation activities may be affected by the need to accommodate stakeholder schedules if the project is to ensure their participation. The ability to do so will need to be assessed and managed on an ongoing basis.

The postponement of the Inception Meeting allowed for the coincidence of Handicap International fielding a young Vietnamese anthropologist to conduct a series of baseline focus group sessions, leadership meetings and baseline interviews in 16 villages, comprised predominantly of Bru/Van Kieu populations in Dakrong and Huong Hoa districts of Quang Tri Province along Highway 9 to the Lao Bao border crossing. Our two Vietnamese Program Officers were able to join this study fulltime and will be credited in the forthcoming report.

An excellent reservoir of good will and collaborative partners has already been identified.

Assessments of the Lao side were formed through a drive across Savannakhet Province and meetings with stakeholders and Provincial (PCCA) officials. Fewer field resources are deployed in the eastern part of Savannakhet Province, but it was clear that sufficient players could be found. Consensus was quick and clear that a Bru language-focused set of technical inputs would be the most strategic and sound use of available program funds.

6. ISSUES

The two main challenges faced by the Project Implementation Team relate to optimizing technical assistance available to the Project Implementation Team, and the programming resources available to implement Subproject 2 effectively**.**

(i) Technical Assistance: Inputs and Time

Increased TAP involvement has obvious benefits for Subproject 2 (listed in section 5.2) and the team are keen to draw on the vast knowledge and experience they are fortunate to have access to through the Panel. Alongside these, the Subproject's demands on both the Team Leader and the M&E Advisor within the time allocated for their inputs are high. The TAP can alleviate this problem in allowing the Team Leader more time to focus on coordination of this complex project. The National team members are located disparately, rather than as a group, and will face the challenge of working cohesively while separated physically for significant periods of time. This risk may be exacerbated by challenges presented by poor infrastructure and high local transport costs. One of the roles of the Team Leader is to ensure project cohesiveness and this will be a challenge when the Team Leader is funded only three months per year. In order for the Team Leader to optimise time on the technical aspects and on coordination, the Project Implementation Team would like to request increased involvement of the TAP.

This is recommended as an alternative to increasing team leader time/inputs. Enhanced TAP involvement involves accessing a larger base of knowledge and experience and alleviates certain technical quality assurance duties from the Team Leader. It also allows him to draw on the array of skills available in the TAP for specific tasks, with the knowledge that the TAP member will be remunerated for their involvement. A standard fee will be set per day for each TAP member day, per diems (the few that may be required) will also be covered from this pool. Nothing will be claimed for travel (international or local) by the TAP.

Given the composition of Subproject 9's TAP, alongside the value the TAP has already provided through delivery of assistance with planning and quality assurance, and the forecast inputs the TAP hopes to offer the Project Implementation Team, the team would like to propose that the TAP inputs are increased, formalized and remunerated.

(ii) Resources: Broadcasting Costs

Whilst the project budget is sufficient to cover the training, development and testing of radio drama and materials, there is no budget allocation for broadcasting. There may need to be further discussions between the project management team and ADB on how this can be resolved.

The Project Implementation Team, for its part, will explore the possibilities of partnering the national Lao and Vietnamese Radio stations to examine whether there is an interest in delivering the radio dramas on air either on a pro-bono basis or at a subsidized rate. If the project can commit technical assistance in drama development and in ethnic minority programming, the radio stations may consider this sufficient 'return' to deliver free/low cost broadcasting.

7. REPORTING REQUIREMENTS

The following reports will be produced:

Report	Submission Date
Inception Report	15 May 2009
1st Quarterly Report	23 June 2009
Baseline Survey Report	28 August 2009
Implementation Report (combined with 2nd Quarterly Report)	28 September 2009
3rd Quarterly Report	23 December 2009
Midterm Report (combined with 4th Quarterly Report)	23 March 2010
5th Quarterly Report	23 June 2010
6th Quarterly Report	23 September 2010
7th Quarterly Report	23 December 2010
Draft Final Report	23 March 2011
Final Report	Within two (2) months of the end of Subproject 2

Copies of these reports in the English language will be submitted to ADB, CHAS and VAAC. Translations of these reports in the Lao Loum language will be submitted to CHAS and provincial AIDS authority of Savannakhet. Translations of these reports in the Vietnamese Kinh language will be submitted to VAAC and the provincial AIDS authorities of Quang Tri.

First Field Assessment: Thua Thien Hue and Quang Tri Provinces, Vietnam 7-9 April 2009

Date and time	Activity	Meeting Participants
April 7 (8am)	Met with Thua Thien Hue Provincial AIDS Committee (PAC)	• Dr. Tran Thi Ngoc, PAC Director • Dr. Nguyen Le Tam, PAC Vice Director • 5 PAC staff
April 7 (1pm)	Visited roads and Districts in A Luoi district and travel to Dong Ha Town, Quang Tri Province by car. The Team travelled via the Ho Chi Minh Trail (Route 14) and Route 9	
April 8 (8am)	Met with Quang Tri PAC. Visited roads and Districts in the Province	• Dr. Nguyen Ngoc Hieu, PAC Director • Dr. Nguyen Thi Tinh, PAC Vice Director • Dr. Nguyen Thi Thanh Tam, Head of Planning Department • Dr. Ho Phong Diep, IEC department
April 8 (11am)	Met with Preventive Medicine Center in Huong Hoa District, Quang Tri Province	• Dr. Tran Anh Tuan, Vice Director of Huong Hoa Preventive Medicine Center
April 8 (3pm)	Met with Preventive Medicine Center in DakRong District, Quang Tri Province	• Dr. Chau Van Hien, Director of DakRong Preventive Medicine Center
April 9 (8am)	Met with Handicap International representative in Quang Tri Province Returned to Danang by car.	• Ms. Isabelle Crespel, HIV project Manager, Handicap International

Second Field Assessment: Savannakhet Provinces, Lao PDR
21-23 April 2009

Date and time	Activity	Meeting Participants
April 21 (4pm)	Met with Handicap International consultant in Huong Hoa District, Quang Tri Province	• Mr. Nguyen Van Tung, Freelance consultant, who is contracted with Handicap International for a baseline survey in Huong Hoa and Dakrong Districts, Quang Tri Province
April 22 (4pm)	Met with World Vision Laos – Savannakhet project office	• Mr. Siddharttha Sahu, Operations Team Leader
April 23(10am)	Met with PSI staff	• Mr. Sisouphane
April 23 (2pm)	Met with Savannakhet Provincial Council for the Control of AIDS(PCCA)	• Dr. Ketsaphone, Secretariat of PAAC

FIELD TRIP NOTE

The First Field Assessment was undertaken by the Project Implementation Team in Vietnam during the first week of Project Inception. The Team travelled from Da Nang to Thua Thien Hue Province and Quang Tri Province using the Highways 1, 14 and 9. The aim was to assess informally the impact of Highway/Route 9 in Vietnam.

Highway/Route 9 is about 85km long and runs from Dong Ha provincial town to the Lao Bao International Border Gate. In Dakrong district, there are 4 communes in Dakrong and 5 communes and 2 townships in Huong Hoa located along Highway/Route 9.

The impact of rehabilitation of Route 9 can be summarized as follows:

Positive impacts: The economic situation of the local people (ethnic minority Van Kieu and Pahco) is improved. They have a lot of opportunities to go out for trading. The number of outside people who came to Khe Sanh and Lao Bao townships is more and more increased. They work in factories and companies.

Negative impacts: The development of transport roads leads to increased mobility and changes in population structures due to movement in and out of local people, change in livelihoods in local communities, changes in cultural and social life, impacting daily life customs as well as sexual relations and habits as "Di Sim". It was a traditional custom of Van Kieu and Pahco ethnic minority group and considered as a specific feather of culture. However, the local people modified this custom as sexual relations. The young people/workers in factories and companies usually find delights such as karaoke, sex women when they earn some money. This leads to a high risk of HIV infection.

Findings

- Number of HIV infected people in Quang Tri province: 147 (Huong Hoa: 16 (6 ethnic minority people and 9 King people)
- The local people use drug (heroin and Bo Da leaf) more than injection.
- The local authorities have not found any case of trafficking in Dakrong and Huong Hoa. However, many women disappeared without any reason.
- Ethnic minority people never think that they could be infected with HIV as others. They have no any knowledge of HIV.
- No IEC materials in ethnic minority language are developed.
- Peer education of drug people has not established yet.

Recommendations

- Conduct KAP survey in mobile group and worker group in factories and companies.
- Set up/enhance networks (facilitators and peer education)
- Increase capacity of networks on HIV knowledge and skills:
- Knowledge of trafficking, HIV, STD
- Skills: life skills, communication skills, facilitation skills
- Support to conduct BCC dissemination among ethnic minority groups and mobile groups.

- Develop IEC material and video in ethnic minority language.

FIELD TRIP NOTE
Survey Information from Handicap International France

Highlights

- Van Kieu ethnic minority have many diseases
- They usually go to Mo Re and Mo Brong (mountebanks) for treatment of ailment. For serious diseases, they go to commune heath station. However, they prefer District hospital to CHS because hospital has more doctors who are good capacity.
- Most of Van Kieu girls get married at 16-19 ages and boys at 18-24 ages.
- Education level of youth is low. 2/3 interviewees completed the primary school level. Their current job is slash and burn cultivation.
- The youth go "Sim" at the age 13. Most youths have sexual relation with 1-4 others before marriage. 1/3 of boys use condom when having sexual relation with one girl. However, after getting married, they do not use any more. They go to commune health station to get condom or VHW but this is rarely. Condom is not available at the village.
- The youth has heard about HIV/AIDs on television. However, they do not understand all information because it is Kinh language. They never receive any leaflet of HIV. As a result, 2/3 answers of the youth to the way of HIV infection are wrong or they do not know.
- They will hesitate to contact HIV people because they think that one reason of HIV infection is living in the same house with HIV people and use the same personal equipments. 2/3 of the youth will be willing to help their relatives who are HIV people.
- Most of the youth think that HIV is a serious disease and it will affect Van Kieu people's life.

Potential problems

- It seems that Van Kieu people have a little chance to access communication means.
- They did not participate in any communication of HIV prevention conducted by VHW before.
- There is no IEC material in local language.
- Their knowledge on HIV is limited
- They can speak Kinh language but cannot understand all programs on television.
- Behavior of using condom among ethnic minority people is low.
- Condom is not available in community and village.

Follow up

- Set up/enhance networks (facilitators and peer education)
- Increase capacity of networks on HIV knowledge and skills for VHW, volunteers:
- Knowledge of HIV, STD
- Skills: life skills, communication skills, facilitation skills
- Support to conduct BCC dissemination on HIV for ethnic minority groups especially the youth group. They need to be trained on life skills.

- Develop IEC material (leaflet, poster) in ethnic minority language.

FIELD TRIP NOTE
Survey Information from Handicap International France

The Project Officers for Hue and Quang Tri Provinces participated in a Handicap International France Baseline Survey.

I. Date of field trip: **13 Apr, 09**

II. Name of consultant of HI: Nguyen Van Tung

III. Location:

a. Morning: Quang Tri Province Women Union and HIV/AIDs Preventive Center

b. Afternoon: Dakrong District Preventive Health Department and Women Union

IV. Methodology: Key informant interview

V. Interviewees:

i. Quang Tri Province Women Union: Ms Thanh and Ms Yen

ii. Quang Tri Province HIV/AIDs Preventive Center: Ms Tinh

iii. Dakrong District Preventive Health Department: Mr Hien

iv. Dakrong District Women Union: Ms Cam and Ms Luong

VI. Contents of interview and findings.

Interviewees	Content	Findings
Province Women Union	General information of WU in Dakrong and Huong Hoa district	Dakrong: 4744 members of WU (3358 ethnic minority women)/6662 women in the whole district Huong Hoa: 9544 members of WU (4815 ethnic minority women)/11460 women in the whole district
	Roles of PWU in social works and HIV prevention	PWU has following tasks: • Do dissemination on knowledge of health care, income generation, gender… • Monitor the implementation of policies at commune level. • Support women at village to increase household economic. • Build model of happy family • Develop network of WU. At commune level, WU established key members and they found some cases of drug traffic. There is one women club named "Women prevent HIV and drug" in Lao Bao township.

		WU at commune level has established one team of carrying goods to get more income. Participating WU, all women have to commit to build their families that do not use drug. HIV is integrated in dissemination in monthly meetings of WU at village level. DWU coordinated with PAC and PHD to provide materials.
Quang Tri PAC	Reproduction health care of women	Through the survey of PAC, there are 7 who had abortions among 200 women interviewed. They think that this is a normal action. Most of the youth do not know how to use condom. In addition, condom is not available in community and village.
	Blood test	There are two services of blood test in District Preventive Health Center and Hospital. Every year, one mobile team of DPHC conducts a blood test for target people (100 samples). However, due to lack of finance support from government, monitoring, the result of blood test is not correct. The chosen of target people is wrong (for example: choosing staff doing washing up instead of sex workers in the restaurant/hotel…Moreover, the local people do not volunteer for blood test.
	Condom use	Condom is delivered to Commune heath stations and "Sim" house (house of the youth or widow). Local people do not volunteer forget condom from CHS. Parent does not accept their children to keep condom. NAV has a project of delivering condom in 4 communes at Lia area in Huong Hoa district.
	Knowledge of HIV of ethnic minority	The youths with 18 – 35 ages have no knowledge of HIV. They do not know alphabets. The youths who go to school, access knowledge of HIV but not change behavior.
	Methodology of communication	It is recommended that communication should be conducted in local people group and peer education group. Communication means: video in ethnic minority language.
	Cooperation between HI and PAC	No close cooperation between HI and PAC. It is difficult for PAC to design project activities and integrate them into their strategy.

Dakrong District Preventive Health Department	Main activities of DPHD	Preventive Health services Social disease prevention Reproduction heath care HIV prevention Communication on health care There is one 1 secretary and 4 staffs for HIV preventive program. There are 14 commune heath centers and 102 village heath workers (34 Pako, 51 Van Kieu and 17 Kinh)
	Common diseases of local people	Malaria, diarrhea, TB, injection, gynecology. The rate of disease of ethnic minority people is higher than Kinh people because ethnic minority people has limited knowledge of primary health care, low behavior and cannot access health services.
	Activities of HIV program	BCC Condom delivery Blood test Management of HIV people Consulting relatives of HIV people about HIV prevention. Train on HIV knowledge for VHW and volunteers.
	Methodology of communication	Pako people receive new knowledge quickly. Their community participation is higher than Van Kieu people's participation. Communication materials of government are not suitable to local context. There are many words in posters, no sign of communities. As a result, the impact of communication means is not high. According to Mr Hien, video should not been applied for communication because the local people will not willing to watch it. The communication should focus on local people so that they have chance to raise their voices. Develop drama of Le Minh Giang
Dakrong Women Union	Knowledge of HIV among women	Most of women have no knowledge of HIV Contents of communication for ethnic minority

		people and Kinh people are similar.
	Trafficking	Two women were cheated for trafficking. However, this action was not successful (will collect information tomorrow)

Conclusions

1. The cooperation between of provincial departments for heath care and HIV prevention is close.
2. Communication via WU network brings a high impact because they have existing networks and strong management.
3. The result of blood test is low because there is no good monitoring system and the local people is not willing to join in.
4. Ethnic minority people has no knowledge of HIV
5. Behavior of using condom among ethnic minority people is low.
6. Condom is not available in community and village.
7. Former communication means are not suitable to local context.

FIELD TRIP NOTE
Survey Information from Handicap International France

The Project Officers for Hue and Quang Tri Provinces participated in a Handicap International France Baseline Survey.

I. Date of field trip: **14-15 Apr, 09**

II. Name of consultant of HI: Nguyen Van Tung

III. Location: Lang Cat Village at Dakrong commune in Dakrong District.

IV. Methodology: Focused group discussion and questionnaire

V. Interviewees:

a. Morning: FGD with elder group

b. Afternoon: - FGD with youth: 6 boy and 2 girl

- Interview 28 boys and girls

VI. Contents of FGD, interview and findings.

Interviewees	Content	Findings
The elder	General information of Lang Cat village	Lang Cat village has 142 households of Van Kieu ethnic minority. The village was established by Aria Groang, one former village head. Local people cannot remember year of establishment. The village head has a highest position in village. He has responsible to conduct village meetings and worship. Apart from village head, there are 12 heads of clan and private mountebanks called Mo Re and Mo Brong. Mo Re usually finds leaves and tree root to treat internal diseases for local people. Mo Brong is able to treat external diseases. The village has also one magician who helps family to worship.
	Main income	Van Kieu people live by traditional career: planting rice, slash and burn, planting pepper, chili and cassava, animal husbandry (piglet, chicken and goat)
	Common diseases of local people	Malaria, diarrhea, TB, injection, gynecology, skin-disease, red eye, ringworm, scabies When being sick, local people usually go to commune heath station. However, they prefer District hospital to CHS because hospital has more doctors who are good capacity.
The youth	Marriage status	Most of Van Kieu girls get married at 16-19 ages and boys at 18-24 ages. Education level of youth is low. 2/3 interviewees completed the primary school level. Their current job is slash and burn cultivation.

	Knowledge and Attitude on HIV/AIDs of the youth	All interviewees answered that they sometimes watch television but do not understand all things. 2/3 of interviewees said that HIV is infected by mosquito. 100% of interviewees said that HIV is infected by injection. 2/3 of them said that using condom is the way to avoid HIV.
	Condom use	Condom is delivered to Commune heath stations and "Sim" house (house of the youth or widow). Local people do not volunteer forget condom from CHS. Parent does not accept their children to keep condom. NAV has a project of delivering condom in 4 communes at Lia area in Huong Hoa district.
	Knowledge of HIV of ethnic minority	The youths with 18 – 35 ages have no knowledge of HIV. They do not know alphabets. The youths who go to school, access knowledge of HIV but not change behavior.
	Methodology of communication	It is recommended that communication should be conducted in local people group and peer education group. Communication means: video in ethnic minority language.
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	Activities of HIV program	BCC Condom delivery Blood test Management of HIV people Consulting relatives of HIV people about HIV prevention.

		Train on HIV knowledge for VHW and volunteers.
	Methodology of communication	Pako people receive new knowledge quickly. Their community participation is higher than Van Kieu people's participation. Communication materials of government are not suitable to local context. There are many words in posters, no sign of communities. As a result, the impact of communication means is not high. According to Mr Hien, video should not been applied for communication because the local people will not willing to watch it. The communication should focus on local people so that they have chance to raise their voices. Develop drama of Le Minh Giang
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Conclusions

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FIELD TRIP NOTE
Survey Information from Handicap International France

The Project Officers for Hue and Quang Tri Provinces participated in a Handicap International France Baseline Survey.

