Mid-term review of regional technical assistance project (RETA 6467) for HIV prevention and infrastructure: Mitigating risk in the Greater Mekong Sub-region

Final Draft

Virginia Loo

12 September 2011

AusAID HRF
HLSP in association with IDSS
GPO BOX 320
15 Barry Drive
Canberra City ACT 2601
Tel: +61 (2) 6198 4100
Fax: +61 (2) 6112 0106
www.ausaidhrf.com.au

Contents

Tables

Acronyms

ADB	Asian Development Bank
AIDS	Acquired Immune Deficiency Syndrome
CBC	Cross-border Committee
CRIP	Cambodia Road Improvement Project
DCCA	District Committee for the Control of AIDS
DFID	Department for International Development (UK)
DMF	Design and monitoring framework
EW	Entertainment worker
EWEC	East West Economic Corridor
FHI	Family Health International
GMS	Great Mekong Sub-region
HCMC	Ho Chi Minh City
IEC	Information, education, communication
INGO	International non-governmental organisation
LNP+	Lao Network of People Living with HIV
M&E	Monitoring and evaluation
MARP	Most at risk populations
MMP	Male mobile populations or Mobile and migrant populations
NAAC	National AIDS Authority of Cambodia
NEC	Northeast Economic Corridor
NGO	Non-governmental organisation
NRIP	Northwest Road Improvement Project
PCCA	Provincial Committee for the Control of AIDS
PP	Phnom Penh
PSI	Population Services International
RETA	Regional Technical Assistance project
SP	Sub-project
STI	Sexually transmitted infection
TOR	Terms of reference
VCT	Voluntary HIV counselling and testing
WVA	World Vision Australia

Executive Summary

Background

Development partners, such as the Asian Development Bank (ADB) and AusAID, invest significantly in infrastructure development projects as a means of achieving the goal of poverty reduction in developing countries. In addition to positive economic and social benefits, development partners recognise that infrastructure development can also lead to negative health and social impacts on local communities, including increasing the risk of HIV. This risk incurred by communities is largely related to increased demand and supply for paid sex, associated with increased numbers of male migrant populations (such as construction workers, truckers, business men) passing through the area where the road is constructed or rehabilitated.

Through co-financing support from the Greater Mekong Sub-region (GMS) Infrastructure Department of AusAID, ADB manages RETA 6467, a USD 4.8 million fund to support regional cooperation to implement HIV prevention programmes that mitigate the harms associated with infrastructure (primarily road) projects in the GMS. This work aimed to build on experience ADB has gained implementing during-construction interventions in the region, with the larger goal of developing models of interventions that might be implemented more widely in the transport/infrastructure sector.

Ten sub-projects and associated knowledge management activities have been launched under RETA 6467. Projects range from delivering pre-construction to post-construction interventions providing services to rural communities living near the road, mobile male populations who are likely to be clients of sex workers, and sex workers/entertainment workers found in hotspots, which have emerged or grown as a result of increased traffic to the local area.

With eighteen months remaining of the 48-month implementation period left, ADB and AusAID jointly commissioned a mid-term review of RETA 6467. The mid-term review had two main objectives:

1. To assess the progress of the RETA activities in terms of six key areas: relevance, effectiveness, consistency/efficiency, sustainability, gender equality, and monitoring & evaluation
2. To use the experience of implementation and management of the sub-projects to generate recommendations about the design and objectives of future interventions designed to mitigate HIV related risk and vulnerability in the context of infrastructure development projects.

Methods

This mid-term review report was prepared by an independent consultant specialising in monitoring and evaluation of prevention interventions in the region. The analysis was based on document review, a joint AusAID-ADB 10-day field mission visiting 4 sub-project sites and follow-up interviews and discussion with key informants via telephone and email. Findings of the review were limited to the seven sub-projects that had been completed or were near completion at the time of the review.

Key findings

Despite some delays in implementation in two sub-projects, overall implementation has resulted in large numbers of people reached with HIV interventions and has contributed to strengthening local governments and implementing agencies ability to conduct outreach and deliver behaviour change communication messages about HIV.

The lasting effects of the sub-projects and the ability for the RETA to contribute to guiding and optimising future projects in mitigation of social/health related harms attributable to infrastructure development have not fully materialised as yet. In some sub-project areas, government and local NGO capacity has been built. To extend the learning gained from implementing the project, ADB has begun organizing the generation of knowledge products, which was the intended focus of the final eighteen months of the project.

Relevance

All 10 sub-projects under this RETA appropriately address HIV risk in areas adjacent to large infrastructure projects co-financed by ADB in the GMS. However, from the perspective of preventing HIV, there is little evidence to suggest that the at risk populations in these project areas would have been likely to generate large numbers of new HIV infections even in the absence of intervention. In a few geographic areas with a more severe HIV epidemic the areas were targeted by national AIDS programmes for prevention interventions prior to the start of the RETA.

While sex workers and clients are a key risk population of focus of national strategies for all GMS countries, interventions for rural communities where women may begin to engage in sex work, or male migrant labourers who may travel for work and buy sex more frequently are not priority populations for these national programmes.

To the extent that one objective of the project is to advocate and help national and local government to address the negative health and social impact populations associated with infrastructure development, the project appears to have strengthened the capacity of local government and NGOs to manage and provide HIV prevention services in some sub-project areas. The work of the sub-projects has been appreciated by government partners, but this has not yet translated to integrating these activities into the national strategy or other relevant policy changes.

Effectiveness

Progress reports and routine monitoring data from the sub-projects suggest that, on the whole, large numbers of people of target populations were reached through various forms of outreach. In about half of the sub-projects with completed end-line assessments, there appear to be gains in knowledge of HIV prevention and modes of transmission and some promising increases in condom use among male beneficiaries. However, because many of the sub-projects do not have clear denominators or numerical targets for coverage for all populations, it is difficult to assess whether sub-projects under-performed or exceeded the expectations of ADB or AusAID.

Large investments were made in building the capacity of local implementing agencies and to engage national and local government partners in the intervention. There are several important examples of how the investment in capacity building resulted in local implementing agencies expressing readiness to continue or take on additional project activities at the conclusion of the sub-project. Meetings with government partners during the field mission consistently recognised the value of this capacity building and lamented the short duration of the implementation period.

Consistency/Efficiency

Overall, the projects were expensive from the perspective of the size of the populations covered and the duration of field implementation. More than 75 per cent of sub-project budgets were allocated for non-service delivery related activities, including administration, assessments, technical support, and training. These types of investments would not be cost efficient, if the only measure of performance were beneficiaries reached. These investments are more justified on the basis of the

project's objective of building the long-term capacity for governments or implementing agencies to provide services; or in the interest of systematically developing models of interventions for a broader program of risk mitigation in the infrastructure sector.