Highlights

- *Lang Vay 2 at Tan Lap commune*:
  - Lang Vay 2 is located on the road number 9. There are 58 households with 360 people. Most of the local people do not remember their ages. They did not go to school before.
  - The boys had sex relation with 1- 4 girls before getting marriage. They were not in habit of using condom when having sex relation. The girls thought that if the boys use condom, the boys will hurt them. The boys never received condom from commune health station and village health workers because they did not need it.
  - Most of interviewees do not know about HIV infection.
  - The youth had not access communication of HIV/AIDs yet.
- *Ka Tang village at Lao Bao town*:
  - The local people migrated to Ka Tang village because their former village was cleared away for building super market. This village is nearby Lao Bao border gate.
  - Most of families live in houses as Kinh people instead of house on stilts because the government provided those houses to them. Some customs of Van Kieu people had not been implemented as before such as lighting fire at night in the house because of no space.
  - The youth rarely go to "Sim". Most of interviewees answered that they had no sex relation before getting marriage. However, if any boy did this with a girl, he will get marriage. Some boys used condom when having sex relation and they bought from pharmacies or get from their friends. They are ashamed to ask for condom from village health workers or commune health station.
- *Ward 6 at Khe Sanh town:*
  - 70% of youth go to school currently. They go to secondary school and high school in Khe Sanh town.
  - 20% of youth go to Lao Bao as bricklayers. They usually stay at Ka Tang village. Their income is 60,000vnd/day.
  - There are 108 young people out of 774 local people in ward 6. The youth union usually has quarterly meetings. They integrate communication on primary health care (including HIV/AIDs prevention) and other topics into meetings.
  - The boys go to "Sim" in Lao Bao town. Most of them do not like to use condom when having sex relation. However, they are aware of the usefulness of condom. The girl like their boyfriend use condom to prevent infectious diseases.
  - There are two boys going to Cambodia as a security guard of casino and Avao commune, DaKrong district as a golden miner. The boy lived in Cambodia in 5 months. He met many HIV people and people using injection. Another boy returned from A Vao after 3 months

because he did not get more gold. Both of them had not sex relation during living far from home.

- The boarding secondary school in Khe Sanh town:
  - All students are selected every year basing on criterions: good CV, good study result, good health. One reason of this selection is that the school has strategy to train personnel resources for community and district.
  - There are 257 students (Van Kieu: 220 (113 girls) – Pako: 37 (19 girls), 18 teachers (1 Pako and 1 Van Kieu)
  - All students receive scholarship with amount 432,000vnd/month for 3 meals. Students rarely visit home because the school does not permit and they have no money for travel.
  - The school has strict policies. The boys are not permitted to come to the girls' room after 19pm. There were two cases of early marriage. They came back to home for summer holiday and then got marriage.
  - Two clubs have established in the school (one club of social evils prevention and another one of the juvenile reproductive health care). All students are encouraged to join the clubs. Clubs' activities are conducted monthly. Teachers usually present topics of social evils prevention and juvenile reproductive health care that are downloaded from internet. Students sometimes participate in group discussion and play roles.
  - According to the head master, clubs' activities have not brought high impact yet to students because of poor contents and limited budget. In addition, the methodology of communication is not good because teachers are not trained.
  - When discussing with the girls, it is found that they are ashamed to talk about HIV and condom although they are raised on HIV prevention via extra activities. The girls have talked with parents, friends about the way of HIV prevention after they came back home. However, their friends who do not go to school did not believe this.
  - Recommendations of the head master and officers of provincial education department:
    (i) Train on communication methodology and raise awareness on HIV prevention for teachers;
    (ii) Train on life skills of self protection and community protection for students;
    (iii) Conduct communication in Van Kieu language so that students could understand easily.
    (iv) Communication methodology via role play or drama should be prioritized.
    (v) Communication on HIV prevention should be integrated into lessons in classes.

Potential problems

- The youth of Lang Vay 2 has no chance to access on communication means and it seems that they don't want to change their behavior on HIV prevention or using condom.
- On the contrary, the youth of Ka Tang and Ward 6 are more active. They know about HIV prevention. However, all youth don't like to use condom.

- Communication on HIV prevention has been integrated into commune/village meetings. As a result, the number of participant is limited and the quality is not good.
- The boarding school is willing to participate in any project on HIV prevention. Students have time to join communication activities.
- Provincial education department supports HIV prevention activities.
- Most of teachers can speak Van Kieu language and understand students' psychology.
- The student is a potential communicator in community when they come back home.

Follow up

Apart from recommendations in previous field trip note in Dakrong district, there are some specific follow up points as below:

- Conduct separate communication on HIV prevention for local people in coordination of all commune departments (the youth union, women union and health workers).
- Focus on existing clubs' activities and enhance them by changing communication methodology such as drama, group discussion to involve students' participation.
- Train on communication methodology, HIV knowledge for teachers
- Train on life skills for students.

Note to the Record: Technical Advisory Panel Meeting, 9 May 2009

The following is a note regarding a project specific TAP that was convened to discuss practical steps following the Inception Mission:

Present: Dr. David Feingold
Dr. Jacques Lemoine
Dr. Li Minh Giang
Dr. Owen Wrigley

The purpose of this meeting was to pull together some of the pieces that will be taking our project forward.

Dr. Lemoine will be available to join the baseline study in its beginning, in the first week of July. He believes his input of three (3) days should be adequate to introduce the basics of the Bru world in our target districts. He will begin by providing a "map" of the various Bru communities. It is best to understand the term "Bru" as a category rather than a single people. Within the Bru there are various sub-groups. We will need to understand the distinctions from the start.

Dr. Kyi Minn and the team will need to coordinate these dates. It does mean that two trips, one end May, the other for the actual baseline, are no longer necessary. Dr. Kyi Minn and team can begin their baseline on the Lao side at the beginning of July and then carry on to the Vietnam side.

Where they will also meet up with Dr. Li Minh Giang's projects. He has two distinct sets of activities. One will be bringing a drama troupe training team from Hanoi to work with young Van Kieu to develop drama and theater programs. His work will begin in May. Our Quang Tri Project Officer, Ms. Yen, will join up with these activities from the beginning to observe and assist in their selection process, and to provide any other technical assistance seen as appropriate.

Giang also has a project, equally in its beginning phase, to explore the needs of mobile and migrant Vietnamese (Kinh) crossing Lao Bao to work in Laos. His interests and our baseline will also overlap. The details for coordination with the baseline team in July will be finalized in the near future.

We will further coordinate with Ms. Isabelle, the Handicap International (HI/F), as their HIV/AIDS project among the Van Kieu will be a key collaborating partner in our training programs. We are also introducing Dr. Lemoine to HI/F for consideration as a direct advisor or consultant to their programs.

The UNESCO training team is tentatively booked for the last week of September, possibly first week of October, 2009. We will shift the first Steering Committee to precede the training by one week.

Those selected for training will include the best and brightest from both the HI selected villages and those working with the Hanoi drama troupe. Other candidates will also be considered in a collaborative and transparent process among stakeholders.

David has repeatedly stressed the need for direct attention to technical content. While the groups and individuals we select to work with may quickly display skills in collecting and expanding on stories, narratives or drama pieces, they generally do NOT have ANY technical knowledge regarding any of the issues we need to communicate. Reproductive health, HIV risk or vulnerability, human trafficking or other matters. Thus, we must continually help "infuse" clear technical information. This, of course, is best achieved through facilitating frequent contact with the district and provincial health staff who have already shown interest and support. Our project officers will consider arranging small workshops for participants on specific subjects.

Thus, we have ample understanding of how we will be approaching our technical support to various stakeholders in the months to come. Our own team will do frequent visits to familiarize themselves among the most likely communities. Where possible, those visits may coincide with HI, World Vision or Li Minh Giang's staff interests. The clear goal is deriving a synergy among the stakeholder interests and inputs.

Commitment to work to such goals was agreed by all present.

Supplementary Appendix 3

Sub-Project 5:

Strengthening HIV Mitigation Associated with the Cambodia Road Improvement Project

TA-6467 (REG):
HIV Prevention and Infrastructure:
Mitigating Risk in the Greater Mekong Subregion

Sub-Project 5 – Strengthening HIV Mitigation Associated with the Cambodia Road Improvement Project

Inception Report

April 2009

ASIAN DEVELOPMENT BANK

TA-6467 (REG): HIV PREVENTION AND INFRASTRUCTURE: MITIGATING RISK IN THE GREAT MEKONG SUBREGION

SUB-PROJECT 5: STRENGTHENING HIV MITIGATION ASSOCIATED WITH THE CAMBODIA ROAD IMPROVEMENT PROJECT INCEPTION MISSION, 27 -30 April 2009

AIDE MEMOIRE

I. INTRODUCTION

1. The Asian Development Bank (ADB) approved a Regional Technical Assistance (TA 6467) for HIV Prevention and Infrastructure: Mitigating Risk in the Greater Mekong Subregion (GMS). The TA, funded by the Government of Australia, supports HIV prevention programs in ADB-supported infrastructure projects during pre-construction, construction and post-construction phases in the GMS. Under the TA, ADB supports a set of distinct subprojects on HIV prevention and mitigation associated with ADB-financed infrastructure projects in Cambodia.

2. An Inception Mission (the Mission)[1] of subproject 5: Strengthening HIV Mitigation associated with the Cambodia Road Improvement Project (CRIP) was fielded from 27 to 30 April 2009 in Phnom Penh, Cambodia. The purpose of the Mission is to discuss and reach an agreement on the subproject design, scope, implementation arrangement, and detailed work plan and timeline with the National AIDS Authority (NAA) and the Consultant.

3. This Aide Memoire (AM) summarizes the major issues discussed and agreements reached with NAA and the Consultant during the inception mission. The Mission also met with officials from NAA, Ministry of Economy and Finance (MEF), Ministry of Health (MOH), Ministry of Public Works and Transport (MPWT) and other partners to discuss the subproject implementation. The list of officials met is shown in Appendix 1.

II. TECHINICAL ASSISTANCE

4. The Mission reviewed and discussed the Consultant's proposed workplan with government officials from NAA and other concerned government offices. NAA agreed on the overall design, scope, workplan, and implementation arrangement of the subproject.

1. Scope of Work

5. The expected impact of the subproject is reduced prevalence of STIs and incidence of HIV transmission in communities associated with ADB financed infrastructure projects in the Greater Mekong Subregion (GMS). The expected outcome is reduced HIV risks and vulnerability among target populations and communities along the National Route 5 & 6 and in the cross-border area in Oddar Meanchey and Banteay Meanchey. The subproject will focus on four areas: (i) addressing HIV, health and social risks and vulnerabilities among targeted communities; (ii) awareness raising and behavior change among migrant and mobile

[1] The Mission comprised Ms. Emiko Masaki, Social Sector Economist/Mission Leader and Ms. Nida Calma, Project Officer.

populations through workplace programs; (iii) capacity and partnership building among key stakeholders; and (iv) monitoring and evaluation.

6. **Addressing HIV, health and social risks and vulnerabilities among targeted communities.** The output is strengthened capacity of local communities to effectively address HIV, health and social risks and vulnerabilities. The subproject will:

(i) develop a behavior-change focused risk mitigation package to address HIV and other locally-relevant social and health risks along Routes 5 and 6 and in selected provincial districts;
(ii) deliver a risk mitigation package in selected districts and communes in Banteay Meanchey and Oddar Meanchey through local NGOs (SEADO and WOMEN)[2];
(iii) conduct awareness and behavior change activities among vulnerable migrant and mobile population in Poipet though the Border Victim Support Team (BVST); and
(iv) promote and increase access to sexual and reproductive health services for mobile and migrant population in target communities.

7. **Awareness raising and behavior change among migrant and mobile populations through workplace programs.** The subproject will:

(i) develop strategies to motivate workplace managers to support HIV focused workplace programs;
(ii) integrate HIV prevention activities into the workplace, including existing occupational health and safety programs, where they exist; and
(iii) promote and increase access to sexual and reproductive health services for mobile and migrant workers.

8. **Capacity and partnership building among key stakeholders.** The output is strengthened capacity of stakeholders for implementing effective HIV and STI prevention activities in the workplace, among migrant and mobile populations and in local communities. The subproject will:

(i) strengthen capacity of key stakeholders for effective policy and programming for migrant and mobile population; and
(ii) support existing structures and bodies for addressing HIV, health and social risks among migrant and mobile population.

9. **Monitoring and evaluation.** The output of this component will be high quality, timely information on HIV-related risks and behaviors, and on the project activities being implemented to address this risk for quality improvement purposes. The subproject will:

(i) develop a project performance and management system (PPMS) to be applied throughout the project duration (baseline, monthly, mid-term and end-term) that is streamlined with the National Monitoring and Evaluation Framework;
(ii) undertake project monitoring at regular intervals and evaluation at project completion.

[2] Social, Environment, Agricultural Development Organization (SEADO) and Women Organization for Modern Economic and Nursing (WOMEN).

2. Implementation Arrangements

10. ADB is the executing agency and oversee the implementation of subproject activities together with the government counterpart. Family Health International (FHI), the Consultant, was contracted by ADB to undertake the subproject implementation under the guidance of NAA and ADB. The subproject activities are implemented with subcontracted local NGOs (i.e, SEADO, WOMEN, and BVST) in collaboration with all relevant agencies and community groups (e.g., Provincial AIDS Secretariats, health departments, border authorities, transport service providers, NGOs, and civil society organizations). The subproject will be implemented with the grant amount of $700,000 over 24 months from 19 March 2009 to 6 June 2011.

11. **Consultant Team.** The Consultant team has been engaged through a contract with FHI since 19 March 2009 and has been mobilized in the field. An international team leader (Ms. Caroline Francis) will be engaged on intermittent basis for 6 months. Two national project officers (Dr. Uch Thuok and Mr. Heng Saly) are engaged full time for 24 months based in the field[3]. A national M&E specialist (Mr. Im Chanry) has been engaged on intermittent basis for 4 months over the project implementation period. Due to withdrawal of Dr. Chinsam Viseth for personal reasons, Dr. Tep Navuth is proposed as a new Deputy Team Leader to replace Dr. Chinsam Viseth. A proposed replacement of the Deputy Team Leader will be reviewed upon submission of the requested documents.

12. **Project Coordination.** NAA is designated as a national coordinating agency for TA implementation (including 3 subprojects) in Cambodia. NAA will coordinate TA activities at national level in close collaboration with National Centre for HIV/AIDS, Dermatology and STI (NCHADS) and other relevant ministries. Provincial AIDS Secretariats (PAS) provide a primary secretariat role to coordinate subproject activities and Provincial AIDS Office will oversee the implantation at provincial level. Dr. Ros Seilavath, Deputy Secretary General of NAA, is appointed as an NAA focal point to coordinate overall implementation of the subproject from the Government of Cambodia. PAS will coordinate the subproject activities at provincial level and liaise with the Consultant team.

13. **Project Steering Committee.** The Mobility and HIV Technical Working Group (MHTWG) Secretariat will serve as a project steering committee to provide coordination for subproject implementation at national level. PAS will serve as steering committees in provinces. PAS comprises representative from provincial offices of relevant departments. MHTWG will meet quarterly. A specific action plan, budget, and monitoring scheme will be developed for each province and will be reviewed and endorsed by MHTWG.

3. Implementation Status

14. Key activities are underway at the inception phase include; the mobilization of subproject staff; preparation of subcontracts; the draft inception report; and the inception workshop and consultation meetings with key stakeholders and government officials. Initial consultations and discussions on subproject implementation have taken place with NAA, NCHADS and other government agencies. The Consultant team has also held discussions with a range of other stakeholders currently engaged in HIV prevention activities along National Road 5 and 6.

[3] FHI office in Batambong is proposed as a field office for the project. The mission requested to consider posting one of the project officers in Poipet where much of the project activities will take place. The Consultant will make an assessment of office arrangement in Poipet and will discuss it with ADB.

15. **Subcontracting**. The Consultant team has held meetings with proposed subcontractors (i.e., SEADO and WOMEN). An organizational and financial assessment of WOMEN has already been carried out to ensure that the organization has the capacity to responsibly handle the funds and to implement the subcontracted activities. An organizational and financial assessment of SEADO is planned in early May 2009. The subcontract activities with WOMEN and SEADO are expected to take place by late May or early June 2009. The Mission was informed that it is not possible for FHI to have a contractual arrangement with a consortium of NGO while it is possible to have contracts with NGO members of Border Victim Support Team (BVST). The Mission suggested to the Consultant team to assess the existing work of BVST and identify most suitable BVST members, in particular, those that are working for returning and deported migrants in Poipet. The Consultant team will hold a meeting with BVST for the subcontract activities.

16. **Situational Assessment and Baseline Survey.** The Consultant is currently conducting a desk analysis of relevant surveys and programmatic reports that will contribute to the development of audience profiles, segmentation of target populations, articulation of key messages and mix of appropriate media and channels. The behavioral and situational assessment is scheduled to take place at the beginning of May. The Consultant is currently developing survey tools and expects to conduct data collection in mid May. The final baseline survey report will be submitted to ADB and NAA on 15 June 2009.

17. **Inception Workshop.** A half day inception workshop was held on 30 April 2009 with participants from NAA, national and provincial government agencies, NGOs, development partners and the Consultant. Opening remarks was delivered by the H.E. Dr. Teng Kunthy, Secretary General of NAA. The Consultant Team and Mission acknowledged that comments and suggestions received were very relevant and useful for further refinement of the subproject activities, in particular for coordination and collaboration in areas where there are potential synergies across various initiatives on the ground. The workshop agenda and list of participants were included in Appendix 2. The highlights of the presentations and the discussions are summarized in Appendix 3. The Consultant's proposed implementation plan for the subproject is included in Appendix 4.

18. **Design and Monitoring Framework.** A draft design and monitoring framework (DMF) will be revised to incorporate comments provided by the international M&E specialist, Ms. Kerry Richter. The national M&E officer, Mr. Im Chanry, will work closely with the international M&E specialist to finalize the DMF and develop a project performance monitoring system. The subproject M&E guideline, including designing and developing DMF and a project performance and monitoring system (PPMS) is being developed by the international M&E specialist and will be shared with the Consultant team. The M&E support mission by Ms. Kerry Richter is proposed in late May or early June to provide technical assistance on designing and development of a PPMS system and implementation of baseline survey.

19. **Office Space and Equipment.** In Phnom Penh and Battambang, FHI Cambodia provides an office space and associated office facilities for the Consultant team. The Consultant is in the process of arranging the procurement of computers, printers, and furniture for the office. The list of equipment to be purchased will be submitted to ADB for approval before the Consultant proceeding with procurement as per ADB procedures. Equipment, furniture, and materials purchased by the Consultant with ADB fund for the subproject will be transferred to the Government at project completion.

4. Reporting, Deliverables and Timing

20. The list of reports to be submitted by the Consultant and the timing is shown in Table 1. All reports will be prepared in Khmer and English languages and submitted to ADB and NAA for review and comments.[4]

Table 1. List of reports and submission date

No.	Type of Report	Submission Date
1.	Inception Report	19 April 2009
2.	Baseline Survey Report	15 June 2009
3.	Implementation Report	10 July 2009
4.	1st Bi-annual Progress Report	19 November 2009
5.	Midterm Report (combined with 2nd Bi-annual Report)	19 March 2010
6.	3rd Bi-annual Progress Report	19 September 2010
7.	Draft Final Report (combined with 4th Bi-annual Report)	19 March 2011
8.	Final Report	Approved before 6 June 2011

III. CONCLUSIONS AND FOLLOW UP ACTIONS

21. The Mission has confirmed that the subproject has started up smoothly and implementation is on track. Performance of the consultant team is considered fully satisfactory and NAA has been providing excellent support for the project implementation.

22. NAA agrees with the scope of the project and implementation plan and fully support implementation. NAA will facilitate the coordination across various ministries and departments for effective implementation of project activities. NAA confirmed that Dr. Ros Seilavath will be the focal point in NAA. The wrap-up meeting was held on 30 April 2009 to reach agreements for follow up actions and firm up arrangements for the succeeding activities.

23. Follow up actions include:

(i) Submission of final Inception Report by the Consultant on 3 May 2009;
(ii) Submission of the translated (in Khmer) final Inception Report on 15 May 2009;
(iii) NAA and ADB comments on the Inception Report by 22 May 2009;
(iv) Subcontract agreements with WOMEN and SEADO by early June 2009;
(v) ADB approval of replacement of Deputy Team Leader by mid May 2009;
(vi) Submission of Baseline Survey Report on 15 June 2009.

24. The Mission extends its sincere appreciation for the support that was provided by NAA. The Mission appreciates the support and cooperation by the Consultant team for the successful mission.

[4] Three copies of reports in English language (together with the electronic version of the report) will be submitted to ADB and NAA. Three copies of report in Khmer language (together with the electronic version of the report) will be submitted to NAA.

Signed on 30 April 2009 in Phnom Penh, Cambodia

Emiko Masaki
Social Sector Economist
Southeast Asia Department
Asian Development Bank

Dr. Ros Seilavath
Deputy Secretary General
National AIDS Authority

Appendixes:

Appendix 1: List of Officials Met by the Mission
Appendix 2: Inception Workshop Agenda and List of Participants
Appendix 3: Key Comments and Recommendations
Appendix 4: Implementation Plan

Distribution List:

H.E Lim Sidenine, Secretary of State, Ministry of Public Works and Transport (MPWT)
Mr. Seng Setha Deputy Director General, MPWT
Dr. Ly Penh SunDeputy Director, National Centre for HIV/AIDS, Dermatology and STI (NCHADS)

LIST OF PERSONS MET BY THE MISSON

National AIDS Authority

H.E. Dr. Tea Phalla	Vice Chairman, National AIDS Authority
H.E. Teng Kunthy	Secretary General, National AIDS Authority
Dr. Ros Seilavath	Deputy Secretary General
Dr. Sieng Sorya	Deputy Secretary General

Ministry of Health

Dr. Sok Touch	Director, Communicable Disease Control Department
Dr. Ly Penh Sun	Deputy Director, National Centre for HIV/AIDS, Dermatology and STI (NCHADS)

Ministry of Finance

Mr. Chhuon Samrith	Chief of ADB Division

Ministry of Public Works and Transport

Ms. Min Meanvy	Under Secretary of State, Vice Chairman of Ministerial AIDS Committee
Mr. Seng Setha	Deputy Director General
Mr. Chav Dam	Chief Office, MPWT
Mr. Van Than	ADB Project Manager to MPWT
Dr. Im Sarun	ADB Consultant to MPWT

Ministry of Women Affairs

Ms. Hou Nimitha	Director, Ministry of Women Affairs
Ms. Seng Phal Davine	HIV Officer, Ministry of Women Affairs

Ministry of Labor and Vocational Training

Ms. Mao Thida	Deputy Director

Provincial Government

Dr. Chum Vannarith	Director, Provincial AIDS Secretariat (PAS) Chief, Banteay Meanchey (BMC), PHD
Dr. Sin Eap	Provincial AIDS Office (PAO) Manager, PHD, Banteay Meanchey
Mr. Pun Sanith	Deputy Commander Police, Police Commissioner, BMC
Dr. Seng Samylan	Deputy Director, PHD/PAS, Oddar Meachey (OMC)

Partner Agencies

Mr. Andrew Cornish	Health Adviser, AusAID
Ms. Jane Batte	Social Mobilization Advisor, UNAIDS

NGOs

Mr. Tim Vora	Program Manager, HIV/AIDS Coordinating Committee (HACC)
Mr. Chea Sarith	President, Women Organization for Modern Economic and Nursing (WOMEN)
Ms. Nhek Sophy	Project Manager, WOMEN
Mrs. Koy Vanlyn	Program Coordinator SEADO, BMC
Mr. Ma Sameath	Monitoring Officer, Cambodian Women's Crisis Centre, BMC
Ms. Chhea Manith	Director, The Poipet Drop In Centre

Family Health International

Mr. Peter Cowley	Country Director
Mr. Tan Sokhon	Coordinator, HIV/AIDS Prevention
Mr. Gautam Bharat Raj	Coordinator, FHI

TA Consultants (FHI)

Ms. Caroline Francis	Team Leader
Dr. Tep Navuth	Deputy Team Leader
Dr. Uch Thuok	Project Officer
Mr. Heng Saly	Project Officer
Mr. Im Chanry	Monitoring and Evaluation Specialist
Mr. Cheap Srun	Finance and Administration Manager

ADB Cambodia Resident Mission (CARM)

Mr. Arjun Goswami	Country Director, CARM
Mr. Eric Sidgwick	Senior Country Economist, CARM
Ms. Karen Schelzig-Bloom	Social Sector Specialist, CARM

RETA-6467: SUBPROJECT 5: STRENGTHENING HIV MITIGATION ASSOCIATED WITH THE CAMBODIA ROAD IMPROVEMENT PROJECT

INCEPTION WORKSHOP
30 April 2009

AGENDA

Time	Activity	Presenter/Facilitator
7:50-8:20	Registration	Mr. Chanry Im
8:20-8:40	Opening: Welcome Speech by FHI Remarks by ADB Remarks and opening by NAA	 Dr. Peter Cowley Ms. Emiko Masaki H.E. Dr. Teng Kunthy
8:40-8:55	Introduction: Participant introductions Objectives and agenda of the workshop	Mr. Sokhon Tan
8:55-9:30	Project Overview: 1. ADB initiatives on HIV Prevention and Infrastructure Development in Cambodia 2. Subproject 5: Strengthening HIV Mitigation Associated with the Cambodian Road Improvement Project	Ms. Emiko Masaki Dr. Navuth Tep
9:30-9:45	Coffee/Tea Break	
9:45-10:45	Group Discussion: 1. Table discussion 2. Presentation and feedback	Mr. Sokhon Tan Dr. Navuth Tep Dr. Thuok Uch
10:45-11:30	Wrap up and Closing	Dr. Navuth Tep Ms. Caroline Francis

LIST OF ATTENDEES - INCEPTION WORKSHOP

30 April 2009

	Name	Position/ Organization
1	H.E. Teng Kunthy	Secretary General, National AIDS Authority (NAA)
2	Dr. Ros Seilavath	Deputy secretary General, NAA
3	Dr. Ly Penh Sun	Deputy Director, NCHADS
4	Mr. Van Than	ADB Project Manager, MPWT
5	Dr. Chhum Vannarith	Director, Provincial Health Department (PHD), Banteay Meanchey
6	Dr. Sin Eap	PAO Manager, PHD/PAO, Banteay Meanchey (BMC)
7	Mr. Pun Sanith	Deputy Commander Police, Police Commissioner, BMC
8	Dr. Seng Samylan	Deputy Director, PHD/PAS, Oddar Meachey (OMC)
9	Mr. Tim Vora	Program Manager, HACC
10	Mr. Chea Sarith	President, WOMEN
11	Ms. Nhek Sopy	Program Manager, WOMEN, OMC
12	Mrs. Koy Vanlyn	Program Coordinator, SEADO (BMC)
13	Ms. Jane Batte	Social Mobilization Advisor, UNAIDS
14	Mr. Chav Dam	Chief Office, MPWT
15	Ms. Seng Phal Davine	HIV Officer, Ministry of Women Affairs
16	Ms. Mao Thida	Deputy Director, Ministry of Labor and Vocational Training
17	Mr. Meas Yem	Director, Poor Family for Development, BMC
18	Dr. Peter Cowley	Country Director, Family Health International (FHI)
19	Ms. Caroline Francis	Associate Director, FHI
20	Mr. Tan Sokhon	Coordinator, FHI
21	Mr. Gautam Bharat Raj	Coordinator, FHI
22	Dr. Tep Navuth	Coordinator, FHI
23	Dr. Uch Thuok	Tech/Proj Officer, FHI
24	Mr. Im Chanry	M&E, FHI
25	Ms. Emiko Masaki	Social Sector Economist, ADB
26	Mr. Ma Sameath	Monitoring Officer, Cambodian Women's Crisis Centre, BMC
27	Ms. Chhea Manith	Director, The Poipet Drop In Centre
28	Dr. Im Sarun	Consultant, ADB
29	Mr. Andrew Cornish	Health Advisor, AusAID

SUMMARY DISCUSSION AND RECOMMENDATIONS AT INCEPTION

1. The following are some of the key comments and recommendations provided at the inception workshop as guidance to the Consultant:

(i) Collaboration and coordination is vital to the program. FHI must focus strongly on the local level such as provincial AIDS secretariat, local authority, etc.
(ii) Provide capacity building opportunity to local NGOs and authorities links to the national strategic plan.
(iii) Monitoring and evaluation should be rolled out to the local authorities and enable sustainability. NAA will plan to have some monitoring trips in that area.
(iv) This project is really relevant to our current national strategic plan for multi-sectoral and comprehensive responses to HIV/AIDS on strengthening effective prevention, empowering to local community and capacity building to local bodies.
(v) Local authorities should consider this project is our project for our people not just ADB or FHI's project.

2. Participants are divided into 3 groups and discussed six main questions. The results of the discussion of the 3 groups are the following:

(i) Who are the key Migrant and Mobile Populations (MMP) we should reach in this project? What are the top five priority groups (according to size, and whether or not they are already being reached)?

<u>Priority Group of MMP:</u>

- Porters, truck drivers (transport company) in Banteay Meanchey, n=5,000 - 8,000
- Construction workers (road & building)
- Entertainment workers in Odor Meanchey
- Community members along border areas (PLHIV) in Odar Meanchey
- Factory workers (small scaled) in Poipet, n=3,000
- Cart pullers in Poipet, n=5,000 - 6,000
- Mototaxi drivers
- Police and military police at the borders
- Deported migrant at Poipet cross-border checkpoint (n~200 – 250/day)

<u>Less Priority due to intervention covered:</u>

- In Banteay Meanchy: Entertainment workers, Casino staffs
- Community along the road

(ii) How can we best reach MMP?

- mapping
- outreach
- focused group discussion
- peer-based education
- IEC materials (leaflet, video sport, posters, billboard banner,)
- special events/campaign, mass media (TV spot show, radio) , mobile video show
- maintain the condom availability

(iii) What are topics and messages do MMP need?

- HIV/AIDS/STIs, reproductive health
- positive prevention, condom use
- gender
- drug use
- human trafficking, safe migration, job safety
- health care
- labor law

(iv) Who will be the main stakeholders in this project?

- National level: NAA, NCHADS, MoPWT, MLVT, MoWA, MoSVY, MoT
- Provincial/implementation: PAS/PHD/PAO, local authorities (commune council, police, military police and their families)
- NGOs partners: SEADO, WOMEN

(v) How can we best share information about this project with our stakeholders?

- Regular stakeholder meeting (quarterly, semi-annual)
- Reports sharing
- Workshop

(vi) What are role /responsibility of government stakeholders?

- National level: coordination, monitoring, evaluation
- PAS/PAO: monitoring, coordination
- NGO: implementation, monitoring

IMPLEMENTATION PLAN (2009-2010)

N°	Activity	Year 1 (2009-2010)												
		Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1	Prepare and finalize inception report													
2	Plan and host inception visit, including inception workshop													
3	Conduct Baseline Assessment in targeted areas													
4	Identify relevant workplace settings													
5	Develop subgrants with WOMEN and SEADO (BVST optional)													
6	Develop partnerships/agreements with key stakeholders (as required)													
7	Develop and finalize monitoring indicators and tools													
8	Prepare and submit implementation report													
9	Develop and formalize referral system and tools													
10	Develop, design and begin use of Risk Mitigation Package													
11	Provide training to subgrantees on Risk Mitigation Package and other tools													
12	Monitor subgrants with SEADO and WOMEN (BVST optional)													
13	Procure project equipment and commodities													
14	Initiate workplace interventions at selected venues													
15	Conduct capacity building to partners on SBC, SI, QA/QI and M&E													
16	Collect, analyze and present project M&E Results													

N°	Activity	Year 1 (2009-2010)												
		Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17	Support meetings/work of existing key structures (e.g. Technical Advisory Committee, etc)													

Key:

IMPLEMENTING

DISTINCT REPORT = inception report; baseline report; implementation report; etc.

SEMI-ANNUAL REPORT

Supplementary Appendix 4

Sub-Project 8:
Post Construction HIV Prevention on the Phnom Penh – HCM City Highway Southern Economic Corridor

TA-6467 (REG):
HIV Prevention and Infrastructure:
Mitigating Risk in the Greater Mekong Sub-region

Sub-Project 8 – Post Construction HIV Prevention on the Phnom Penh – HCM City Highway Southern Economic Corridor

Inception Report

June 2009

World Vision Australia

Acronyms and Abbreviations

ADB	Asian Development Bank
BCC	Behaviour Change and Communication
CRC	Cambodian Red Cross
GMS	Greater Mekong Subregion
HIV	Human Immunodeficiency Virus
HCMC	Ho Chi Minh City
MMP	Mobile and Migrant Populations
MoU	Memorandum of Understanding
PAC	Provincial AIDS Center (Vietnam)
PP-HCMC Highway	Phnom Penh – Ho Chi Minh City Highway
RETA	Regional Technical Assistance
RHAC	Reproductive Health Association of Cambodia
STI	Sexually Transmitted Infection
SW	Service Women
VCT	Voluntary Counselling and Testing
WU	Women's Union (Vietnam)
WV	World Vision

TABLE OF CONTENTS

1 INTRODUCTION

TA-6467 (REG): Sub-Project 8 – Post-Construction HIV Prevention on the Phnom Penh – Ho Chi Minh City (PP-HCMC) Highway, and the overall Regional Technical Assistance (RETA), responds to the linkages between migration, mobility, and the spread of HIV which have been well documented, with increases in prevalence being observed along major transport routes, cross-border areas and in regions experiencing high seasonal and long-term population mobility. This RETA is consistent with the ADB's intent to take a consistent approach to activities aimed at mitigating the spread of HIV. By recognising the need for and supporting HIV prevention programs targeting post-construction workers and the local communities affected by infrastructure projects, the ADB has affirmed World Vision's (WV) experience in the GMS and has enabled WV to partner with the ADB on this project.

The development of new and improved transport routes often brings about dramatic changes for local communities as has been evidenced along the Phnom Penh – Ho Chi Minh City Highway (PP-HCMC Highway), particularly at the Cambodia-Vietnam Border. The number of people crossing the border since the rehabilitation of 245km of highway between Phnom Penh, Cambodia and Thu Doc, Vietnam has greatly increased. Economic and industrial development was slow until the road was rehabilitated and the economic industrial zone was established in Bavet, Svay Rieng in Cambodia on the border with Moc Bai, Tay Ninh Province in Vietnam. This development attracts an increasing number of migrants and mobile workers in search of employment opportunities. On the other hand the development of casinos and other entertainment venues is attracting increasing numbers of tourists. Vietnamese women work in the entertainment venues and Vietnamese are also the patrons of the casinos. Service industries are expanding on both sides of the border but Bavet is the primary zone for migrant and mobile populations.

Many of the changes following on from rehabilitation of the highway are positive, including improved access to markets, employment opportunities, facilities and services. This in turn can provide a wide range of benefits and opportunities at both local and national levels, ranging from increased economic development to improved education and healthcare.

However, there are challenges presented by the changes brought about by such transport projects and some of these challenges are negative in nature, rather than positive. This is particularly true in the short-term, where the often rapid nature of change provides severe challenges for traditional community coping mechanisms. Road development projects, for example, have been shown to exacerbate the spread of HIV and STIs, and the ease of travel facilitates rural populations in migrating out for work while also facilitating the access to villages of agents and traffickers. The risks for trafficking in humans are enhanced while the movement of illicit drugs may increase, even though they may avoid the official border crossing. While the vulnerability of mobile and migrant populations (MMP) to HIV/STIs transmission has long been recognised, the magnitude of risk and vulnerability is not well understood, due to lack of data.

This document, prepared following the initial weeks of fielding the response team in June 2009, and after the Inception Workshop, represents an update of progress made in respect to Inception phase formative research findings, partner and stakeholder meetings and consultations; proposed revisions to the project's objectives, geographical focus, and implementation schedule (for the interim period - prior to a comprehensive plan and timeline being submitted as part of the first Project Progress Report). The Project Implementation Team will finalize the work plan, personnel schedule, etc. prior to the first Progress report – based on the outcomes of the ADB's Inception Mission and the Tripartite Aide Memoire (ADB, Cambodia and Vietnam) which are to be held from 1st – 7th July 2009.

Highway One Phnom Penh to Ho Chi Minh City

1.1 Project Scope

The goal of Subproject 8 is to reduce the risks and vulnerabilities of individuals and communities to HIV/STIs along the PP-HCMC Highway, particularly in the cross-border area. This will result in reduced prevalence of STIs and reduced incidence of HIV transmission in these communities. The Subproject will focus on five areas of implementation which include:

- Community-based Risk Mitigation Program to increase awareness and promote positive behaviour change among local communities
- HIV prevention package in entertainment settings targeting migrant and mobile populations
- HIV prevention package in the Workplace
- Capacity Building to strengthen partnerships with key stakeholders in HIV prevention activities

- Improved Monitoring and Evaluation system

Focusing on these elements will enable individuals, communities and institutions to: raise public awareness; address vulnerability by empowering the vulnerable to protect themselves; and empower stakeholders to protect the vulnerable.