Sustainability

Sustainability is a challenge with these types of projects due to the changing social-economic conditions related to infrastructure development. The target populations are also mobile, meaning over time there is a continuous need to reach more people with prevention services. Given that a majority of the service delivery sub-projects explored models of intervention for the post-construction period of an infrastructure project, concerns about sustainability should have been a more influential principle in designing the interventions and defining the indicators of success. Financial sustainability may not be a realistic objective for the RETA sub-projects. Strong government ownership over the planning and management of the activities is another aspect of sustainability that was the hallmark of one sub-project's approach to implementation. Integrating sub-project approaches or highlighting risk populations that are uncovered and should be incorporated into the national AIDS strategy is another dimension of sustainability. In particular, stimulating government interest and facilitating collaboration between governments in the GMS to, for example, address HIV risk among sex workers from one country working in another country. To improve the sustainability of the project, the RETA must step up this level of engagement of government partners over the last 18 months of implementation.

Gender equality

Considerable effort was made by ADB management to systematically integrate consideration of gender dimensions into sub-project activities. However, these efforts were not always value added, due to the inability to source consultants with sufficient practical experience, and the lack of specificity of the inputs provided. For example, outreach coverage data was disaggregated by gender, but there was little guidance or targets set about the expected proportion of women that should be reached to meet gender equality standards. The gender action plans did not recognize that most HIV prevention interventions are gender specific given the focus on specific risk populations, e.g. female sex workers, male clients, etc. Despite this missed opportunity, many sub-projects had incorporated gender sensitive approaches to providing prevention interventions pro-actively addressing women's lack of power in sexual decision making and taking decisions for their own health and well-being. This includes the adoption of structural interventions at entertainment establishments, campaigns to change perceptions of masculinity, empowerment of sex workers, and training on gender based violence, and alcohol abuse, and so on.

Monitoring and evaluation (M&E)

Despite a fair amount of technical support, in the form of international level consultants allocated to support M&E, this area of the project was fairly weak. Some particular areas of weakness were ability of the Design and Monitoring Framework (DMF) to explain the project logic, selecting indicators that measure all key objectives, the lack of targets and indicator definitions and standardisation, and the design of some key data collection activities. Efforts to correct weaknesses in the DMF were undertaken between the third and fourth quarters of 2010. However, this process of revising the DMFs did not sufficiently address important weaknesses in the M&E system.

Key recommendations

Over the next eighteen months, opportunities remain to consolidate lessons learned and produce guidance and tools for both the remaining RETA sub-projects as well as future projects planned in this sector. More specifically:

1. More systematic criteria for justifying the need for an intervention for a specific target population should be applied in future projects. Need should be defined in terms of both the risk of HIV and whether this increased risk is not being addressed by current prevention interventions;

2. HIV prevention projects implemented in the context of mitigating the harms of infrastructure development should place more emphasis on the objective of building community capacity to address the emergent social and health-related harms they face. For example, advocating for resources to conduct education and awareness activities, to work with government partners or NGOs to plan and provide services for the community;

3. Guidance should be developed to clearly define the different objectives for interventions at different phases of construction (pre, during, and post);

4. Efficiencies in project management and effectiveness of activities can be gained by contracting the same implementing agency to conduct pre-, during, and post-construction phases of the intervention;

5. The design of pre- and during-construction project timing and implementation period must build in some contingency plan to allow for the frequent interruption or delay of the main infrastructure project work itself. Management must recognise that delays have implications for either cost or scope, depending on the flexibility of the project.

6. The intensity of project management at ADB level may be lessened by having clearer guidance, tools, and standards for designing and implementing pre-, during, and post-construction mitigation interventions. This guidance applies to the monitoring and evaluation systems, which have been generally weak in the sub-projects implemented so far. The models developed should draw concrete examples from the RETA sub-projects, as well as best practices in HIV prevention interventions in the region. Special emphasis should be placed on developing models that prioritise and give examples of how to incorporate the concepts of sustainability and gender sensitivity;

   These models and tools are an important output of the knowledge management component of the project and can be completed within the time remaining for the RETA.

7. Sub-projects would benefit from sharing best practices and joint problem solving. While individual sub-projects must put effort and energy into being in contact with each other, RETA management can facilitate and encourage this cross-fertilisation. Efforts to engage SP6, 7, and 10 with each other and to participate in the GMS workshop in October will be key to applying the lessons learned to the remainder of the RETA implementation period;

8. The preparation of additional knowledge products, which share the experience of the RETA sub-projects, is an important set of activities for the remaining period of the RETA. These products include case studies of key issues/strategies of the implementation teams and costing studies to understand costs associated with different models of service delivery and capacity building.

1. Background

1.1. Mitigation of harms associated with infrastructure development

Development partners, such as ADB and AusAID, invest significantly in infrastructure development projects as a means of achieving the goal of poverty reduction in developing countries. Infrastructure development such as the construction or refurbishment of roads can bring significant benefits to the surrounding communities, including improving access to health and social services, as well as greater participation in economic opportunities. At the same time, development partners recognise that infrastructure development can also lead to negative health and social impacts on local communities. Negative impacts, perceived as direct consequences of infrastructure development project, such as displacement of communities, environmental hazards, and road accidents, are addressed as part of loan project preparation, as part of development partners' social safeguards policy. However, mitigation of less direct, but still real social and health-related harms, including increased risk and vulnerability to HIV has been more difficult to address.

The specific HIV-related risks associated with such projects, largely involve sex work[1]:

- During construction - large numbers of construction workers converge in the project area, there is an increased demand for sex workers or other forms of transactional sex that may be filled by women from local communities living near the road; as well as
- Post construction - the increased connectivity and mobility created may create new areas along a road that attract mobile male populations to stop for rest and recreation, including buying sex. Greater connectivity can also facilitate human trafficking, specifically trafficking women for sex work. In addition, greater mobility of villagers living in communities along the road may make it more likely for men to migrate for work in larger urban areas where the likelihood of paying for sex is greater and higher risk for acquiring HIV.

1.2. Purpose and scope of RETA 6467

To support ADB's effort to develop approaches to address this issue, AusAID Greater Mekong Sub-region (GMS) Infrastructure Department funded RETA 6467, as a set of projects exploring intervention models for mitigating risk and vulnerability to HIV associated with infrastructure (in particular, transport) projects in the GMS. This work would build on ADB's prior experience in the GMS, which focused largely on HIV interventions addressing increased risk to local communities during the construction phase of transport projects. As a regional technical assistance fund, regional cooperation was a fundamental aspect of how the sub-projects should operate. Each of the sub-projects addresses the added challenge of implementing interventions at border points and organising services for beneficiaries of multiple nationalities and cultural and linguistic backgrounds.

Funding for the RETA was AUD 6 million (USD 4.8 million) to be implemented from 2009 to 2011. Midway through 2010, most sub-projects were granted a no-cost extension and overall the RETA implementation period was extended to December

[1] Increased drug availability and use in the GMS, due to the proximity to drug production centres is also an issue for HIV transmission. However, in the sub-projects implemented under this RETA, injection drug use did not emerge as prevalent risk behaviour among the populations targeted.