1.2 Geographic Coverage

The Geographic Coverage of Subproject 8 is the PP-HCMC Highway, a section of the Southern Economic Corridor connecting Thailand (Bangkok), Cambodia (Phnom Penh) and Vietnam (Ho Chi Minh City and Vung Tau). A 165km section of the road from Phnom Penh to Bavet/Moc Bai in Cambodia and an 80km section of the road from Moc Bai to Thu Doc in Vietnam were reconstructed under a previous PP-HCMC project, and it is these two sections of the road that Subproject 8 will focus on.

While the project area encompasses Highway No 1 from Phnom Penh to Ho Chi Minh City, the focal is the border provinces and for Cambodia the Project area includes a second province. The provinces in Cambodia are Prey Veng and Svey Rieng, and Tay Ninh in Vietnam. Currently, there are organizations working in these provinces that collaborate across the border: The Red Cross on both sides of the border has an MoU for collaborating on disaster relief and health issues, including HIV/AIDS. The Women's Union of Tay Ninh collaborate with women's associations in Svey Rieng.

Tay Ninh, in Vietnam, shares a 240 km border with Cambodia. There are two international border gates - Moc Bai and Xa Mat. Tay Ninh has one town and eight (8) districts with a total population of just over one million. Of the three districts that may be involved in the project, only one is on the border, and the other two are further along Highway No.1. Tay Ninh town is over 40 kilometres from the Moc Bai border in a different direction to HCM City and thus not on the National Highway.

Across the border in Cambodia, Svey Rieng has 7 districts with a population of around half a million. Svey Rieng town is over 30 kilometres from Bavet border crossing. The road runs through Svey Rieng town and then to Neak Leuong where it crosses the Mekong in Prey Veng province. Prey Veng town, however, is 70 kilometres to the North of the road. Prey Veng has a population of around one million with 12 districts but only 2 districts run across the national highway. Thus, the project area in Cambodia begins at Prey Veng Province, where it borders Kandal Province. Following the Highway to Bavet and into Vietnam the project area ends at the third district in Tay Ninh, Bang Trang.

2 PROJECT CONTEXT & BACKGROUND

2.1 The Southern Corridor

National Highway 1 links Vietnam and Cambodia through the cities of Phnom Penh and HCM. In the bigger picture the Phnom Penh – Ho Chi Minh City Highway is the a crucial section of the Southern Economic Corridor, spanning three (3) countries and linking Bangkok (Thailand) - Phnom Penh (Cambodia) - HCMC and Vung Tau (Vietnam) on the coast.

This is part of the ADB program to promote integration and connectivity across the Greater Mekong Sub-region (GMS). The more specific goal of this project was the promotion of economic activities and facilitation of trade between Cambodia and Viet Nam. For the three years since completion there has been a significant increase in the cross-border activities at Bavet and Moc Bai. The number of people crossing the border increased at an average annual rate of 53% between 2003 and 2006.

> 'The PP-HCMC highway has definitely improved the quality of life along the entire route, and is contributing to the longer-term goal of regional economic integration. Local goods are easily moved

to sub-regional markets and command better prices. People are also able to move more easily, including both migrants and those able to commute to both casinos and factories in search of work.' [1]

On the other hand increased commerce and mobility generates conditions and circumstances that increase HIV vulnerability. Increased opportunities, disposable incomes, and exploitation or abuse that migrant and mobile populations face may lead some to engage in high-risk behaviours such as unprotected sex or drug use, which may put them at risk for HIV infection. They are also vulnerable to being exploited by agents or employers when seeking work.

2.1.1 The Highway through Tay Ninh Province, Vietnam

Ho Chi Minh City (HCMC) – Cu Chi – Trang Bang – Go Dau – Ben Cau (and Moc Bai border)

From HCMC to the border at Moc Bai in Ben Cau District, National Highway 1 is a 4-lane carriageway. This makes for easy driving most of the 90 minutes to 2 hours it takes to get to the border. The last several kilometres from the town of Go Dau district is just two (2) lanes. The road passes through Cu Chi District before passing into Trang Bang district of Tay Ninh Province. Along the early stretches of the road from HCMC the road is divided by grassy strips, sometimes with barriers dividing a small frontage road for motor bikes and other vehicles.

Beyond Cu Chi to Trang Bang towns and then the smaller Go Dau there is no frontage road and the 4 lanes are divided by a concrete barrier rather than a grassy strip. Much of the road has built up areas, especially up to Trang Bang town. There is an industrial park just before reaching the town of Trang Bang. The Highway passes through a small section of the lower reaches of Go Dau District but this includes the major township of Go Dau. From here to the border there is very little development but there are sporadic guest houses, hotels, restaurants and massage over the 10 kilometres to the border. Moc Bai is little more than the immediate border area which covers a market and duty free areas off the road, in addition to a dozen shops and a little further out a small shanty town.

Travelling from HCM City the traffic is initially heavy, and continuing through outer HCM City remains heavy. It gets lighter between towns but is only noticeably lighter nearing Trang Bang, and much lighter on the way to the border.

2.1.2 The Highway through Svey Rieng and Prey Veng provinces

Phnom Penh – Neak Leuong – Svey Rieng – Bavet

From Phnom Penh south to the border crossing at Bavet, Highway 1 is a two-way single carriageway. In the initial segment from the outskirts of Phnom Penh, through Kandal Province the road is paved but without shoulders and the road is falling into disrepair. Currently, there are some minor road-works underway. For 20 kilometres before reaching the Neak Leuong ferry crossing over the Mekong River the road was upgraded in the last year or so. The twin-ferry operation is efficient but there can be a backlog of traffic. The Japanese government is supporting the construction of a bridge to begin in 2010[2]. (East) Neak Loeung is a bustling town in Peam Ro District of Prey Veng Province. West Neak Leuong is across the Mekong River in Kandal Province.

From Neak Leuong to Bavet, the highway is an improved two-way, single carriageway, where traffic appears to be relatively light. Svey Rieng town is roughly halfway between the Neak Leuong ferry and the Bavet border. The upgraded highway skirts the town of Svey Rieng that now shows very little evidence of any commerce except small local needs and mobile phone shops.

[1] Inception Report: TA - 6467 HIV Prevention and Infrastructure: The Cross-Border Transport Agreement

[2] Why this bridge has been excluded from previous upgrades is hard to fathom, but it does appear the government has delayed the bridge construction.

Several kilometres before reaching the border the special economic zone can be observed. The first operational industrial park, called the Manhattan (Svey Rieng) Special Economic Zone, represents an estimated US$30 million investment. It is Taiwanese owned with currently seven (7) businesses. One report suggests that five (5) of the seven (7) operating factories in the Manhattan Industrial Park currently employ more than 2,500 workers, while another report suggests 10,000 workers. This figure may include other factories nearby on the other side of the highway which is being developed for industry. Most workers are locals and dozens of small truck taxis take them to and from work with 10 to 60 people standing in the back. Transport of goods from the operating industrial zone apparently goes both to ports in Vietnam as well as to those in Cambodia.

Driving toward the border coming into Bavet the rice fields give way to the off-road factories and then the low key dwellings and other buildings in this small town in the resource-poor province of Svey Rieng. One hundred metres from the border 7 casino complexes lining the Highway provide a stark contrast to this environment. Three more casinos are under construction, and five more are planned. The clientele is almost entirely Vietnamese with some Chinese from the mainland and elsewhere plus Koreans.

An ambitious investment by an international consortia based in Kuala Lumpur, Malaysia, intends to expand beyond the gambling-only focus of current investments into a more expansive family-entertainment resort destination that will include family-focused entertainments such as a water park and international standard golf course that will span the border.

2.1.3 Risk and road safety

> The *immediate* risk factor that is most obvious from the combined road improvement, transport speed and efficiency is less that of increased risks of HIV infection than of traffic fatalities. Without road signage or exit preparation, high rates of traffic fatalities are guaranteed.[3]

Traffic accidents and fatalities are part and parcel of new roads and upgraded roads. Road safety, therefore, is included in programming but rarely given the precedence it requires with officials tending to play down the extent of accidents. They are often aware of high rates of injury and fatalities following the upgrading of highways.

Small businesses, feeder roads, local pedestrians and animals intrude directly onto the highway. There are no service roads and small village shops, vendors and farmhouses face immediately onto the highway, with farm vehicles, pedestrians and animals entering directly onto the highway.

2.2 HIV and AIDS in the Provinces

Cambodia has declining rates of HIV/AIDS in a generalized epidemic spread through sexual transmission, but is dealing with a large caseload from a national rate of almost 3% of the adult population a decade ago. The prevalence of HIV fell under 1 percent for the first time in 2005.

Vietnam is dealing with a concentrated epidemic which is slowly moving from Intravenous Drug Users (IDUs) to a more generalized epidemic.

The caseload of deaths and AIDS is much lower than Cambodia and this is reflected in the two border provinces.

Tay Ninh Province in Vietnam had 1,900 people living with HIV/AIDS (80% men) in April 2009. This number is not very high compared with other border provinces. Hoa Thanh District has the highest number of people with HIV/AIDS, 419, due to high numbers of IDUs, which is the main form of HIV transmission. One of the project districts, Go Dau, has 336 people who are HIV+. Tay Ninh town is the third highest with 263, and Trang Bang, also in the project area, has the 4th highest incidence with 240. Ben Cau District on the border ranks 8th of

[3] Inception Report: TA - 6467 HIV Prevention and Infrastructure: The Cross-Border Transport Agreement

9 districts with 103 people. There are obviously risk factors on the border but people who are infected are most likely mobile and are probably tested elsewhere.

Svey Rieng province in Cambodia had a prevalence of 1.9% in 2008. Ante-natal Care (ANC) rates of pregnant women fell from 1.7% in 2002 to 0.5 % in 2006. In the whole country ANC rates have fallen from 2.1% in 2001 to 1.1% in 2006.

In Svey Rieng 25% of sex workers tested positive in 2002, by 2006 this was only 10%. In the nation as a whole 27% of sex workers were infected in 2005, falling to 15% in 2006.

Of 12,500 Voluntary Counseling and Testing (VCT) clients in Svey Rieng in 2008, 239 people tested positive. In 2006, 431 people tested positive, out of 9,500 tests. Of 1088 people living with HIV and AIDS in 2008, 771 are receiving Anti-retro virals (ARVs).

2.3 Risk Mitigation

Casinos and other entertainment venues are attracting increasing numbers of tourists. At the same time, the number of factories is increasing in Bavet Industrial Zone, attracting more female Vietnamese, who already have substantial populations working in the casinos and other entertainment venues, and working as shopkeepers and waitresses. Vietnamese are also the majority of patrons of the casinos.

Subproject 8 responds to the linkages between migration, mobility, and the spread of HIV. It also recognises the need for HIV programming that targets a broader range of stakeholders than has been targeted in the past. There is a need to widen the scope of HIV prevention activities in order to address the underlying structural factors that influence an individual's and a community's vulnerability to HIV. This is particularly important for villagers which is a key target group; and of mobile populations, especially migrant workers, both of whom are the other key target groups. Mobile populations, which include drivers, moto taxis, traders, and service women are found along the highway and not just near the border.

2.3.1 The border zone and beyond – determining risk situations

Bavet is the primary risk zone at the border., with no high risk areas identified in immediate vicinity of Moc Bai on the other side of the border in Vietnam.

The casinos dominate the Bavet border area with some hotel buildings ten stories high. The bright lights of Las Vegas, Le Macau, King Crown and others light up the area during the night. On the side of the road in front of some of the casinos Vietnamese have opened small restaurants to serve a mix of mobile populations including some staff and clients from the casinos. A few small hotels and several guest houses are found beyond the casinos. There is an off the road market and small side streets with restaurants and other commerce. One Vietnamese shop-keeper estimated that there are more than 200 Vietnamese moto-taxi drivers, with smaller numbers of Cambodian drivers. These men provide transport services to the border and across the border. They can also take visitors to local entertainment venues that provide sex services.

There are several small venues with little to disguise the fact that sexual services are the primary business, and some venues provide women for the casinos that do not have their own massage or other service women (SW). Both direct and indirect sexual services are obviously available; indirect are mostly through karaoke or a night club/discotheque. The numbers of SW reported range from 40 to over 100, mostly Vietnamese, and some support services are available for many of them.

While the area develops into a bustling but tiny town in the presence of mobile populations and service women, the risk factors are confined to a relatively contained area outside of the casinos. Many of the clients in the casinos may not venture out into the streets, but there are those that do. Some may leave the casino/hotel complex for arranged meetings with women in local hotels or guest houses. Generally, they have all the entertainment facilities they need inside the hotels and casinos but massage and related services will be cheaper outside the casinos.

The town has not grown to the extent of some border towns. There is no major market (cf. Poipet on the Thai border). Bavet has always been a thoroughfare rather than a stopping place, for trucks, for example. Given the relative proximity of Ho Chi Minh City and Phnom Penh to the border area, and the existence of major towns along the highway, Bavet has not drawn many to this small border zone. However, the casinos of recent years have given rise to more trade and commerce and services. The factories are bringing more people into the vicinity of the border zone, and more Vietnamese are being employed in casinos, factories, and the informal sector.

There are 3 environs of concern in Bavet, the casinos, just outside the casinos, and in and around the factories. At present they appear as fairly discrete spheres, but it may be that the junctions where they do meet are the areas of concern, especially with the casinos and the immediate vicinity outside. The interaction of the populations that span both these areas is where certain high risk situations might occur. The populations at risk include male casino clients and SW outside, casino workers and their interactions outside, especially the rolling staff, young Vietnamese women who are independent of the casino management.

The risk factors within the casino are still unclear, it may be that casual unsafe sexual relationships are the major concern compared to commercial sex where safe sex may be relatively common. Sometimes the divide between casual sex and commercial sex may not be clear. If we compare the risk situations in the town itself outside of the casinos there may be other towns along the road where similar risk factors exist. On the Cambodian side of the border, in Neak Leuong town, at the ferry crossing and the border between Prey Veng and Kandal provinces, the risk factors are high, with a reported 200 sex workers. Here there is river traffic as well as the ferries, and trucks and cars often have to wait some hours for the ferry. While on the Vietnamese side there are no identified high risk situations in Moc Bai just beyond the border there massage parlours and guest houses dotting the road that suggests some risk behaviours. Further along the road in the next district, Go Dau, and then Trang Bang (two districts removed from the border) higher risk situations are reported. On both sides of the border Go Dau and Trang Bang in Vietnam, and Neak Leuong in Cambodia - the health departments have been conducting programming over recent years for some high risk groups.

2.3.2 Factory Workplaces

The economic industrial zone in Bavet is just 5 kilometres from the border. Most of the reported 10,000 factory workers are women, and the majority of workers are locals who are driven home in truck taxis each evening. There are some from further afield and these include Vietnamese. Most of these workers rent dwellings outside the factories, near the main highway. While there are some restaurants and drink shops beyond the more built-up area of the market, guest houses, etc. there is little in the way of karaoke or other entertainment places between the built-up area and the factories. The risk factors appear to be minimal for locals but possibly higher for non-locals. The presence of a lot of single people, or people a long distance from home, provides potentially volatile risk situations in and outside the factories. Further exploration is required to understand the extent of risk in Bavet.

The growing numbers of factories and manufacturing facilities being built will lead to increasing numbers of migrants entering the area, despite the fact that the majority of workers are currently locals. Reportedly, there are up to 2,000 Vietnamese working in the factories.

It may be that, at present, the risk is higher in Trang Bang in Tay Ninh Province, with 27,000 workers which includes 19,000 females, and with large numbers coming from other provinces. Most appear to be residing outside the factories but further exploration is required to understand the context.

3 PROJECT APPROACH AND OBJECTIVES

The Project is designed to mitigate the adverse consequences of the spread of HIV/AIDS due to the construction and rehabilitation of Highway No 1 and the resultant economic growth and changes in the post-construction period along the highway and the proximity of the border between Phnom Penh and HCMC.

The objective is to develop effective programs that reach out to vulnerable populations in villages along the road, and to mobile or migrant populations who use the road.

For **rural populations,** effective programming means empowering them to be more secure and less vulnerable in their community, and reducing their vulnerability to being exposed to STI/HIV and to exploitation in their dealings with outsiders, especially in regard to migrating out.

For **mobile populations,** effective programming involves understanding their situation and determining the relevant messages that will raise their understanding of HIV transmission and their personal risk assessment. Access to further information, to condoms and to health services will be part of the HIV/AIDS mitigation package. Mapping of health services and coordination with health departments and provider providers will be undertaken to facilitate access to services, exploring the barriers to access and provision of quality services.

In Cambodia there will be committed partnerships with NGOs to undertake the important work in the rural communities. Capacity building and shared learning will be an important part of this process. The health departments and other departments will be involved, and training workshops will build capacity and be an integral part of advocacy for vulnerable and mobile populations.

In Vietnam there is the opportunity to build on recent work of the Provincial Health Department with mobile populations and in rural communities. The experience of the Women's Union, with their reach into the villages of the project area, will make them a valuable partner. Extensive capacity building will build good relationships and provide effective teamwork to promote empowerment and resilience for rural communities and other vulnerable populations, such as migrant workers, many of whom work in local factories.

Partnerships will be built with the government at all levels, including Red Cross, police and border units, departments of labour, trade unions and women's affairs. The workplace in factories and in the casinos provides possibilities for public and private cooperation.

Raising awareness through BCC approaches that are well-designed and reflect findings of secondary sources, observation and the baseline survey can lead to behaviour changes that may be measured at least by the end of the project, with some indications during the project that programming is leading to behaviour change.

The behaviour change among rural communities is more difficult to measure if the baseline survey does not have clear findings on risk behaviour. Perhaps the most important measures will be increases in knowledge and attitudes in relation to STI/HIV/AIDS but also in relation to safe migration and the means to avoid exploitation by agents and employers.

Social indicators will point to socio-economic behaviours that make people vulnerable per se, whether they are vulnerable to STI/HIV or trafficking. Rural populations are generally vulnerable due to low education, absolute or relative poverty, lack of services and information. The ToR recognize that improvements in these conditions are as important as direct raising of awareness on STI/HIV/AIDS in protecting people from risk situations. The project aims to address the livelihoods and well-being of these communities while at the same time raising awareness of STI/HIV/AIDS and safe migration and trafficking.

Advocacy work will heighten awareness of the rights of individuals to access health services and information, to not be discriminated against due to HIV positive status, to confidentiality in testing for STI/HIV, to be able to choose to migrate and have safe passage, to be employed according to labour laws and regulations.