2012. Ten sub-projects comprised the first component of the RETA, exploring different aspects of HIV risk mitigation in a variety of settings and implementing arrangements:

- Sub-projects 1, 2, 5, 8 developed post-construction interventions, recognising that sex work areas tend to develop at the completion of a road project, as road users increased;
- Sub-projects 9 & 10 address the pre-construction phase in order to determine whether preparing communities before road construction began was an effective strategy.
- Sub-projects 6 & 7 would be funded entirely under the larger development project loan, offering an opportunity to develop a different approach to managing the HIV mitigation activities;
- Sub-projects 3 & 4 took the form of situation analyses, investigating the need for risk mitigation in the context of rural road connectors to national highways and the role of cross border transport agreements in preventing human trafficking.

Table 1: Summary of RETA sub-projects

	Type of project	Contract to	Start date	End date	Road covered	Countries collaborating
SP1	Post	Burnett	Mar 2009	May 2011	NEC	Lao PDR, PRC
SP2	**Post**	**World Vision Australia**	**Mar 2009**	**June 2011**	**EWEC**	**Lao PDR, Vietnam**
SP3	**Situation analysis**	**Allan Beesley**		**Dec 2010**		
SP4	**Situation analysis**	**Owen Wrigley**	**Sep 2008**	**Dec 2008**		
SP5	Post	Family Health International	Mar 2009	Sept 2011	CRIP	Cambodia
SP6	**During**	**Loan project (TBD)**	**Not started**			
SP7	**During**	**Loan project (TBD)**	**Not started**			
SP8	Post	World Vision Australia	May 2009	July2011	PP-HCMC	Cambodia, Vietnam
SP9	Pre	Family Health International	Nov 2009	Sept 2011*	NRIP	Cambodia
SP10	**Pre**	**Burnett Institute**	**Aug 2011**	**Nov 2012**		**Laos, Cambodia**

Sub-projects in bold were not included in the site visits by the mission team.

* *The request for 3 months extension of SP9 until December 2011 is being proposed.*

Generating knowledge products was the second component of the RETA, as learning from the service delivery component of the project could benefit both future infrastructure projects co-financed by ADB and AusAID, as well as those financed by other development partners.

1.3. Scope of the mid-term review

This report presents findings and recommendations of an independent mid-term review of RETA 6467, jointly commissioned by ADB and AusAID in July-August 2011. At the time of the mid-term review, less than 18 months of the project implementation period remained. Five of the ten sub-projects had been completed (1, 2, 3, 4 & 8); two sub-projects were scheduled to close field activities within 2 months (5 & 9); and three sub-projects had yet to begin field implementation (6, 7 & 10).

The mid-term review had two main objectives:

1. To assess the progress of the RETA activities in terms of six key areas: relevance, effectiveness, consistency/efficiency, sustainability, gender equality, and monitoring & evaluation;
2. To use the experience of implementation and management of the sub-projects to generate recommendations about the design and objectives of future interventions designed to mitigate HIV related risk and vulnerability in the context of infrastructure development projects.

Although the areas of evaluation were described in detail in the Terms of Reference (TOR) for the review (See Annex 3), developing a framework for review was challenging given the design of the RETA. This RETA **has multiple objectives** (such as prevention of disease and human trafficking, ensuring gender equality, fostering regional cooperation, building capacity of implementing organisations, creating sustainable structures or effects and so on) and **tests multiple intervention approaches, in diverse environments** (such as by epidemic context, government engagement, economic conditions, ethnic groups), which by design are **undergoing significant social-economic change**. There are also **multiple layers of management** (between AusAID, ADB, contracted international non-governmental organisations (INGOs), sub-contracted local NGOs/government partners, field staff, and technical assistance consultants) that vary for each sub-project; each having influenced the design and ongoing adjustment of field activities and measures of achievements.

The success of the overall RETA can be defined in terms of how services were delivered to the intended beneficiaries, and the degree to which sub-projects contributed to larger lessons learned on developing effective approaches to HIV risk mitigation in the infrastructure sector. This mid-term review report recognises that there are many valid dimensions and perspectives to consider when evaluating the effectiveness, relevance, and efficiency of such a project. Thus for each area of evaluation, the report introduces multiple perspectives and considers achievements across several dimensions.

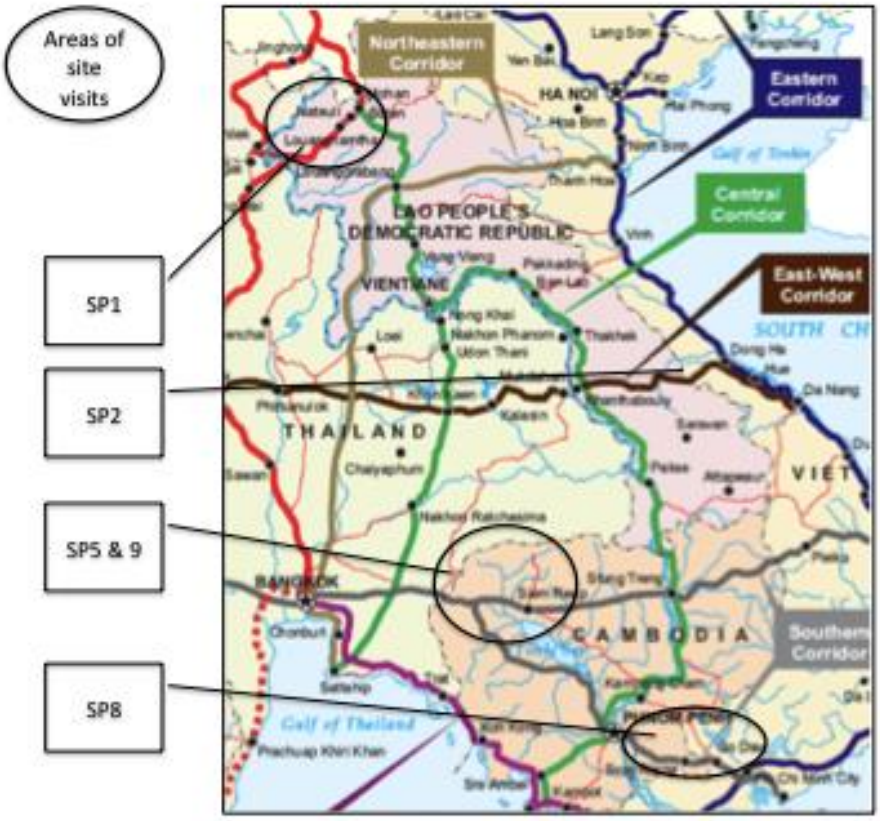
1.4. Methodology

The review methods encompassed:

1) A review of project documents (such as proposals, contracts, budgets, progress reports, and baseline/end-line assessments);

2) A 10-day field mission, from 25 July to 4 August 2011, to visit four of the sub-project areas and to meet with project implementers, beneficiaries, and government partners (See map below for project locations and site visits made. Annex 4 provides the full mission schedule and Annex 5 lists stakeholders met); and

3) Follow-up interviews and email correspondence conducted with key informants.