Effective programming will highlight the inter-dependency of social factors that lead to exploitation of rights, to discrimination, to exposure to STI/HIV and exposure to exploitation. Other issues that have to be integrated include drug use, drug trafficking, MSM and HIV/AIDS, and broader health issues.

Government and NGO partners will be empowered through an all embracing framework that integrates HIV/AIDS with migration and trafficking. The focus is on vulnerability for exposure to STI/HIV and exploitation, but the big picture of the broad range of social issues that lead to risk and to drug use, and implicates health and welfare is the framework for advocacy and effective programming.

This focus will enable individuals, communities and institutions to: raise public awareness; address vulnerability by empowering the vulnerable to protect themselves; and empower stakeholders to protect the vulnerable.

4 PROJECT IMPLEMENTATION

4.1 Community- Based Risk Mitigation

In Cambodia, the Provinces of Svey Rieng and Prey Veng are economically depressed areas. They are source areas for migrants: in one area many migrants work in the fishing industry in Thailand, in another area many have migrated to Malaysia. However, from the communes along the road they are more likely to migrate to Phnom Penh. Both source provinces are to be included in the community-based programs.

The focus of the Project intervention is to raise awareness of HIV/AIDS and migration/trafficking with local populations at selected locations near the border and along the road. Acknowledging that many people are vulnerable to being exposed to STI/HIV and exploitation when migrating due to low socio-economic status, the mitigation package will be implemented by an NGO that has been working on rural development and livelihoods in the two Provinces over 10 years. The NGO, Partnering for Development in Kampuchea (PADEK), has already taken steps to incorporate HIV/AIDS into their development projects with the Khmer HIV/AIDS NGO Alliance (KHANA) providing its first 3 day training for them in HIV/AIDS.

PADEK has a comprehensive program of developing Commune Community Based Organizations (CCBO) and it is possible for the Project to fit into the structure. PADEK are already in the initial steps of mainstreaming HIV/AIDS into their rural development work. A core of the structure is community resource people and the Health Agent is the entry point for HIV/AIDS. Enhancing livelihoods, such as animal raising and agricultural support are priority areas within this structure. Working with PADEK would involve using existing structures in existing communes along the road in Svey Rieng and Prey Veng.

HIV/AIDS and migration/trafficking awareness programs would be additional training for Health Agents, or other community resource people, at the village and commune level and in follow-up activities.

Next steps

Develop ToR for PADEK and undertake further consultations

Prepare ToR for KHANA for training and capacity building

(KHANA are already funded to provide HIV/AIDS training for their partners, including PADEK. The second training for staff, previously for management, is to be undertaken soon, as a process of mainstreaming HIV/AIDS into existing PADEK programs).

Combined consultations with PAS and PADEK on implementation.

Discussions on the government decentralization and de-concentration programming through the Ministry of Interior and how the Project through PADEK can work within this structure also.

In Tay Ninh Province, Vietnam, all three districts along the road in Tay Ninh Province will be included, Ben Cau on the border, Go Dau and Trang Bang. The criteria for selection of communes will be the most vulnerable populations who have had little or no HIV/AIDS programs before; as well as the vulnerability for exposure to HIV through migration or other risk factors. The project will contract the Women's Union (WU) to work in

tandem with the Health Department and the Provincial AIDS Centre (PAC) to deliver HIV/AIDS awareness. However, the focus will be on micro-credit and livelihood programs that integrate HIV/AIDS and migration/trafficking in the training and follow-up activities. The Women's Union have much experience in micro-credit and also have divisions dealing with trafficking and HIV/AIDS. The aim will be to get the three divisions working together – micro-credit, HIV/AIDS and trafficking.

Next steps

Consultations with WU and Health Department

Combined planning meetings

Financial and logistics primarily with WU

Discussion on training needs and provision of training specialists

The baseline survey will cover areas in the three Provinces in both countries and will include mapping of health services in order to assess access and barriers to provision of health and STI services and availability of VCT centres.

4.2 Trafficking and Migration

HIV/AIDS is the focus for most activities but issues around youth and migration, and the dangers inherent in migration, will be integrated. Safe-migration is focused on safe travel to the destination and work-place, workers rights and working conditions, and avoiding deception and manipulation by agents and managers/owners. The aim is to avoid exploitation that might lead to becoming a trafficking victim. Part of this package is promotion of safe sex and awareness of STI/HIV/AIDS. The concept of safe migration comes out of a trafficking discourse while safe-mobility pertains to vulnerability of exposure to STI/HIV.

Trafficking generally occurs in the context of migration through unscrupulous recruiters, and exploitation at the workplace in the destination. Thus, understanding migration is crucial to determine how trafficking occurs, and who is vulnerable to exploitation and why.

Local populations from Prey Veng and Svey Rieng have migrated to Thailand and some to Malaysia. The majority, however, migrate internally, especially to Phnom Penh. It is not common to go the other way into Vietnam. The improved highway facilitates agents coming into the region as well as people migrating out. Villagers from adjoining communes may have better access to the road, and so the catchment area for people who may be at more risk is much broader than just those closer to the highway.

Migration is a valid livelihood strategy for families but some will be vulnerable to exploitation and becoming trafficking victims, and risk exposure to STI/HIV. Safe migration approaches will be built into all training programs and messages reinforced through IEC/BCC programs.

There is little evidence of trafficking occurring among SW from Vietnam to Bavet or beyond. The presence of Vietnamese women working in the sex trade of Cambodia has existed for almost 2 decades. They can be found all over the country and many have been exploited in their workplace and abused, and many have been trafficked through deceit and promises of riches and a good job. However, in recent years there is little evidence of trafficking across the border. Women appear to voluntarily enter into the sex trade in Bavet through well-known networks and friends. In 2002 there was the case of one woman being rescued from a casino in Poipet on the Thai border and repatriated. Thus, there is the need to monitor the situation in casinos and other venues.

Programming, however, will focus on STI and HIV prevention for SW and mobile populations. Training will include components on trafficking but most of the activities and safe migration approaches will be for villagers on both sides of the border.

Source - destination

Tay Ninh is regarded as the source area for Bavet. It is, however, only one source province for migrants entering Bavet and working in Bavet, with many travelling to several main destinations in Cambodia. This also can be a route to Thailand and Malaysia and overseas destinations.

Thus, Bavet is a transit and destination area for Vietnamese migrant and mobile populations, and some Cambodia populations. Areas surrounding Bavet in Svey Rieng are also source areas (mainly to Phnom Penh). In-migration to Bavet includes factory workers, moto-taxi drivers, petty traders and shopkeepers, SW, casino staff and rolling staff. It is not likely that any of these are trafficked, and some are daily or weekly commuters (rolling staff, some factory workers and some moto drivers). Traders, drivers and others may be either migrant populations, that is, staying in Bavet for long periods, or mobile populations, that is, transiting through Bavet, for example, or commuting.

Svey Rieng and Prey Veng are mainly source areas for Phnom Penh, although it is likely that there are other destinations in and outside Cambodia for some migrants.

Programming

Built into capacity building and training programs for all levels, especially at the level of implementation – the WU in Tay Ninh and PADEK staff and resource people in Svey Rieng and Prey Veng.

IEC in the form of videos and leaflets/posters for source communities.

Intermittent workshops or group discussions on migration, promoting labour laws and safe migration approaches.

4.3 HIV prevention package in entertainment settings and mobile populations in surrounding areas.

Service women (SW)

Most of the sex work in Bavet is in the casinos and the Cambodian Red Cross (CRC) and Reproductive Health Association of Cambodia (RHAC) are covering much of this population of Vietnamese SW. Outside the casinos, RHAC is working with many of the direct SW, although indirect SW may be more difficult to work with and they may not reach them easily. Some services outside the casinos provide SW to go into some of the casinos that do not have their own massage or other SW. Estimates of SW outside the casinos vary from 50 to 150 with up to 13 venues. Most are Vietnamese and most of the clients are Vietnamese. There may be some SW immediately across the border in Moc Bai, most are likely to be found further along the road in Ben Cau District and Go Dau District. away from the border, along the highway in Tay Ninh and Svey Rieng.

Next steps

- Working with PAS Srey Vieng and PHD Tay Ninh to enhance Red Cross' work in the casinos through increased support from VRC.

Cambodia

- Collaboration with RACH to determine the efficiency of sexual health and reproductive service provision to SW and support to enhance the reach and quality of services.
- Collaboration with RACH to determine gaps in working with SW in casinos and entertainment venues in Neak Leuong, Svey Rieng town and Bavet.
- Working with RACH and CRC to determine whether workplace programs in casinos are adequately reaching women who may be involved in sex work (massage, karaoke), rather than more regular staff (or rolling staff).
- Baseline survey supported by key informant interviews should reveal network of women in sex work, especially the movement of SW and those who enter the casinos or service casino clients outside.

Vietnam

- Planning with PHD Tay Ninh to enhance their work with SW in selected sites of entertainment venues and mobile populations.

Mobile populations

The greatest numbers of mobile populations in Cambodia are found in Neak Leuong and Bavet, and in Vietnam the three districts of Tay Ninh Province, - Ben Cau Go Dau and Trang Bang. In Trang Bang District the focus is on the areas outside of the Industrial Zone while in Go Dau it is the main town on the highway and selected sites closer to the border in Ben Cau border.

The Ministry of Public Works and Transport will provide increases in road use and cross-border traffic over the past 3 years. Currently, 150 trucks per day can lawfully pass through the border gates. Other trucks have to unload and reload or wait. The backlog of trucks is not high but there are many other drivers, including bus drivers, taxi drivers and hired drivers or private vehicles, especially in Bavet where many are associated with the casino clients.

Other drivers are local moto-taxi drivers who carry many people to the casinos and also know all the entertainment venues outside the casino. Petty traders transit through Bavet but also have businesses in Bavet. Shopkeepers are mostly Vietnamese and some hotels and restaurants are managed by Vietnamese or have Vietnamese staff, thus, they are part of the migrant/mobile population.

Summary

- No single mobile population group predominates in Bavet or other areas, truck drivers are not so conspicuous as they pass through but drivers of different vehicles – truck, bus, and private vehicles maybe prominent.
- Mobile populations also are found in local transport of goods, buses and taxi trucks (taking home factory workers) for smaller towns in between the major towns.
- Clients of service women are mostly mobile population groups – from drivers to male clients of casinos.

Programming

- Mapping hot spots, mobile groups and key entertainment venues (adjunct to baseline survey)
- Mapping of service centres – health services (STI, VCT), condom distribution points
- Improving access to STI, VCT and other health related services
- Capacity building for specific areas of need; for cross-border cooperation and activities.
- At least 6 main sites from Neak Leuong, to Trang Bang will be selected for campaigns
- IEC and BCC approaches involves cooperation with hotels, guests house and entertainments venues.
- IEC materials will be utilized to reinforce key messages along the road using the same or similar messages but in the respective languages.
- Vietnamese language materials will be required in Tay Ninh and Bavet
- Cambodia language materials will be required in Neak Leuong and to a lesser extent in Bavet.
- The social marketing of condoms may be a core activity that much of the above is built upon.
- Potential for PSI input on both sides of the border (PSI Cambodia and Vietnam)

In Vietnam the health department in Tay Ninh have been supported by Difid for programming in all 3 project districts for high risk groups. Thus, the capacity exists for continuing this work which suggests that minimal capacity building may be necessary to support this work, allowing for more focus on enhancing programming

through planning new logistics, defining any specific training needs, defining target groups and building relationships.

In Cambodia the health department was supported by NCHADS but is now seeking support to continue programming with high risk groups in Neak Leuong. As stated above RACH is working with SW and REDA with IDUs and DUs. Further meetings will be held with PAS to exchange ideas and plan approaches.

KHANA may also be an important player. They are supporting REDA for their work and are a Technical Agency with the capacity for training, advocacy, capacity building and IEC development. They could do any or all of this in one package.

Next Steps

Meeting with PHD in Tay Ninh and PAS/PHD in Prey Veng and Svey Rieng

Correspondence with PSI in Hanoi for working in Tay Ninh

Consultations with PSI Cambodia for partnering with PAS to implement the social marketing of condoms. (REDA have a PSI person in their community program for social marketing in village communities.[4])

ToR to be prepared for KHANA.

Discussion on alternative trainers for HIV/AIDS training

4.4 HIV prevention package in the Workplace

4.4.1 Casinos

In the ToR workplace interventions include factories and casinos. However, currently there are interventions in casinos but not in factories. Cambodia Red Cross and RACH cover the workers in 7 casinos. CRC have expanded their program from working with Cambodian staff in 4 casinos to working with peer education projects with Vietnamese casino staff and rolling agency staff. Of the estimates of over 4,000 staff 20 to 40% are reported to be Vietnamese. In addition, the rolling agency staff and many massage women are Vietnamese but are independent of the casino management. Most of these workers are reported to be from Tay Ninh Province. However, large numbers of Vietnamese staff are reported to be Kamphuchea Khrom (ethnic Khmer) from further south in the Mekong Delta. Women providing sexual services are more likely to be from the dominant Kinh Vietnamese.[5]

RHAC has projects in the other 3 operating casinos. Vietnamese staff may not be fully covered in all 7 casinos RHAC is also working with Vietnamese SW in entertainment setting outside of the casinos.

Due to the status of the CRC they have been able to gain access to the casinos. They also have an MoU with Vietnam Red Cross for such cross border activities. However, in Tay Ninh there appears to be limited coordination or cooperation with the Health Department and Red Cross. However, there may be limited capacity building with management. The focus of the work, thus far, appears to be comprehensive programming with the casino staff, and only recently with the rolling agency women, who are mostly Vietnamese. There is some research (FHI see above) but more needs to be done to understand more fully the context for the rolling agency workers. Furthermore, there appears to be no differentiation between those who are likely to be offering sexual services and general workers. In addition, the male clients, largely Vietnamese, have not been

[4] PSI had 2 representatives at the NGO forum in Phnom Penh, they noted that one of their senior staff is very knowledgeable on Svey Rieng and should be consulted.

[5] 'A HIV-related Risk Assessment of Vietnamese Female Casino Workers in Bavet, Svay Rieng of Cambodia', FHI, October 2008

covered. On a recent visit to the casino on a Friday afternoon it was observed in one casino the clients were mainly women. However, males are dominant in evening and on weekends.

Male clients of the casinos

It is possible to approach the clients for research and programming outside the casino, as part of the mobile populations. However, the use of services outside of the casino by male clients is probably limited. The great majority of clients are Vietnamese and a concerted effort would need to be made to reach them and conduct surveys, quantitative or qualitative.

Male clients fit into the category of mobile populations and into the important category of Mobile Men with Money (MMM). It is this category that is often determined as one of the most at risk groups and as potential vectors in the spread of HIV. This category includes some drivers and traders, senior government officials, development workers, company managers, construction supervisors and other business people.

Reaching male clients through:

- Tour agencies that arrange bus trips to the casinos
- Working through CRC and RACH in the casinos

Researching to gain:

- A profile of the socio-economic strata they belong to
- Risk behaviours and attitudes
- Accessing information and services

Programming though:

- Targeted IEC design, development and delivery
- Complementary programming for all casino workers, independent workers, management and clients

Generally, the Project can offer:

- Further research on rolling agency staff and male clients
- Personnel who speak Vietnamese, and input to Vietnamese language materials
- Coordination for further collaboration across agencies

4.4.2 Factories

The economic industrial zone (IZ) in Bavet is approximately 5 kilometres from the border while that of Trang Bang is some distance from the border. Any interventions are going to require a concerted effort to, firstly, access the factories, and secondly, design and implement programming. The employees in Trang Bang IZ are Vietnamese internal migrants but with most coming from other provinces, many are likely to be a long way from their home. In Bavet most of the workers are local Khmer but there are those from further afield, including across the border in Vietnam. The majority of workers in both cases are females. While there may be high risk situations in Bavet for factory workers the risk situations for factory workers in Trang Bang, Tay Ninh, are likely to be greater. It appears that many workers in Trang Bang reside in the areas of higher risk along or near the highway. Yet HIV/AIDS prevalence is lower in Tay Ninh than in Prey Veng and Svey Rieng. Drug use is likely to be much more prominent in Trang Bang than across the border in Cambodia.

While accessing the factories may be more straight-forward in Trang Bang it may be more efficient to reach them outside through a concerted campaign that covers all mobile populations through IEC and BCC approaches.

A program for factory workers must first of all engage the owners and managers and get their support. The Department of Labour in Svey Rieng can assist in gaining this support. The Department of Labour has policies in place to have special HIV/AIDS committees in all factories. At present there are very few committees formed, and all are in Phnom Penh. And enforcement is difficult, especially without sufficient funds and resources. Nonetheless, having the policy in place and working with the Department of Labour can ensure access and work toward implementation of policies. Policies may extend to workers accessing health services after working hours if adequate services cannot be provided in the workplace.

The Kampuchea Youth Federation of the Trade Union (KYFTU) have had difficulties in gaining access to the factories in Bavet and this is a common problem in attempting to work in the private sector. CARE Cambodia have strategies where they work with the buyers who can enforce collaboration on the owners. CARE has also cooperated with the Ministry of Labour and Vocational Training (MLVT), but in their projects they work through local NGOs. The MLVT have a project office in Svey Rieng with the capacity to arrange access to the factories and support programming on HIV/AIDS.

Programming

Programming has to be designed for both men and women with different risk behaviours. While men, the minority, may be more at risk from commercial services outside the factory, women may be more vulnerable through relationships with other workers or supervisors. Female workers may also be sought after by local men outside of factory hours. Young women a long way from home may be at risk of having unprotected sex with multiple partners.

Next Steps

- Consultations with the central and provincial office of Labour and Vocational Training to determine potential for collaboration.
- Consultations with PAS and DoL

Possibilities for such collaboration include:

- Consultations with CARE and ILO to further understand the possibilities for implementation
- Cooperation with RAC and CRC who have the capacity for training and IEC development

4.5 Capacity Building

One of the outputs required of the project is to build capacity for stakeholders to implement effective HIV prevention activities. The goal of capacity building is to build greater understanding that leads to commitment and full cooperation. The goal is also to build a shared ownership. A key objective in capacity building is to protect individuals, groups and communities against HIV transmission and exploitation, but the means of doing this is the crucial issue. All components of the Project will encourage areas of empowerment, resilience of communities, and the ability for self-assessment of risk. Enhancement of capacity of provincial and district level agencies in project management, in multi-sectoral collaboration, and in greater understanding of social issues will not only lead to effective programming but to greater potential for sustainability.