The field mission team included representatives from AusAID and ADB and was led by an independent consultant primarily responsible for generating the mid-term review report. The independent consultant had not been previously involved with the project design or implementation activities and specialises in surveillance and monitoring and evaluation of HIV/AIDS prevention programmes in low and concentrated epidemic settings. The field mission schedule was developed by ADB and agreed upon by AusAID; all meetings with implementers and stakeholders were jointly attended. Throughout the field mission, members discussed findings and shared their assessment of the RETA and individual sub-projects and ideas for both what should be prioritised during the remaining period of the RETA and how to design future HIV mitigation projects in the infrastructure sector.

In the interest of maintaining objectivity in the review process, the independent consultant was solely responsible for writing the mid-term review report. Discussions with field mission members were regarded as data gathered from key informants rather than findings determining the results of the assessment. A first draft of this mid term review report was shared with field mission members for comments and clarifications. The choice to revise report sections based on these comments was an independent decision, made by the independent consultant.

1.5. Limitations

At the time of the mid-term review, most of the service delivery sub-projects had completed activities. For this reason, it was not possible to directly observe the implementation of activities or speak to a full array of project staff for many of the sub-projects. This means that a large part of the review is based on information from existing reports and discussions with key informants, which may, or may not have fully or objectively captured activities in the field. Information regarding SP 6 & 7 was not available at the time of the review and it was not possible to assess the progress of these activities.

Given the constraints of very complex logistics (such as need for translation, and tight schedules due to long-distance road travel) and the interest of AusAID and ADB representatives to participate in the field mission, the independent consultant was not able to have separate discussions with most partners and stakeholders. This may have resulted in some key informants feeling unable to give fully candid responses and should be recognised as a potential limitation of the assessment.

2. Findings

2.1. Relevance

Assessing the relevance of RETA sub-projects toward the goal of mitigating HIV related risk and vulnerability associated with infrastructure projects in the GMS must be done on two levels. First, establishing whether an infrastructure project has resulted in increased risk for HIV in the area surrounding the project (for example, is there a need for mitigation activities)[2]; and second, whether the sub-project designs adequately address the risk (such as providing prevention services for the populations at greatest risk in the areas where the largest numbers of at risk populations are located). Another aspect of relevance has to do with how the HIV prevention interventions supported by the RETA relate to the larger national HIV/AIDS strategies of the countries in which they are implemented. Over the course of a project, relevance may shift due to any number of social, political, economic conditions or changes in HIV/AIDS programming implemented by the national programme and its development partners. Consequently, project activities may need to shift to remain relevant to the need for HIV prevention and mitigation activities.

2.1.1. The need for HIV prevention and mitigation activities

- ***Is there evidence to indicate the need for HIV prevention and mitigation activities associated with infrastructure projects in the GMS?***

Cambodia, Laos, and Vietnam are the GMS countries that have been most directly involved in sub-project activities under RETA 6467. Each country has a distinct epidemiologic context, which directly influences the assessment of need for HIV prevention and mitigation activities. Cambodia faces the most severe epidemic of the three countries, but is believed to have made considerable progress in reversing the rate of new infections in many areas of the country, including among sex workers and clients. Sub-project areas encompass one of the highest prevalence areas in Cambodia, Poipet (SP5). In Vietnam, the epidemic is much more concentrated and except in large cities such as Ho Chi Minh City (HCMC), Hanoi, and Hai Phong, the prevalence among sex workers and clients has remained fairly low (less than 5 per cent). Sub-project 8 addresses a road that connects HCMC to Phnom Penh, but intervenes along a stretch of road spanning the more rural, lower prevalence districts in between these two metropolitan areas. In the People's Democratic Republic of Laos (Lao PDR), the epidemic has remained at very low levels in different areas of the country, despite its proximity to higher prevalence neighbours, and the well-recognised presence of sex work in some parts of the country.

From what is understood about the epidemiology of these three countries, the greatest risk for road projects to spark HIV transmission in sex work settings established along newly connected areas is greatest in Cambodia, but is unlikely to occur in the parts of Vietnam and Laos where the sub-projects are located. In Cambodia, the area around Poipet (SP5) is a well-established epidemiologic hotspot for HIV, and is where some

[2] At different phases of an HIV mitigation project, the assessment of increased risk may use a different standard. For example, at the pre-construction phase, the relevant assessment relates to how aware the local community may be to the effects of the road with respect to increasing HIV risk and vulnerability and other conditions which make it more likely for the emergence of paid sex venues, etc. During-construction, the assessment may be based on the number and types of construction workers that are engaged and the duration of the project. Other considerations of risk are the large urban hubs or border areas that will be better connected due to the road project and the potential for large numbers of sex workers and male clients to pass through the affected areas.

of the highest levels of HIV prevalence among sex workers have been measured. However, the identification of this important epidemic area was identified well before the refurbishment of ADB co-financed road project and it is difficult to attribute a specific mitigation responsibility to the infrastructure project.

This is the primary dilemma of establishing the need for mitigation of HIV risk associated with infrastructure projects. On the basis of the number of new HIV infections which may be attributable to increased engagement in sex work emerging around new infrastructure projects, it would be difficult to find geographic areas in the GMS, where large numbers of infections are likely to occur, and justify a heavy investment in prevention interventions. This is only possible in large transport hubs where large numbers of potential male clients pass through and sex workers are congregated. In these situations, the area may become a priority area for sex work interventions coordinated under the national AIDS programme. The mitigation responsibility may be less about providing time-limited prevention services to the current group of sex workers and male clients, but documenting a growing risk area and doing evidence-based advocacy for the national programme to expand prevention coverage to this area, as needed.

HIV prevention is a complex endeavour, in part because the ideal form of prevention takes place before risk behaviour begins (such as preventing women from selling sex, cultivating norms for men using condoms from the first act of paid/high risk sex), yet it is difficult to predict which individuals may be prone to adopting such risks and should be the beneficiaries of the intervention. A core aspect of the HIV mitigation interventions in these sub-projects relates to raising awareness and imparting knowledge about HIV transmission and prevention to local communities living in the road project areas. In some cases, this includes prevention of sex trafficking, particularly among young village women. While the number of HIV infections occurring among people from rural villages taking up sex work is likely to be small, this risk can be seen to be more directly attributable to the development of infrastructure and most likely will not be addressed by any national AIDS programme. Need, in this instance, is acute for a small number of people, and the mitigation responsibility is heightened due to the lack of coverage by other interventions.

Mitigation responsibility can also be framed in terms of preparing communities to handle the broader negative health and social impacts of an infrastructure project, of which increased risk of HIV is one issue. For example, community members interviewed during the field mission expressed concerns about road accidents, alcohol abuse, the spread of malaria, and trafficking for forced labour, that they associate with the completion of the road. The HIV prevention intervention becomes the means of building community resilience to face broader challenges, by empowering and capacitating community members and local support organisations. In this way, the HIV sub-projects fill a need for mitigation activities.

2.1.2. To populations being targeted

- ***Are the interventions effectively targeted at the most appropriate groups?***

In general, most sub-projects addressed a diverse group of risk populations, including sex workers/entertainment workers, truckers and other transport workers, rural communities living near the road, factory workers, and military personnel. By design, all consultants contracted to implement sub-projects had to work with rural communities living near the road. The decision of which villages or communes to work in was often based on criteria of proximity to the road and low economic status. These criteria were believed to make it more likely for village women to enter into sex work and/or be trafficked and areas where out-migration by men might be more probable.

Some sub-projects appeared to use more systematic criteria for ranking candidate villages along the road. However, the process of selecting village areas was also guided by logistics (for example, the ability to communicate in Lao with some ethnic minority groups vs. others, SP1), the previous history of local implementing partners in working with specific villages (SP8), or the existing capacity of local villages (SP1). In most cases a reasonable rationale for selecting intervention areas was articulated by the sub-project deputy team leader, during discussions held in the field mission, but was not well documented in inception reports, baseline assessments, or early Aide Memoires. Knowledge about HIV among villagers was generally low at baseline - for example, 20 to 30 per cent with correct knowledge of modes of HIV transmission and prevention - suggesting a need for more HIV information and awareness raising.

Sex worker/entertainment worker populations were mapped by most sub-projects. However, due to the presence of existing interventions for these groups, not all sub-projects provided prevention services to all groups of sex workers/entertainment workers identified. This decision was appropriate given the scope and duration of the sex worker interventions already in place. In some areas (such as Poipet (SP5), Tay Ninh (SP8)) this type of delegation to other intervention partners could have been applied to a greater degree. Mobile male populations, such as truckers, moto taxi drivers, and so on, were the target of interventions in several sub-projects, and baseline assessments showed high proportions of this group who bought sex recently, suggesting they were an appropriate target group.

Table 2: History of paying for sex among male respondents in SP baselines

	SP1	SP2	SP5	SP8	SP9
% of village males bought sex in the last 6 months	23.6	7.5%	5%	<2%	NA
% of mobile men bought sex in the last 6 months	27.0	NA	30-40%	18% & 29%[3]	NA

Outreach to female mobile populations (such as female migrant workers) was the target of SP5. Similarly, SP8 conducted outreach to male and female factory workers. These groups were perceived to be at risk due to the greater frequency of casual sex facilitated by living outside of traditional family structures. These types of sexual practices may be conducive to higher rates of sexually transmitted infections, but regional experience suggests that casual sex in low prevalence populations does not generally occur with sufficient frequency or concurrency, such as sexual network density, for rapid spread of HIV.

The appropriate apportioning of resources on sex workers vs. male client populations vs. rural communities is difficult to assess. This is partly due to the lack of numerical targets or denominators of coverage for most of the target populations in most sub-projects. It is also difficult to weigh the importance of meeting different objectives by targeting different populations. For example, the number of HIV infections among rural communities is likely to be much smaller than those occurring among mobile male populations and sex workers coming into the area because of increased connectivity, but the objective of strengthening community resilience justifies the focus on rural communities.

[3] Data were presented separately for transport workers in Vietnam and Cambodia

2.1.3. To GMS governments and development partner priorities

- ***Are the interventions relevant to GMS government and other development partner programs and priorities?***

National and provincial government stakeholders met with during the field mission expressed appreciation for the subprojects. Officials saw specific utility in strengthening relationships with INGOs, establishing cross-border partnerships, and building capacity with the public sector to deliver interventions. Continuation or absorption of sub-project activities into the national programme would be a sign of the project's relevance to government priorities. In Tay Ninh, specific plans to continue gains from the project suggest government ownership of the intervention approach.

Throughout the implementation period of the sub-project, UK Department for International Development (DFID)/World Bank funded sex worker prevention interventions in Tay Ninh province. On the one hand, sex worker interventions in Tay Ninh under SP8 may appear duplicative, however Tay Ninh provincial representatives noted that the interpersonal communication skills of outreach workers developed through the sub-project were very valuable and would be incorporated into the DFID/World Bank funded activities. The National AIDS Authority of Cambodia also mentioned mobile populations as a component of their new prevention strategy, however, the specifics of the package of services or scale of the mobile population interventions is not yet described.

Neither the concept of mitigation for infrastructure development related harms, nor the prioritisation of prevention among rural communities affected by such projects are part of national HIV/AIDS strategies in Lao PDR or Cambodia.[4] However, at the closing workshop for SP2, through the work with ethnic communities, the national AIDS programme was able to develop new model for working with these groups in the future.

2.1.4. To changes in the development context

- ***Has the project been responsive to any relevant changes in the development context?***

There have been a number of significant changes in the development context of several sub-projects during the course of implementation. For the most part, sub project teams responded appropriately by adjusting their activities to optimise effectiveness. For example, increasing tension and outbreak of conflict between Thailand and Cambodia resulted in an increase in military presence in the area around SP9 and disrupted intervention activities briefly as refugees fled the border area. The decision to work with military populations early on in SP9 positioned the project well to address this increase in potential male client population.

Changes in the Chinese government policy related to cross-border casinos resulted in the closure of establishments in Boten, Lao PDR (SP1). Newer casino areas have been established in other areas near the border, where casino workers and entertainment workers appear to have shifted. In response, SP1 reallocated some funds to other target population, but did not start up intervention activities in the newer casino area.

[4] Vietnam is in the process of launching its new strategic plan. Whether the strategy will address mobile populations or border areas is not yet known.

2.2. Effectiveness

2.2.1. Is the project on track?

- ***Is the project on track to achieve its objectives, as set out in the Design and Monitoring Framework (DMF)? Given this, what has been the impact of individual subprojects on the progress of the overall project?***

The DMF provides the core indicators that define the expected outcomes and outputs of the sub-project. At the time of the review five service delivery sub-projects were completed or near completion. Two of these five (SP5 & 9) had not yet completed their end-line assessments, so progress can only be assessed at output level. The tables and narrative below review the progress across sub-projects focusing on the core indicators of the sub project DMF.