The private sector will also be important in some areas and they can be encouraged to join training sessions and be involved in some activities. Owners of factories will be important, especially in Bavet. Owners and/or managers will be crucial to effective programming in entertainment settings, including karaoke, guest houses and hotels, small beer shops, massage and other venues. NGOs will be crucial to the Project only in Cambodia, although they may play a role in capacity building and training in Vietnam.

Chart 1

Stakeholders at provincial, district and commune level: Training type 1.

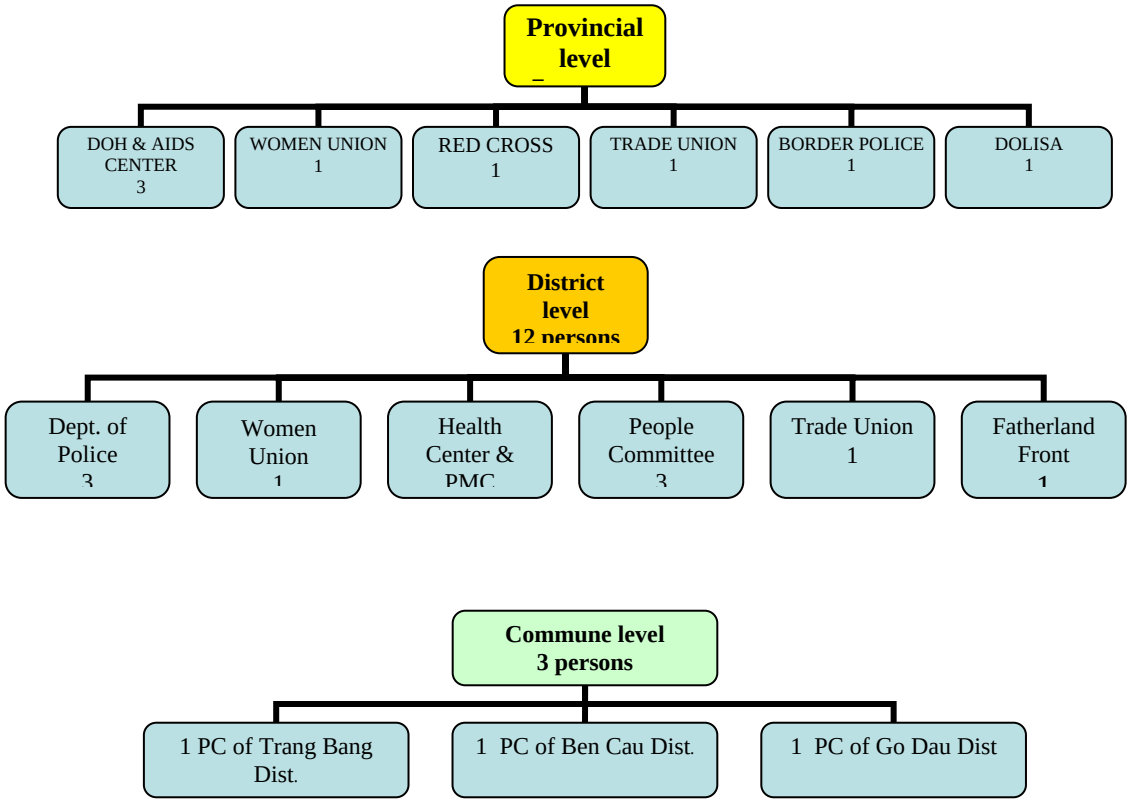

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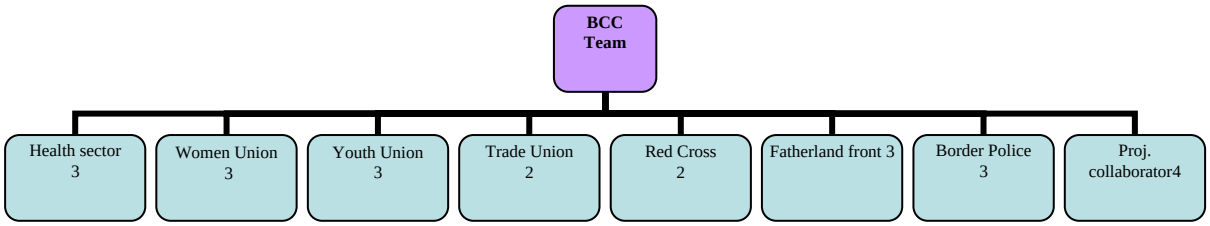
Chart 2

Building capacity for core team members in charge of communications (24 members) : Training type 2



Capacity building is built around training which incorporates the following areas:

1) Project management and project ownership (for government officials at all levels)
2) Skills on BCC (for officials directly involved in the project implementation at all sectors)
3) Knowledge on HIV/AIDS/STI prevention, vulnerability of migration and trafficking issue for owners of entertainment settings (for other target groups including owners of entertainment settings)

These areas overlap but each area will be the focus for different levels and different training sessions from the province down to the village. Initial meetings to introduce the project are also opportunities for advocacy and sharing new approaches and core issues with the main decision makers. Informal workshops and on-the-job

training will be the value-added capacity building blocks for targeted programming and sustainability, with the same core messages and the promotion of learning from and working with the target groups. Type 3 training will be the focus for the private sector, for commune leaders and other implementers (peer educators) community leaders and the target groups themselves.

In addition, the Project will organize periodic meetings to share experiences with and between relevant partners (from provincial to community level), including private and public sectors when applicable, as part of the capacity building effort. Exchanges will include cross border meetings for the implementation teams (e.g between Bavet and Neak Leuong with Go Dau, Ben Cau in Vietnam), but also for other stakeholders in order to have a comprehensive picture of population movements and risk of HIV transmission along the highway and the social issues that lead to vulnerability of some populations to exposure to STI/HIV and exploitation.

The basic structure for Cambodia is outlined in 5.0 Management and Organization, below. The structure will be based on more involvement of NGOs in capacity building, training and implementation. KHANA, and NGO, may be our partner for training and capacity building as they work closely with NGOs in the areas, and have the HIV/AIDS expertise required for training and guiding effective implementation. The government structure, however, will be the lead agencies at the provincial level through PAS/PAC (see Chart 4)

The following chart provides the levels of training to be implemented, and the multiple sectors that will require capacity building in Tay Ninh. A needs assessment for training will be conducted to determine how this program can best be implemented. Training curriculum will be tailored to each level of the departments and the level of involvement through varying the focus of the three areas noted above.

Local HIV/AIDS agencies may work the Department of Labour

The training curriculum will be tailored to the target audience in terms of content. In addition to project management and ownership each training session on will have to cover the issues of STI/HIV prevention, vulnerability, safe mobility, trafficking prevention and safe migration. The curriculum will focus on a common effort of working with poverty and disadvantage while implementing STI/HIV prevention among diverse population groups. Outside expertise will be sought for some curriculum development and/or training, such as, trafficking and migration issues.

4.6 Monitoring and Evaluation

A design and monitoring framework is a core part of the Project Performance Monitoring System. The key indicators will follow national M&E frameworks of Vietnam and Cambodia. The Project has the benefit of Sub-project 2 experience as well as Sub-project 5, and arrangements are being made for Kerry Richter, the TA for M&E on RETA 6467, to visit the Project in July.

The social indicators developed will feed into supporting the development of the questionnaire for the baseline survey, in fact both will be developed at the same time. Gender-sensitive monitoring indicators will be included and findings of surveys will disaggregate the data along lines of gender and other key indicators. Gender will be a central indicator in implementing and monitoring the project, see 6.0 Gender Action Plan, which is yet to be developed, but this provides a comprehensive guideline to develop policies and practice.

The baseline survey design considers three physical areas that must be surveyed:

1. Mobile populations along the highway, with a focus on 5 sites – leading from HCMC to Phnom Penh : Trang Bang, Go Dau, Moc Bai – Bavet, Neak Leuong.

2. Service women as a sub-group.

3. Rolling staff in Casinos as a sub-group.

4. Factory workers in Bavet and Trang Bang as a sub-group.

5. Rural population in Svey Rieng and Prey Veng and Tay Ninh in Vietnam.

Gender

Mobile populations are predominantly men but the questionnaire will include some separate questions for men and women to determine specific risk factors and attitudes. Similarly, factory workers in both sites are predominantly women but the questionnaire will cover both. However, the questionnaire for mobile populations will be mainly designed for men, while the questionnaire for factories can try and capture risk factors and attitudes among women. Male casino clients fit into the 3 Ms category, Mobile Men with Money.

Service women and rolling staff responses will provide further information on women.

Both men and women will be interviewed in relatively similar proportions in the villages to compare responses.

Mobile populations will include drivers (truck, bus, car), moto taxi drivers, traders, construction workers and other itinerant workers and visitors in the 5 sites. Male clients can be captured in the survey in Bavet which will focus on only Vietnamese populations.

Male casino clients may be reached in the entertainment, food and drink shops outside the casino. However, other strategies will be designed to capture them in the casinos and en route to the casino. The questionnaire on mobile populations will be modified for them.

Factory workers in Bavet include substantial numbers of Vietnamese workers so both languages will be necessary. The questionnaire for mobile populations will have to be redesigned for the majority population in the factories, women. This is the case for workers in the IZ in Tay Ninh also.

A similar questionnaire can be used for the casino rolling staff who are overwhelmingly women.

Service women are another sub-group, a separate questionnaire will be designed for them that includes more questions on their background and work situation, in order to know more about this population. The majority of women are Vietnamese but questionnaires in Khmer will be necessary for Neak Leuong and Svey Rieng town.

Rural populations in Svey Rieng and Prey Veng and Tay Ninh in Vietnam will include all adult villagers 18 years and older.

5 PROJECT MANAGEMENT AND ORGANIZATION

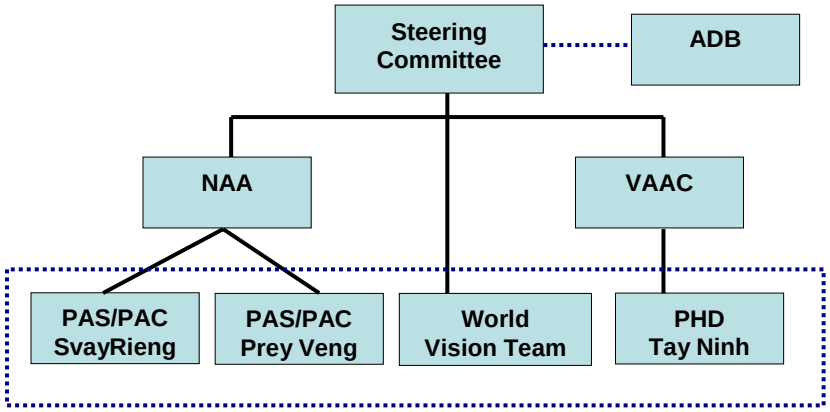
5.1 Project Team

The core project staff are 3 full-time nationals – one deputy team leader and one project officer to be based in Tay Ninh Province, and one project officer based in Svey Rieng. These staff are supervised by the International Consultant who is currently scheduled to have 6 months input across the duration of Subproject 8, and supported by the management staff of World Vision Australia.

Position	Name	Date Started
International Team Leader	Allan Beesey	May 25
National Monitoring and Evaluation Consultant	Dr. Dao Thi Minh An	June 19
Deputy Team Leader	Le Ngoc Hai	May 25
Project Officer – Vietnam	Mai Thi Kim Hoang	May 25
Project Officer – Cambodia	Kong Villa	May 27
WVA Innovative Partnerships	Natalie Craig-Vassiliadis	
WVA Innovative Partnerships	Andrew Binns	

A steering committee will be established that will include NAA and VAAC with the respective lead agencies in the participating provinces, namely, PAS/PAC in Prey Veng and Svey Rieng, Cambodia, and PHD in Tay Ninh. Other members of the steering committee will be selected from the Women's Union, Labour Departments, Red Cross, INGOs/NGOs, private sector employers, border officials. Meetings will be bi-annual.

Chart 3. Implementation Arrangement
National



Coordination Mechanism At National Level

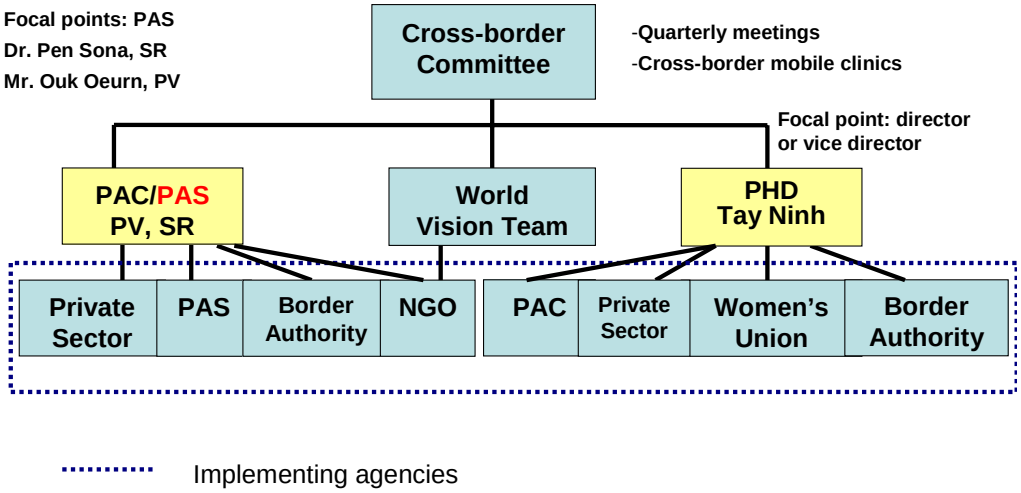
Red Cross has an MOU for working across the border with their respective communities, and this includes the casinos. For the Project a cross-border committee will be established to oversee the Project activities and the

coordinating bodies at the implementation level. The cross-border committee will be comprised of PAS/PAC in the 2 provinces, and the PHD in Vietnam and selected representatives from the coordinating/implementing agencies as shown in Chart 4

The focal points have been selected as follows:

Dr. Pen Sona of Svey Rieng and Mr Ouk Oeurn of Prey Veng, and in Vietnam the director or vice-director of the PHD will be appointed.

Chart 4. Implementation Arrangement Provincial



Smaller technical working groups will be formed as appropriate to facilitate cross-border and in-country activities.

5.2 Implementation Schedule

A Work Plan for the two years is included in Appendix I and includes the Personnel Schedule. The initial activities are as follows:

The key tasks for July to September are listed below

Inception report - Timelines, gender strategy, DMF; Translating and distributing inception report

Establishing office in Tay Ninh: Hiring administration/bookkeeping person

M & E development and baseline survey
Hiring specialists for baseline survey for 2 countries
Planning logistics and finalizing target groups
Developing questionnaire
Consultations with partners for teams and support
PHD and WU in Tay Ninh
PAS/PAC, DoL, PADEK in Svey Rieng
Sharing questionnaire for feedback NAA/PAS VAAC/PHD
Training and data collection

Establishing SC and border committee
Selecting and inviting participants

Meetings with Tay Ninh
PHD and WU
Defining objectives, approaches and outputs
Mapping and planning for baseline survey
Planning for mobile populations 3- 4 sites PHD
Planning for community WU
Planning with district/commune

Meetings with Svey Rieng and Prey Veng
PAS/PAC PAO
Defining objectives, approaches and outputs
Mapping and planning for baseline survey
Planning for mobile populations 3 sites PAS/PAC
Planning for community WU

Cambodia:July – August
Consultations with RACH and PHD on SW
Consultations, ToR, and planning with PADEK for community
Consultations, ToR, and planning with KHANA for training plus
Consultations with PSI for social marketing
Consultations with MoLVT and Department of Labour

Implementation report and full budget (early October)

5.3 Reports and submission dates

As per the Aide Memoire, it was agreed that the following reports will be produced:

No.	Type of Report	Submission Date
1.	Inception Report	20 July 2009
2.	Baseline Survey Report	22 September 2009
3.	Implementation Report	15 October 2009
4.	1st Bi-annual Progress Report	25 November 2009
5.	Midterm Report (combined with 2nd Bi-annual Report)	25 May 2010
6.	3rd Bi-annual Progress Report	25 November 2010
7	Draft Final Report (combined with 4th Bi-annual Report)	25 May 2011
8.	Final Report	Within 2 months of the end of the project

In addition, quarterly progress reports will highlight achievements, issues, and proposed remedial actions.

Monthly narrative reports will be sent to World Vision Australia and also sent to ADB.