Table 3: Scope of sub-projects

	SP1	SP2	SP5	SP8	SP9
Project Name	**NEC**	**EWEC**	**CRIP**	**PP-HCMC**	**NRIP**
Post or Pre-construction period	Post	Post	Post	Post	Pre
Time period (original)	3/09-3/11	3/09-3/11	3/09-7/11	5/09-7/11	11/09-7/11
No-cost extension	5/11	6/11	9/11	?	12/11
Consultant	Burnett Institute	World Vision Australia	Family Health International	World Vision Australia	Family Health International
Overall Budget (USD)	600K	700K	700K	694K	350K
Government sub-contractor	Y	N	N	Y	Y
NGO subcontractor	N	N	Y	Y	Y
Amount/ % of total budget to sub contracts/field activities[5] (USD)	?	175,000 (~25%)	73,219 (~13%)	49,237 (7%)	73,653 (~15%)
Target Population – Size					
Sex/Entertainment workers	200-300	N	N	208-218	130
Mobile men	Y	2517	7700*	300 moto*	1,000*
Other male client populations	N	N	N	N	2,000[6]*
Affected communities – male & female	3 villages*	22,033	6,000*	Y	4,000*
Other populations (includes male and females)	130 Mine workers; casino workers			9,700 factory workers	

** Indicates a target for service coverage, but no information about the total size of the specific risk population.*

[5] Detailed budgets for all sub-projects were not available and it was not possible to confirm whether the activities/costs included under "field activities" and in sub-contracts were consistent across sub projects.
[5] (cont) Sub projects without sub-contracts (i.e. 1 & 2). Information about the amount allocated to "field activities" were taken from Biannual progress reports prepared by ADB and submitted to AusAID.
[6] Military personnel

Overall the results are mixed. At an output level, most sub-projects reported large numbers of outreach contacts to various target populations. However, few sub-projects specified output targets or defined expectations of contact, making it difficult to determine whether the outreach was meaningful or the target group had been saturated. For the sub-projects that had baseline and end-line survey data, HIV knowledge and awareness targets were achieved by most groups, but there were puzzling decreases in knowledge among the Cambodian beneficiaries of SP8, and there were disappointing results among village women covered by SP 2. Only one sub-project had measures of condom use among males, and saw modest rises in condom use during high-risk sex among male villagers.

More impressive results were in the area of capacity building, the engagement of government partners, and efforts to establish cross border collaboration. These achievements are difficult to measure in terms of outcomes and outputs indicators of the DMF, but have been systematically documented in sub-project progress reports.

Sub-projects were similar in budget amount and duration. However focus of projects in terms of target population and approach used to deliver services, varied considerably. This is partly reflected in the different amounts allocated to sub-contracted implementing agencies/field activities (ranging from 7 to 25 per cent). Across all sub-projects, the vast majority of the budget (greater than 75 per cent) was spent by the international NGO/consultant on technical support and management of the project.

2.2.2. Key achievements

Each sub-project DMF identified behaviour change and/or knowledge indicators as well as coverage indicators for information, education and communication (IEC) sessions and/or provision of STI services. Different services were intended for different target population and the definitions of indicators varied by sub-project. The tables below summarise achievements by sub-project for each type of indicator and target population, where comparable.

Condom use among risk populations is a key measure of effectiveness of IEC and promotion/increasing access to affordable and accessible condoms. However, end-line assessments were being conducted at the time of this review for two sub-projects (5 & 9); and a third sub-project (#8) chose not to collect these data in the end-line survey because the baseline level of condom use was very high. High levels of condom use at baseline may suggest the target population had already been well covered by previous prevention interventions or potentially some social desirability bias common to self-reported condom use.

Table 4: Core indicators

Project Name	SP1 NEC	SP2 EWEC	SP5 CRIP	SP8 PP-HCMC	SP9 NRIP
Behaviour change – percentages presented reflect change from baseline to end-line					
% using condom at last sex with high risk partner – target % point increase	Not a DMF indicator	10%	End-line not yet available	Not measured at end-line	End-line not yet availabl e
Affected community – males	72.7% to 76.2%	3.6% to 15.6%			
Mobile male population	76.7% to 100%				

The ten percentage point increase target set for condom use among affected community males in SP2 was achieved, however the targets set were fairly modest considering the baseline level of only 3.6 per cent. Condom use with high-risk partners stayed the same for village men in SP1 and increased to 100 per cent among mobile men engaging in high-risk sex. Very high levels of self-reported condom use are not unusual in these types of surveys and may reflect some amount of social desirability related over-reporting. However, the data suggest at least universal awareness of the utility of condoms and probable high use.

Table 5: Capacity building, Partnership, and Leadership

Project Name	SP1 NEC	SP2 EWEC	SP5 CRIP	SP8 PP-HCMC	SP9 NRIP
Capacity building					
# STI /HIV trainings given	2	25			3
# of people trained in STI/HIV					33
# of peer educators trained – male and female	98	30			41
# IEC trainings given	18				14
# of people trained to give IEC		24	129		60
Cross border collaboration:					
# CBC meetings held	2		NA	6	NA
Leveraging other partners					
# private sector partnerships (for workplace type interventions)	5			11	19
# partnerships with other service organisations	2 (PSI, LNP+)				

Data on training and capacity building is not collected in a uniform manner across sub-projects, including the definitions used for what constitutes a training, who are the subjects of trainings, and how training by different topics are categorised. Nonetheless, sub-projects recognised capacity building of implementing partners (such as provincial health departments, women's union, local NGOs) as well as outreach and peer education staff as core activities and an important aspect of sustainability. What is not as easily captured is the significant effort made by many sub-projects to engage government partners in all aspects of planning, management, assessment, and service delivery. This is especially true for sub-projects in Lao PDR and Vietnam (SP1, 2, and 8), where government agencies have historically played a key role in implementation of prevention interventions.

Cross border collaboration was a key activity for SP1 and SP8. While some challenges arose in conducting joint activities between Tay Ninh and Svey Rieng governments for casino workers (SP8), the Tay Ninh government partners described an initiative to extend the work of the cross border committee to address a broader set of health issues in the near future. In the context of SP1, the PRC government partners provided support and education materials in Chinese to support outreach activities, but in the absence of implementing services on the PRC side of the border and working more actively and without funding for activities to incentivize PRC government partners, the cross border partnerships were less substantial in this setting.

Table 6: Knowledge and awareness

Project Name	SP1 NEC	SP2 EWEC	SP5 CRIP	SP8 PP-HCMC	SP9 NRIP
Knowledge/Awareness – change from baseline to end-line					
% with correct knowledge of HIV- target % point increase	M: 10% F: 20%;	10%	End-line NA	20%	End-line NA
Mobile men	54.1 to 72.6*			Vietnam: 35.3 to 40.8 Cambodia: 35 to 23.7	
Affected community – males	49.4 to 68*	14.2 to 41.7*		Vietnam: 26 to 38 Cambodia: 28.4 to 12.5	
Affected community – females	20.6 to 64.7*	17.4 to 20.6			
Other populations – factory workers				Vietnam: 25.8 to 36.5 Cambodia: 48.3 to 7.3	
% who know where to go for VCT services – Affected communities (male and female combined)				Vietnam: 16.9 to 41.5 Cambodia: 65.7 to 83.9	

** indicates target was achieved. Red font indicates indicator results of concern. Dark grey cell indicate no targets were indicated in the DMF.*

More data is available for changes in knowledge and awareness of modes of HIV transmission and prevention. The target percentage point increases were achieved in all surveyed groups in SP1, among males in affected communities in SP2, and among Vietnamese target populations in SP8. However, there appears to be a bias in the knowledge/awareness gained by females in affected communities in SP2. No acknowledgement or explanation for this discrepancy is given in the reports submitted.

In SP8, knowledge/awareness dropped significantly among the Cambodian target groups. This is difficult to understand, because once knowledge/awareness is gained, it is not usually lost. It is important to consider whether faults in the sampling design or mistakes in the data analysis could explain these results. The final report for this project acknowledges this difficult to interpret result, and suggests more investigation is needed to determine the reasons why.

Table 7: Outreach contacts

Project Name	SP1 NEC	SP2 EWEC	SP5 CRIP	SP8 PP-HCMC	SP9 NRIP
Outreach contacts (individuals)					
Sex/Entertainment workers	207 (100)			1721	(192)*
Mobile men	240 (122)		17,074*		(4300)*
Other male client populations	303 (200)				
Affected community – male & females contacts through 1:1 sessions	2161 (841)				
% of 1:1 contacts made with female villagers	41%				
# Affected community – male & female contacts through group sessions	1690 (1107)	(4323)	(15,387)*	(3721)	(3897)
% of group contacts made with female villagers	40%	59%			
Other populations	Miners: 118 (60) Casino workers: 313 (100)			Factory workers: 4589	

** indicates target was achieved. Red font indicates indicator results of concern. . Dark grey cell indicate no targets were indicated in the DMF.*

Outreach to deliver IEC sessions is a core activity of each sub-project. However, with the exception of SP5 and SP9, explicit targets or denominators of target populations are not described in sub-project documentation, making it difficult to assess whether teams underperformed, or achieved appropriate levels of coverage.

The outreach targets set by SP5 and 9 were exceeded in almost all cases, with the exception of outreach to affected communities in SP9. Teams from SP5 were able to cover more than twice the expected number of individuals among both mobile male populations and affected communities.

Among the mobile male population, this is partly explained by a change in Thai deportation policy that resulted in very large numbers of illegal migrants travelling through the border point in Poipet where the intervention was in place. The much larger number of individuals reached among affected communities is not clearly explained, but may be the result of confusion in counting contacts as individuals. There are also some discrepancies in the numbers reported by SP8. Baseline assessment and implementation reports suggested only about 200 entertainment workers, but progress reports suggest coverage of more than 1700 entertainment workers. Similar issues persist for affected communities as well.

Table 8: STI services provided

Project Name	SP1 NEC	SP2 EWEC	SP5 CRIP	SP8 PP-HCMC	SP9 NRIP
STI services provided					
# Male patients treated	?	485			
# Female patients treated	Data pending	3208			
# successful referrals of mobile population to STI, VCT, and /or family planning services			1325 (13% of reached) *		
# successful referrals of entertainment workers to STI and/or VCCT services			?		99 (51%)

** indicates target was achieved. Red font indicates indicator results of concern. Dark grey cell indicate no targets were indicated in the DMF.*

The approach to enhancing sexually transmitted infection (STI) services in project areas ranged from promoting services (SP2, SP5, SP9), to training public sector teams to provide better STI services (SP1, SP2, SP8), reducing the cost of STI treatment (SP1, SP2). Large numbers of STI patients were treated using project funds in SP2. The large numbers of women treated, reflects the high level of interest for this service. There is some question about the effectiveness of this type of STI treatment without also partner referral and treatment. The possibility that many of the infections treated are reproductive tract infections, such as bacterial vaginosis or candidiasis, but not STIs is another issue to consider. Additionally, successful referral targets were achieved in SP5 for mobile populations accessing local STI, HIV testing, or family planning services. The percentage of successful referrals reported in the most recent project update shows much lower percentages than what was submitted in the last several biannual progress reports. This discrepancy is not explained, although during the review mission some differences between definitions used by implementing NGO and FHI in calculating some indicators, including referral success, were identified.

2.2.3. Negative or adverse impacts

- ***Have project interventions produced negative changes directly or indirectly? What are some specific examples of adverse impacts, if any?***

Sub-project interventions do not appear to have caused specific adverse impacts on beneficiary populations. There have been some instances where misunderstandings have occurred between partners. For example, expectations of larger budgets or the ability to fund microfinance was an issue in SP8. In other sub-projects there were delays in getting approvals from ADB, or activities were funded before ADB approval given. Poor communication channels for SP8, prevented ADB approval for a cross border committee initiative, and the inability for ADB representatives to attend a closing workshop for one sub-project. In only one sub-project did issues within a team management structure appear to create more serious dysfunction in team management. However, these issues do not seem to have caused serious rifts in the ongoing relationships between partner organisations, at most the situation caused irritation and slowed down the process of implementation.

The decision to revise the DMF of the overall project and sub-project in mid 2010 took some sub-projects by surprise and was a source of irritation for others (such as changing the goal posts and measures of success in the middle of implementation). While perhaps a necessary action, the DMF revision process could have been handled more strategically, and the process should have resulted in much greater improvements to the M&E system overall. In the end, the revision process appears to have consumed a fair amount of management attention without substantial improvements in the data collected or system of monitoring.

During the field mission meetings with provincial government partners, leaders expressed strong interest in continued funding for the project, citing the very short implementation period and the need to cease activities just as the teams felt fully capacitated and empowered. In some cases, the lack of developing a clear exit strategy and a fuller concept of what sustainability should mean for the project, may have contributed to these differences in expectations. It is not unexpected for government partners to lobby for continued funds when meeting with donors. However, few government partners expressed a clear justification for additional funds based on the need filled by project activities. Such arguments may have been more persuasive if they indicated a more strategic assessment of what essential activities should be continued, what contribution government resources were being leveraged, and what gap in funding remained.

2.3. Consistency, performance and efficiency

2.3.1. Evidence of cost effectiveness

- ***Is there evidence to indicate the cost-effectiveness of HIV prevention and mitigation activities associated with infrastructure projects in the GMS?***

Cost effectiveness is predicated on need, such as the existence of a problem or situation to address. In the case of RETA 6467, the overall project and sub-project DMFs define the problem in terms of preventing large numbers of HIV infections from being transmitted in the project areas. As discussed in the section on relevance, the low levels of HIV combined with relatively small numbers of most at risk populations covered by the intervention makes it unlikely that these interventions have averted large numbers of HIV infections. The sub-projects themselves are also considered relatively costly given the area covered and the numbers of (potentially) at risk populations reached.

From this perspective the cost effectiveness the sub-projects would not rate very highly. However, many other important effects of the sub-projects are not well captured in the DMF. Many of these effects are not easily valued, making assessments of cost effectiveness difficult and subjective. However, these effects are real and should not be dismissed because they are not easily described with numerical indicators. These types of outputs include capacity of government and local NGOs to implement and manage these types of prevention activities; introduction of good practices in prevention interventions funded by other donors in different geographic areas; and heightened awareness or strengthened relationships among government partners to initiate cross-border collaboration to address the health needs of migrant populations.