6 GENDER STRATEGY AND ACTION PLAN

The general principles of the project will include:

- Enhancing a gender balance in the capacity building of provincial and district government authorities, private sector, commune councils and target communities
- Ensuring gender of facilitators is commensurate with the gender of the audience
- Addressing specific factors that enhance vulnerabilities of men and women (including youth) rather than individual behaviour
- In any assessment or intervention, including MSM as a vulnerable group, taking into account the differences between the different types of groups constituting the MSM community
- During BCC activities and peer education training encourage discussion about socio-cultural norms and values that increase vulnerabilities of men and women and perpetuate power imbalance between them
- Develop interventions with participation of the men and women of target groups
- Aiming to strengthen the power, skills, knowledge and resources for women, men, girls and boys to protect themselves and/or others from HIV infection and to access health and treatment services
- Making reduction of stigma and discrimination of men and women an integrated part of all interventions

Outputs	Specific Actions
1. Community-based risk mitigation program implemented	
a) Develop and deliver behaviour change-focused risk mitigation package for target communities near and along PP-HCMC highway	Make use of existing materials as much as possible, but assess gender specificity
	Conduct separate consultations and BCC assessments with men and women of the different target groups, to better understand the different needs of target groups, levels of knowledge and attitudes.
	Gender stereotypes, double standards and dominant perceptions of masculinity and femininity that disempower any group have to be challenged in the materials; include approaches that challenge the audience to rethink common perceptions that increase vulnerabilities
	BCC package to address conditions/factors that facilitate or hinder safe behaviour in a gender specific manner
	Pre-test the package materials for different target populations with men and women separately.
	Work with organizations and commune groups of men, women and youth to help disseminate information, in places which are frequented by men, by women, by boys and by girls, by MSM and by PLHIV
	Conduct sessions in places and at times that are convenient for the different target groups
	Build the capacity of the contracted NGOs to deliver the package in a participatory manner and based on the level of knowledge and understanding of the intended target audiences

Outputs	Specific Actions
b) Support for improved access and utilization of sexual and reproductive health services by men and women in target communities	The intervention strategy needs to be based on an assessment of current service delivery and mapping of integrated HIV and SRH capacity among male and female staff in the health service.
	The intervention strategy needs to be based on an assessment of barriers for uptake of services among men, women, boys and girls of the different target groups
	Strategies have to be in line with MoH guidelines but have to have attention to gender issues
	Protocols on HIV/STI/VCT, care and support have to take into consideration the specific needs and concerns of male and female clients (adults and youth)
	Health workers and pharmacy staff that are trained in HIV/STI/VCT should be male and female commensurate with gender of intended clients
	Disseminate information on the health services through appropriate male and female networks and organizations
2. HIV prevention package in entertainment settings implemented and mobile populations in surrounding areas	
a) Develop and deliver HIV prevention package in entertainment settings	Conduct separate assessments with men and women of the different target group to map needs and gaps in current knowledge and practice
	Participatory activities have to be part of the peer education sessions to be held in the entertainment settings – these have to be gender specific
	Build on the work that has already been done and use existing modules and materials – ensure sufficient attention to gender
	Gender stereotypes, double standards and dominant perceptions of masculinity and femininity that disempower any group have to be challenged in the materials
	BCC package to address conditions/factors that facilitate or hinder safe behaviour in a gender specific manner – this also applies to condom social marketing
	Where ever applicable, work in cooperation with organizations that represent the interests of the target group (sex workers associations, unions, truck driver associations, youth organizations)
	Ensure HIV/STI prevention commodities are available in entertainment settings

Outputs	Specific Actions
b) Support for improved access and utilization of sexual and reproductive health services by men and women in entertainment settings	Conduct an assessment of current services, identify gaps and include barriers for uptake of services for the different target groups, including assessment of the attitude of health staff towards their different clients as well as the perceived level of confidentiality
	Based on outcome of assessment, work with local health providers and client representation to increase client responsive sexual and reproductive health services
	Promote dissemination of information on available health services in the entertainment settings
3. Workplace HIV prevention introduced and strengthened	
	Materials for owners and managers should show the vulnerabilities and risks of their workforce, male and female (where relevant)
	Advocacy materials should show evidence of benefits of workplace policies for both men and women as well as for the workplace management
	Build on the work that has already been done and use existing modules and materials – ensure sufficient attention to gender
	Ensure participatory activities are part of the peer education sessions to be held in the workplace – these have to be gender specific
	BCC package to address conditions/factors that facilitate or hinder safe behaviour in a gender specific manner – this also applies to condom social marketing
	Where ever applicable, work in cooperation with organisations that represent the interests of the target group (sex workers associations, unions, youth organisations)
	Ensure that male and female workers are aware of and encouraged to use health facilities that provide VCCT and STI services in or nearby and at appropriate hours for day workers and/or referral arrangments
4. Strengthened capacity and partnerships for HIV prevention	
	Promote gender awareness in the implementation of cross-border collaboration for addressing HIV and STI risks, along with other social/health risks.
	Encourage gender-balanced membership in the Cross Border Committee and technical working groups.
	Capacity building with the people in the Committee and Working Groups has to include an increased understanding on the factors that facilitate or hinder safe migration and sexual health specified by gender and age.
	Advocacy with key private sector partners needs to address the benefits for the private sector in applying a gender sensitive approach to safe migration and sexual and other social/health risks
	Ensure that gender considerations are included in discussions and analysis of project results with key players at all levels.

Outputs	Specific Actions
5. Improved monitoring and evaluation	
	PPMS to include gender-specific indicators and sex- and ethnic disaggregated data to be collected and reported
	Include gender in each report on design/implementation lessons and report on specific gender actions in the subproject and its implementation
	Each study, forum and dissemination activity should include attention to gender aspects of the intervention (where relevant)
	Ensure that the plan/strategy for sustainable implementation of interventions after project completion includes appropriate measures for gender equality.

Appendix 1 – Work Plan, including Personnel Schedule

B. WORK PLAN			2009							2010												2011		
		Personnel	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Personnel																								
Team Leader (International) - Intermittent		TL																						
M&E Consultant (National) - Intermittent		M&E																						
Deputy Team L:eader (National) – Full time		DTL																						
Project Officer – Vietnam (National) – Full Time		PO Vietnam																						
Project Officer – Cambodia (National) – Full Time		PO Cambodia																						
1.0 Inception																								
i.i	Finalise ToR - Agree on Roles and Deliverables	TL, M&E, DTL																						
i.ii	Establish communication channels with ADB, VACC & NAA	TL. DTL																						
i.iii	Establish country Network and Stakeholder lists	Entire Team																						
i.iv	Review similar initiative experiences (in GMS)	TL, M&E, DTL																						
i.v	Establish Project Steering Committee	DTL																						
i.vi	Establish Project Cross-Border Committee	DTL																						
i.vii	Inception Report	TL		®																				
i.viii	Quarterly Progress Reports	DTL, POs			®			®			®			®			®			®			®	
2.0 Outputs 1: Community-based risk mitigation program																								
2.1	Launch Cambodia & Viet Nam Events	TL, DTL, POs																						
2.2	Local NGOs contracted in Cambodia and PHD/WU in Vietnam	DTL, POs																						
2.3	Capacity Building/Training Workshops	DTL, POs																						
2.4	Develop IEC Strategies	DTL, POs																						
2.5	IEC Material Production and Dissemination	DTL, POs																						
3.0 Output 2: HIV Prevention Package in Entertainment Settings																								
3.1	Launch Cambodia & Viet Nam Events	TL, DTL																						
3.2	Partnership with NGOs & Collaboration of INGO/NGO/GO	TL, DTL																						
3.3	PSI in Cambodia to develop condom social marketing	DTL, POs																						
3.4	Contract with PHD in Vietnam to develop a condom social marketing plan	DTL, POs																						
B. WORK PLAN			2009							2010												2011		
		Personnel	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

Appendix 1 – Work Plan, including Personnel Schedule

3.5	Mapping of Hot Spots	DTL, POs																						
3.6	Capacity Building/Training Workshops	DTL, POs																						
3.7	Develop IEC Strategies	Entire Teams																						
3.8	Dissemination	DTL, POs																						
3.9	Model and Implementation Report (including budget and work plan)	TL, DTL																						
4.0 Output 3: Workplace HIV Prevention Program																								
4.1	Review existing protocols on VCT for mobile populations and workplace settings	TL, DTL																						
4.2	Review referral services targeted at all female workers, including service women	TL, DTL																						
4.3	Develop policies and strategies for workplace HIV prevention program (including Standardized protocols)	TL, DTL																						
4.4	Build in VCT referral information and social support	DTL, POs																						
4.5	Training sessions with managers to support HIV prevention program	DTL, POs																						
4.6	Workshops for workers	DTL, POs																						
5.0 Output 4: Strengthened Capacity and Partnerships for HIV Prevention																								
5.1	Enhancing networking & cooperation of a range of partners	TL, DTL, POs																						
5.2	Review cross-border policies and collaboration between PHDs	TL, DTL																						
5.3	Advocacy for Cross- Border Committee	TL, DTL, POs																						
5.4	Capacity Building for Border officers	TL, DTL, POs																						
6.0 Component 5 Monitoring and Evaluation																								
6.1	Develop PPMS	TL, M&E, DTL		®																				
6.2	Baseline Survey Design	M&E,DTL,POs																						

Supplementary Appendix 5

Sub-Project 9:

Pre-Construction HIV Prevention and Safe Migration Initiatives Associated with the Northwest Provincial Road Improvement Project

TA-6467 (REG):
HIV Prevention and Infrastructure:
Mitigating Risk in the Greater Mekong Subregion

Sub-Project 9 – Pre-Construction HIV Prevention and Safe Migration Initiatives Associated with the Northwest Provincial Road Improvement Project (NRIP): 2009 - 2011

Inception Report

TA-6467 (REG): HIV Prevention and Infrastructure: Mitigating Risk in the GMS

SUBPROJECT 9
Pre-Construction HIV Prevention and Safe Migration Initiatives Associated with the Northwest Provincial Road Improvement Project (NRIP): 2009-2011

I. INTRODUCTION

1. The proposed Cambodia Northwest Provincial Road Improvement Project (NRIP) will construct National Road (NR) 56 in the provinces of Oddar Meanchey and Banteay Meanchey and improve the cross-border facility at O'smach in Oddar Meanchey. In order to address the potential negative impact of the road construction, NRIP will implement a mitigation package for HIV/AIDS, human trafficking and road safety, which will be expanded to also cover NR 68. Separately-funded but in parallel with NRIP, the Government of Cambodia will construct NR 68 to complete a ring road (NR 56-NR 68) that connects to the main national highway (NR 5-NR 6). Civil works for NR 56 and NR 68 are expected to start end-2010 and early-2011, respectively, and completed within 4 years.

2. NR 56 and NR 68 are in the region of the country with one of the highest HIV prevalence. Banteay Meanchey, particularly the border town of Poipet, is considered the epicenter of the national HIV epidemic. Local communities interviewed during the ADB design mission[1] reported HIV prevalence to be highest among the wives of migrant workers and military personnel, emphasizing the facilitating role of migration and mobility in the spread of HIV. Migration to seek seasonal or long-term work in Thailand or other provinces is a mode of survival for many Khmer, but the steady supply of migrant workers willing to cross the border has sustained human trafficking activities in the project areas. The border dispute over the Preah Vihear temple has also led to increased mobility of military soldiers along the border areas and new recruitment of soldiers from the local communities. With the construction of NR 56 and NR 68, there will be a large influx of migrant workers that may increase the demand for paid (and unpaid) sexual services in the local areas.

3. Recognizing potential HIV and human trafficking vulnerabilities along NR 56 and NR 68 when road construction starts, a package of pre-construction initiatives on HIV/AIDS, safe migration and anti-trafficking will be conducted. NRIP is one of the subprojects (Subproject 9) under RETA 6467[2], which aims to mitigate HIV vulnerabilities associated with the pre, during and post construction stages of infrastructure development. Subproject 9, a pre-construction initiative, aims to strengthen community resilience along NR 56 and 68 two years prior to the commencement of civil works. To develop the detailed plan, a design mission was conducted on 23-31 March 2009 that included field visits and key stakeholder interviews[3]. Subproject 9: NRIP was also designed to complement a separate but similar past construction initiative (Subproject 5: CRIP/RETA 6467) in the same project areas, focusing on different 'hotspots' and at-risk populations.[4]

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[1] Conducted on 23-31 March 2009

[2] ADB. 2008. *Regional Technical Assistance Report for HIV Prevention and Infrastructure – Mitigating Risk in the Greater Mekong Subregion (RETA 6467).* Manila. This RETA is co-financed by AusAID.

[3] Key stakeholders interviewed include the National AIDS Authority (NAA), Ministry of Women Affairs (MOWA), provincial and district governments, military and provincial police, commune councils, nongovernmental organizations (NGOs), and other development partners

[4] Subproject 5: Strengthening HIV Mitigation Associated with the Cambodia Road Improvement Project (CRIP) is one of the subprojects under RETA 6467. It is being implemented by Family Health International from 2009-2011 and focuses on HIV and human trafficking prevention among local communities along NR 5 and NR 6, formal and

II. BACKGROUND

4. **National HIV Situation.** Cambodia has made good progress in containing the HIV epidemic with HIV prevalence falling from 1.2% in 2003 to an estimated 0.9% in 2006. The decline has been attributed to the 100% Condom Use Programme and safe-sex campaigns that have targeted brothel-based sex workers and their clients.[5] However, a second wave of HIV infections is being seen among most-at-risk populations, including indirect female sex workers[6], clients of sex workers and their partners, men who have sex with men (MSM), and injecting drug users (IDUs).[7] The confluence of unprotected paid sex and sharing of contaminated needles during illicit drug use is flagged as a key driver in the current epidemic, even if HIV prevalence among female sex workers have decreased from 21.4% in 2003 to 12.7% in 2006.[8] According to 2006 data, HIV prevalence among IDUs tested was at 14.3%.[9] As male clients of sex workers also have sex with their wives and girlfriends, more traditionally low-risk women are increasingly getting infected. In 2006, among the total number of people living with HIV, 52% were estimated to be women compared to 37% in 1998. In 2005, married women accounted for almost half of new infections.[10]

5. Under the Decentralization and Deconcentration (D&D) policy of the Government of Cambodia, local governments at district- and commune levels are being strengthened to plan, implement and manage their own community development plans. In 2002, commune councils were established in all of the 1,621 communes in the country, each one receiving a discretionary budget of $15,000 per year as their community *sangkat* fund. Selected communes are also receiving additional funds from development partners (mainly from UNDP, UNFPA and UNICEF) to create and pilot different committees on social sector issues, e.g. Commune Committee on Women and Children (CWCC). In line with the D&D policy, NAA mandated the creation of District AIDS Committees (DACs) and Commune AIDS Committees (CACs) in 2006. Roll-out of this NAA sub-decree commenced in 2009, but it has been slow due to limited funding.

6. **Local HIV Situation and Response.** National roads 56 and 68 span three provinces: Siem Reap, Oddar Meanchey and Banteay Meanchey. In **Siem Reap** province, according to 2008 voluntary confidential counseling and testing (VCCT) data, new HIV infections are highest among housewives and lowest among sex workers. In the Srey Snam district along NR 68, STI cases are highest among housewives of migrant workers and uniformed personnel (military and police). The disproportionate number of female STI cases is because men rarely seek sexual and reproductive health (SRH) services in community health centers, but instead self-medicate or go to other districts. A decrease in entertainment sites has been reported in Kralanh, the junction between NR 68 and NR 6, as less people are stopping now after NR 6 was completed.

7. In **Oddar Meanchey,** there is still no official count of the number of people living with HIV (PLHIV) as VCCT sites have just been established. However, based on a local NGO for

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informal workers in Poipet, and selected migrant communities in Oddar Meanchey The design paper is available at: http://www.adb.org/gms/HIV-Prevention-Infrastructure-Sector/subproject5.asp

[5] Annual reports for 2005 and 2006 and Third Comprehensive Quarterly Report 2007 from the National Centre for HIV/AIDS, Dermatology and STDs in Phnom Penh.

[6] A person whose primary job is to provide services at the entertainment establishments but she could provide sexual services to clients as an extra job upon mutual agreement (definition of NAA)

[7] Cambodia UNGASS Report, 2008

[8] Footnote 2

[9] From the 2006 Report on Illicit Drug data and Routine Surveillance System in Cambodia prepared by the National Authority for Combating Drugs (NACD), which include data gathered by two NGOs working with drug users in Phnom Penh

[10] UNAIDS. 2006. *Overview of the Global AIDS Epidemic for 2006.* Geneva.

home-based care and support, PLHIV can be categorized into 3 groups: 30% former military soldiers, 30% former migrant workers in Thailand, and 40% in-migrants from other provinces who tested HIV positive prior to moving to this area. Some communes, especially where NGOs have provided support, have PLHIV self-help groups. STI prevalence is reported to be high - one commune reported around 20% STI prevalence among its total female adult population (15-49 years old). However, the capacity of health center staff to correctly diagnose and treat STIs seems weak.

8. The border dispute over the Preah Vihear temple has resulted in an increase of military presence in the northwestern border areas. Several military camps have been established and soldiers are actively recruited from the local communities. According to the military police in Oddar Meanchey, soldiers are required to attend semi-annual HIV education workshops and monthly IEC activities, both of which have contributed to an increase of condom use during paid sex and a decrease in the number of soldiers purchasing sex. At the O'smach border town, two Thai-owned casinos operate, mainly catering to Thai clientele. According to one casino worker interviewed, the hotel management strictly prohibits sex work or solicitation inside its premises, but it was difficult to confirm this given time constraints. There seemed to be very few entertainment sites outside the casinos, except for one restaurant reported to have Vietnamese sex workers. However, NAA said that O'smach had the fourth largest sex industry in Cambodia before the border dispute; hence, should not be passed over for HIV interventions.

9. In **Banteay Meanchey**, HIV prevalence is concentrated in Sisophon and Poipet. Most of the communes interviewed along NR 56 reported an average of 10-17 PLHIV residing in the community (equal number of men and women), but also said that many had left because of "shyness" - indicating a high level of stigma and discrimination within local communities. Most PLHIV have worked as migrant workers and military soldiers, or were married to them. STI prevalence was high among women; while men's uptake of STI services was low.

10. **Human Trafficking.** According to the Banteay Meanchey police force, human trafficking is a big concern in the area. Cambodians are being illegally traded into Thailand's sex industry, fishing vessels, factories, and private homes, in debt bondage or physically unable to escape.[11] Several syndicates/cartels operate in the area, kidnapping people and selling/trading them to Thailand or elsewhere. However, it is important to understand that many people who eventually end up being trafficked started out as willing migrants, who plan or pay others to assist them to illegally cross the border, but then find themselves in exploitative and physically abusive labor environments once outside Cambodia. Unsafe migration is a key factor that can lead to human trafficking and/or high-risk settings for the transmission of HIV.

III. DESCRIPTION OF THE SUBPROJECT

A. Impact and Outcome

11. The impact of the proposed pre-construction intervention is reduced HIV transmission and prevalence of STIs among workers and communities associated with ADB-financed infrastructure projects in the GMS. The outcome is strengthened community resilience to HIV and human trafficking vulnerabilities among communities along NR 56 and NR 68, including the O'smach border town. The subproject will focus on four outputs: (i) community-based risk mitigation package for HIV and safe migration; (ii) HIV interventions for entertainment workers and uniformed services personnel; (iii) improved SRH services at district-level; and (iv) a rigorous M&E system. The design and monitoring framework (DMF) is provided in Appendix 2.

[11] UN Intra-Agency Project on Human Trafficking in the GMS (UNIAP) website

B. Methodology and Key Activities

12. The subproject will focus on four outputs:

13. **Output 1: Community-Based Risk Mitigation Package for HIV and Safe Migration.** The output of this component will be strengthened capacity of local communities along NR 56 and 68 to address existing and expected HIV and human trafficking vulnerabilities associated with road construction. In line with the D&D policy, focus will be placed on building the capacity of commune officials. This will include training for commune AIDS committees and village health support groups to conduct situation analyses and vulnerability mapping, then using the collected data to develop action plans to promote HIV prevention and safe migration in their communities. These action plans will address the social and cultural norms and values that create gender imbalance and increase vulnerabilities of men, women and youth. The activities under this component are presented below.

(i) HIV Mapping. Capacity building mapping will be provided to communities, particularly the commune AIDS committees and village health support groups (one man and one woman), to conduct situation analyses and vulnerability. Communities will acquire knowledge and skills to assess their own vulnerabilities towards HIV, STI, unsafe migration and human trafficking. The communities will be assisted by consultants to develop, update and maintain a community database on issues such as (i) HIV awareness and risk behaviour; (ii) high-risk settings; (iii) HIV and STI prevention initiatives; (iv) existing HIV and STI treatment, care and support services, including factors for encouraging or discouraging service uptake; (v) stigma and discrimination of PLHIV; (vi) employment opportunities for adults and youth; (vii) migration patterns, practices and experiences (e.g. human trafficking); and (viii) other social and health issues important to the community. Based on the database, the commune AIDS committees will be guided in developing strategies and action plans for continued HIV and human trafficking risk mitigation during the construction of NR 56 and 68 (in consultation with the NRIP road project team).

(ii) HIV/AIDS. An HIV/AIDS awareness and behaviour change campaign will be conducted using the methods and materials developed for Subproject 5: CRIP. The methods will be tailored to suit the various communities and target groups, which can be in the form of multi-media, drama, peer education, and focus-group discussions. Materials already developed by FHI for Subproject 5: CRIP will be revised to suit the various settings and groups.

(iii) Safe Migration and Human Trafficking. Safe migration and anti-trafficking activities will be developed and implemented at community-level, using methods and materials that are participative, evidence-informed and takes into account the low educational attainment of the communities. Audio-visual materials, drama-based activities and peer education will be used, including any relevant methods and materials used in Subproject 5: CRIP. An Anti-Trafficking Advisory Group (ATAG), made up of selected agencies[12], will be established in Bangkok to provide consultants with regular feedback on the design and implementation of activities.

(iv) Condom accessibility, availability and affordability in the targeted communities will be addressed through social marketing.

[12] UN Interagency for Project on Human Trafficking in the GMS (UNIAP), International Organization for Migration (IOM), UN Education, Scientific and Cultural Organization (UNESCO)

14. **Output 2: HIV Prevention Initiatives for Entertainment Workers and Uniformed Services.** The output of this component will be strengthened HIV and STI prevention services for entertainment workers and uniformed services in selected project areas. Through partnerships with the provincial, district and commune AIDS committees and selected NGOs, HIV prevention activities and services should include the activities below.

(i) For entertainment sites, HIV awareness and behavior change activities will be implemented at selected entertainment sites (Sisophon, Chong Kal, Samraong, O'smach, and Kralanh). Activities will include motivating entertainment owners/managers to support and sustain HIV prevention programs in the workplace. Interventions should also consider foreign entertainment workers in the project areas, e.g. Vietnamese.

(ii) For uniformed services personnel, HIV prevention and behavior change activities that target the military police, military soldiers and provincial police will be intensified at the border and semi-urban areas. This will be done in collaboration with NAA and the heads of the uniformed services personnel in the project areas. Existing methods and materials, such as from FHI's HIV program for the military, will be reviewed and used, if and when appropriate. Peer education will be a key mechanism for delivery of HIV prevention messages to uniformed services personnel.

(iii) Ensure that condoms are accessible, available and affordable at entertainment sites and among uniformed services personnel.

15. **Output 3: Strengthened SRH Services at District-Level.** The output of this component will be strengthened and responsive SRH services targeted to the separate needs of men, women and youth in the community. This output will be developed with the full involvement of the Ministry of Health (MoH) to complement ongoing efforts under the Health System Support Program (HSSP I and II). In addition, the output will include a strategy to deal with the temporary influx of contract labor during construction of the roads. The activities will include:

(i) Mapping of integrated HIV and SRH capacity in health clinics in the target area and gender-specific analyses of barriers for uptake of services for adults, youth, PLHIV, and entertainment workers;

(ii) Developing and implementing strategies for improved access and integration of services (for men, women, male and female youth) in coordination with MoH, provincial health authorities, operational districts (OD), district aids committee and commune aids council, with the involvement of target group representatives from the client population;

(iii) Training of public and private health workers on integrated SRH and client friendly services; and

(iv) Development of a strategy for health services that can respond to expected increased demand during road construction.

16. **Output 4: Monitoring and Evaluation.** The output of this component will be high-quality, timely information on HIV and human trafficking risks and vulnerabilities, as well as the progress and effectiveness of the project activities being implemented. The component will be implemented in close collaboration with the provincial, district and commune AIDS committees. The activities included are presented below.

(i) Development of a project performance and management system (PPMS) to be applied throughout the project duration (baseline, mid-term and end-term) that is informed by, and can inform, the national monitoring and evaluation (M&E) framework.
(ii) Documentation, forums and dissemination activities on the changing risks and vulnerabilities faced by local communities around HIV, safe migration, and human trafficking, particularly associated with the real and perceived impact of road construction.
(iii) Mid- and end-of-project workshops will be conducted among key stakeholders to discuss lessons and recommendations for remedial measures and improving strategies for future interventions in the project area or other similar areas.

C. Cost and Financing

17. The total cost of the sub-project is estimated to be $350,000.

D. Implementation Arrangements

18. ADB is the Executing Agency (EA) and proposes to contract Family Health International (FHI) as the implementing consultant using the single-source selection process, in accordance with ADB's Guideline on Use of Consultants (2007, as amended form time to time). FHI has been active in HIV prevention and treatment efforts in Cambodia for more than ten years, including targeted interventions among local communities, uniformed service personnel, entertainment and casino workers, and the clients of sex workers. FHI has also been contracted by ADB to implement Subproject 5: CRIP (RETA 6467) in the same project areas, under a similar timeframe. FHI will be best placed to implement the activities under Subproject 9: NRIP because of their involvement in Subproject 5: CRIP combined with their extensive HIV prevention expertise and experience.

19. A Steering Committee will be established, led by NAA and comprised of one representative each from Ministry of Interior, National Centre for HIV/AIDS Dermatology and STDs (NCHADS) of the Ministry of Health, provincial AIDS committees (Siem Reap, Oddar Meanchey and Banteay Meanchey), and ADB. The implementation of the subproject is expected to commence in June 2009 and completed in April 2011. The project will support a total of 69.5 person-months of consulting services. The consultant team will consist of one international HIV prevention specialist (1.5 person-months), one national team leader (22 person-months), one national M&E specialist (6 person-months), and two national project officers (a total of 44 person-months). Local NGOs can be subcontracted to implement specific activities under the lead consulting firm or organization. The indicative terms of reference for subcontracted local NGOs should be first approved by ADB before recruitment commences.

E. Reporting

20. The consultant will prepare the following reports: (i) an inception report, within 4 weeks after commencement of services; (ii) baseline study report 8 weeks after commencement of services; (iii) an implementation report detailing activities and annual budgets, 1 month after completing the baseline study; (iv) bi-annual progress reports; (v) a mid-term report including results from mid-term survey, achievements, implementation issues, and proposed remedial measures; and (vi) a final completion report, 2 months after completion of the Project. Three copies of these reports in the English language will be submitted to ADB and the Anti-Trafficking Advisory Group. Three copies of these reports in the Cambodian language will be submitted to NAA and the Steering Committee. The consultant should also present the project's key lessons

and recommendations to the team preparing the round 10 proposal for the Global Fund to Fight AIDS, Malaria and Tuberculosis (GFATM) in order to advocate for sustained support to district and commune AIDS committees in the project areas.

INDICATIVE TERMS OF REFERENCE FOR CONSULTANTS

1. The Consultants will be responsible for implementing four components outlined in Section III-B, and carrying out the necessary tasks for effective implementation of the subproject activities. If needed, the consultants will be responsible for recruiting, managing and supervising subcontracted local NGOs ("subcontractors"), including validating payments for subcontractors, transferring of funds, and monitoring and supervising activities and performance of subcontractors.

A. Team Leader (22 person-months) – National

2. The team leader will have at least 10 years of public health experience in HIV prevention, and as team leader of projects. Work experience with HIV prevention in non-health sectors would be beneficial. The HIV consultant will be responsible for overall project management, coordination, implementation, monitoring, and evaluation for the HIV prevention package. In coordination with ADB and the Steering Committee, the international team leader will undertake the following tasks, but will not be limited to them:

(i) Report to the designated ADB Project Officer;
(ii) Lead consultations on HIV prevention in the subproject area with key stakeholders;
(iii) Develop detailed designs for the four outputs, including all the activities to be conducted in the various settings;
(iv) Prepare a detailed implementation program and budget;
(v) Lead consultations with the project team under Subproject 5: CRIP/RETA 6467;
(vi) Lead consultations in Bangkok with the Anti-Trafficking Advisory Group;
(vii) Manage and provide technical guidance to the consultant team;
(viii) Ensure regular liaison, progress update meetings and collaboration with the National AIDS Authority (NAA), Steering Committee, Anti-Trafficking Advisory Group, and other key players;
(ix) Ensure that all activities and actions are consistent with ADB policies, protocols and regulations, including the *Practice Guidelines for Harmonizing HIV Prevention Initiatives in the Infrastructure Sector*[13];
(x) Supervise the development of the PPMS and ensure its overall implementation;
(xi) Prepare documents (e.g. Memorandum of Understanding, contracts, terms of reference, project reports, etc.) required for the subproject;
(xii) Ensure formal and documented approval of the subproject at provincial and district levels;
(xiii) Manage the administration, finance, implementation, and monitoring and evaluation of the subproject, including subcontracted activities;
(xiv) Ensure complete and on-time submission of technically-sound, formal written reports, including the inception report, quarterly progress reports, mid-term report, and completion report;
(xv) If subcontractors are hired, manage the contracting and monitor and supervise their activities; and
(xvi) Liaise with the ADB Project Officer to ensure proper and timely disbursement of the subproject funds for project implementation, including subcontracted activities.

[13] This is being finalized by Charmaine Cu-Unjieng, Program Coordinator for RETA 6467. Available upon request.

B. Project Officer (22 person-months) – National

3. The project officers will have a bachelor's degree in health, social service, or any related field and at least 3 years of work experience in project implementation and/or coordination. Work experience in HIV prevention in Cambodia is highly desirable. At least one project officer is required to have skills and work experience in gender. The consultants will undertake the following tasks but will not be limited to them:

(i) Report to the team leader, and support him/her in managing the project implementation team and other consultants and making all arrangements for the smooth implementation and administration of the team's work;
(ii) Closely collaborate with the Subproject 5: CRIP project team;
(iii) Provide coordination, support and technical assistance to the commune councils and commune AIDS committees;
(iv) Assist in the preparation and implementation of all four outputs;
(v) Assist in ensuring appropriate consultations at provincial, district and commune levels to obtain consensus and endorsement of the subproject;
(vi) Take responsibility for the smooth implementation and monitoring of the provincial program of activities and financial and reporting mechanisms;
(vii) Provide the team leader with monthly progress reports based on the implementation plan and budget of the province, including detailing achievements and challenges, implementation and financial issues, and recommendations for remedial measures;
(viii) Assist the team leader in preparing formal written reports, including the inception report, quarterly progress report, mid-term report, and completion report.
(ix) Support the development of the PPMS and ensure its smooth implementation; and
(x) Assist the M&E consultant in arranging meetings and logistics to design and conduct the PPMS surveys and other M&E tasks when required.

C. Monitoring and Evaluation Specialist (6 person-months) – National

5. The M&E specialist will have relevant educational qualification in health, social service, or any related field and at least 5 years of work experience in project monitoring and evaluation. Work experience in M&E of HIV prevention in Cambodia is highly desirable. The M&E specialist will undertake the following tasks but will not be limited to them:

(i) Assist Team Leader in developing the design of the 4 outputs and oversee its day-to-day implementation;
(ii) During the inception phase, develop a PPMS that includes data sources and a set of performance indicators based on the subproject targets and outputs and anticipated outcome;
(iii) Design and conduct training of the commune councils and commune AIDS committees in situation analysis, vulnerability mapping, and participating in the PPMS activities; and
(iv) Coordinate with the national M&E consultant of Subproject 5: CRIP;
(v) Ensure that the PPMS is informed by the *Practice Guidelines for Harmonizing HIV Prevention Initiatives in the Infrastructure Sector*;
(vi) Prepare appropriate formats, procedures, and mechanisms for the participation of key stakeholders and periodic collection and processing of data;
(vii) Design and oversee the baseline survey that considers the challenges doing follow-up surveys with migrant and mobile populations, uniformed services

personnel and that is culturally- and linguistically appropriate to non-nationals and ethnic minority populations;

(viii) Review and assess the provincial HIV and SRH services, including testing and treatment protocols, costs and clinic monitoring and record system;

(ix) Design and conduct a mid-term evaluation and a project completion evaluation to analyze the outputs against the performance targets, and recommend corrective measures;

(x) Provide inputs to the project meetings or seminars organized by the project implementation team (when needed); and

(xi) Ensure complete and on-time submission of technically-sound, formal written reports.

D. HIV Prevention Specialist (1.5 person-months) – International

3. The international HIV prevention specialist will have at least 12 years of public health experience, including at least 5 years in Asia, in HIV prevention, and as team leader of projects. Work experience in Cambodia and with HIV prevention in non-health sectors would be beneficial. The HIV consultant will be responsible for overall project management, coordination, implementation, monitoring, and evaluation for the HIV prevention package. In coordination with ADB and the Steering Committee, the international HIV prevention specialist will undertake the following tasks, but will not be limited to them:

(i) Lead consultations on HIV prevention in the subproject area with key stakeholders including the Anti-Trafficking Advisory Group in Bangkok;

(ii) Provide quality assurance to the designs for the four outputs, including all the activities and provide technical assistance in developing detailed implementation program and budget;

(iii) Ensure the coordination with the project team of Subproject 5/RETA 6467;

(iv) Provide technical guidance to the consultant team;

(v) Work with the team leader to ensure regular liaison, progress update meetings and collaboration with the National AIDS Authority (NAA), Steering Committee, Anti-Trafficking Advisory Group, and other key players;

(vi) Ensure that all activities and actions are consistent with ADB policies, protocols and regulations, including the Practice Guidelines for Harmonizing HIV Prevention Initiatives in the Infrastructure Sector ;

(vii) Provide technical assistance and quality assurance on the development of the PPMS and its overall implementation;

(viii) Support the team leader in preparing documents (e.g. Memorandum of Understanding, contracts, terms of reference, project reports, etc.) required for the subproject and ensure formal and documented approval of the subproject at provincial and district levels;

(ix) Provide quality assurance on implementation, and monitoring and evaluation of the subproject, including subcontracted activities;

(x) Work with the team leader to ensure complete and on-time submission of technically-sound, formal written reports, including the inception report, quarterly progress reports, mid-term report, and completion report;

(xi) If subcontractors are hired, provide technical guidance, monitor and supervise their activities; and

(xii) Support the team leader to ensure proper and timely disbursement of the subproject funds for project implementation, including subcontracted activities.

Appendix 2

INDICATIVE DESIGN AND MONITORING FRAMEWORK

Design Summary	Performance Targets/Indicators	Data Sources/Reporting Mechanisms	Assumptions and Risks
Impact Reduce HIV transmission and prevalence of STIs among workers and communities associated with ADB-financed infrastructure projects in the GMS.	Reduced HIV prevalence among adults aged 15-49 Reduced HIV prevalence among young people aged 15-24	• HIV sentinel surveillance • Population-based survey • UNGASS country progress report	**Assumption** • HIV and STI sentinel surveillance is conducted regularly at project sites **Risks** • Weak political commitment from the governments • Government does not support a multisectoral approach to HIV
Outcome Strengthened community resilience to HIV vulnerabilities and safe migration among communities along NR 56 and 68, including the O'smach border town.	Increased percentage of local communities along NR 56 and NR 68 reached with HIV prevention and safe migration programmes Increased percentage of women and men aged 15-49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse Increased skills among commune AIDS committees on assessing, and designing activities, on HIV and human trafficking prevention	• Special survey • UNGASS country progress report • PPMS reports	**Assumptions** • Data are available • Support and commitment from national and local governments for implementation of the HIV prevention activities **Risk** • Security situation in the border areas worsens and impedes on project implementation
Outputs 1. Community-based risk mitigation package for HIV and safe migration	Percentage of young women and men aged 15-24 who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions	• Special surveys • PPMS reports	**Assumption** • Support and commitment of local and border authorities **Risk** • Weak or no commitment from local authorities

	about HIV transmission		
2. HIV interventions for entertainment workers and uniformed services	Increased percentage of female sex workers reporting the use of a condom with their most recent client Increased number of males in military who reported condom use the last time they had sex with a FSW Increased number of male police who reported condom use the last time they had sex with a FSW	• Special surveys • PPMS reports • Provincial HIV and STI sentinel survey	**Assumption** • Support and willingness of the local communities, uniformed services personnel and entertainment establishments to participate **Risk** • Security situation in the border areas worsens and makes project implementation unsafe
3. Strengthened sexual and reproductive health services at district-level	Increased number of women and men with STIs at health care facilities who are appropriately diagnosed, treated and counselled Increased percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results	• Provincial health department's routine reports	**Assumption** Provincial health departments provide STI- and HIV-related services **Risks** • Provincial health staff lacks the required capacity • Lack of confidentiality in the provision of STI- and HIV-related services in the project area may lead to stigma and discrimination
4. Rigorous M&E system established	Developed M&E indicators used by provincial health authorities in a standard M&E system	• Provincial health department's routine reports	**Assumption** Government is willing to adopt indicators for actions related to HIV in association with mobility and infrastructure development
Activities **Output 1: Community-based risk mitigation program implemented** 1.1. Conduct a risk assessment of local communities 1.2. Design and implement the capacity building training of commune councils, commune AIDS committees and village health support groups 1.3. Guide communities in updating the database and developing action plans 1.4. Develop and implement HIV prevention awareness and behavior change methods and materials for targeted men and women 1.5. Develop and implement safe migration and anti-trafficking activities 1.6. Consult with the ATAG 1.7. Design and implement the condom social marketing			**Inputs** • ADB: $300,000 • National team leader (22 person-months) • National project officer (22 person-months) • National M&E consultant (6 person-months) • International HIV prevention specialist (1.5 person-month)

Output 2: HIV initiatives for entertainment workers and uniformed services 2.1. Conduct a risk assessment and mapping to identify needs and gaps in existing services for the target populations 2.2. Develop methods and materials for entertainment settings 2.3. Develop methods and materials for uniformed services personnel 2.4. Implement education and behavior change activities 2.5. Design and implement the condom social marketing **Output 3: Strengthening SRH services at district level** 3.1. Map and analyze HIV and SRH capacity of health clinics 3.2. Develop and implement strategies for improved access and integration of SRH services, including during road construction 3.3. Train health staff 3.4. Develop referrals services for workers that are accessible to outside regular work hours **Output 5: Monitoring and evaluation** 5.1. Develop a project performance and management system (PPMS) 5.2. Conduct routine monitoring and data gathering of key indicators 5.3. Design and conduct a mid-term evaluation and a project completion evaluation 5.4. Document and conduct forums on assessment results, good practices and lessons learned 5.5. Disseminate final report and evaluation products	