2.3.2. Consistency of sub-projects with project objectives

- ***Are subproject interventions consistent with the overall project objectives?***

The service delivery sub-projects (1,2,5,8, 9 & 10) consistently carry the theme of designing an HIV prevention intervention for populations in close proximity or which are the result of greater connectivity of a road project co-financed by ADB. All sub-projects address client populations as well as local communities whose members might be vulnerable to engaging in sex work or to be trafficked. Three of the five service delivery sub-projects also worked with sex workers/entertainment workers.

The less explicit objective of the project, to test models for HIV prevention mitigation, was partially met. Sub-projects incorporate a diversity of approaches, however, it does not appear that variety or innovation was a strong factor in selecting consultant proposals, nor were efforts made to coordinate between sub-projects to systematically test and evaluate different approaches during the implementation period.

In some sub-projects large numbers of beneficiaries were included who were likely to have some HIV risk (such as large military installations (SP9), deported illegal migrants channelled through a specific border crossing (SP5), factory workers, but whose presence or vulnerability to HIV was not a specific consequence of the increased connectivity/mobility afforded by the road project. These decisions could be seen as not adhering to impetus for the project, mitigation of harms caused by the road; however focusing on these populations may ultimately have had a greater impact on HIV prevention than stronger focus on rural communities.

2.3.3. Technical analysis and continuous learning

- ***Are the interventions based on sound technical analysis and continuous learning?***

At the sub-project level, some intervention areas were selected based on evidence: such as mapping of sex workers, mobile populations, and other vulnerable populations; selection of communities based on poverty, as well as previous experience of local NGOs working with specific communities. In some areas, the obvious intervention areas (such as large border crossings with well-known concentrations of sex work establishments, e.g. SP5) already had in place interventions by other partners. Consultants may have felt compelled to work in these areas, because of the relative ease and perceived expectations that the project should intervene with the highest risk groups in the area. However, in the bigger picture, a more cost-efficient approach to ensuring coverage of these risk populations may have been to determine whether existing implementing partners should have been given resources to extend their reach, or for sub-projects to work in different areas altogether.

Sub-projects also demonstrated the ability to adapt and customise their interventions. The work with a coal mining company required SP1 partners to try several approaches to providing education and awareness to workers, due to the constraints in engaging peer educators and reaching miners during work hours.

In several instances implementation partners expressed that information gathered that could have addressed longer-term community resilience or address broader (non-HIV) social harms attributable to greater connectivity was not acted on because the TOR was believed to be inflexible on these issues. In some cases the broader, but less explicit intent of the project to strengthen communities, would have been better served by greater flexibility in the scope of activities. There appears to be some inconsistency by sub-project about what aspects of the original TORs were strictly adhered to and which were adjusted.

2.3.4. Efficient use of financial and human resources

- ***Are financial and human resources being used efficiently?***

A relatively small proportion (generally less than 25 per cent) of the budget of consultants went to service delivery. This result is after efforts to increase the amount to field implementation during contract negotiations for the initial sub-projects. At the same time, ADB acknowledged the need to engage relatively high-cost international NGOs to lead the sub-projects due to the intensive administrative/financial control system used by ADB, and the interest in capacity building of local partners. Other contributing factors to the high management costs of the sub-projects include the engagement of international staff (stipulated by the TOR of the consultants), and the need to establish multiple project offices by sub-projects that spanned two countries or covered large geographic areas.

A significant disadvantage to sub-projects in the efficiency of using funds and human resources was the very short duration of the implementation phase of the projects. Most sub-projects were designed to have a duration of two years, however, the administrative and financial arrangements of most ADB managed projects can take between 4-6 months from the time the consultant is fielded. In the case of these sub-projects a longer duration for the start-up was encountered because of the complexity of the project (e.g. need to obtain multiple levels of government approval, coordinating availability of target population engaged in agricultural work, etc.) Another factor reducing the amount of time of actual service delivery was the heavy burden of quantitative formal baseline surveys to serve as a point of measurement for outcome level achievements. Initial assessment of the baseline situation is important for both planning and measuring project achievements; however, there may be a more efficient way to accomplish these tasks that would not necessarily have delayed the implementation period. One example may be the use of short pre-post-test assessments for groups provided IEC sessions.

Given the significant up-front costs of training, engaging stakeholders and providing technical support, the short duration of actual implementation makes it hard for any sub-project to be rated as efficient.

The levels of investment in these projects are more appropriate if seen as the initial stage for larger on-going programming, or a project with the specific intent of piloting approaches or launching demonstration projects, which will guide a larger set of programming in the future. Such projects would normally be designed to invest more in evaluation studies, which would be unreasonable to launch for every intervention area. In general, unit costs or developing cost efficient, sustainable intervention approaches did not appear to be a primary guiding principle for sub-projects. One exception being the decision by all sub-projects to minimise free distribution of condoms and instead promote socially marketed brands.

Significant amounts of money were allocated by ADB for operational costs of the overall RETA, including a full time national programme officer, social sector specialist to coordinate the project, and two social sector ADB project officers to support specific sub-projects, an international technical consultant to provide inputs and support monitoring of sub-projects, and international consultants to support the M&E and gender equality components of the sub-projects. These technical staff provided support and oversight to counterparts within the international NGO implementation teams, also adding to the high management costs. There was also difficulty in maintaining an M&E specialist for the duration of the sub-projects resulting in three different consultants each with different viewpoints working on the DMFs with the sub-projects. This type of arrangement does not seem to have been as productive and in some cases became frustrating or confusing for intervention partners. Some efficiency

in management of sub-projects could be gained by giving sub projects clearer objectives, and selecting international NGO partners with more in-country experience and content expertise.

The structure for consultant teams recommended in the TOR raised an area of inefficiency for some sub-projects. Team leader positions were intended to be international level staff, but due to costs, budgeted for only 6 person months over the course of the project duration. Full time deputy team leader positions and country-specific programme officers were to be filled by national level staff. Several sub-projects suffered from lack of clear delegation of authority between team leaders and deputy team leaders, causing inefficiency in some cases and palpable friction and poor team morale in another. Team structure arrangements that appear to have worked well were those in which team leaders oversaw more than one sub-project and had full-time in-country presence, afforded by responsibilities for other similar interventions funded through other partners. In a similar vein, sub-projects whose teams had existing experience in-country were able to forge relationships with government partners at national and provincial level more quickly, and consequently received faster approval and cooperation for smoother implementation.

2.4. Sustainability

- ***Have the subprojects been appropriately addressing sustainability so that the benefits of the activity will continue after funding has ceased? Do beneficiaries of the project, and/or in-country partners, have sufficient ownership, capacity and resources to maintain the project benefits after the project has concluded?***

The definition of sustainability in the context of an HIV prevention intervention is multi-dimensional and runs a spectrum along most axes. For example, most HIV prevention programming in the region and even globally is funded by bilateral and multi-lateral partners. In this sense, programming is not financially sustainable. Similarly, while all government partners expressed an interest in continuing activities, many are unable to for lack of funds to pay staff per diems or afford transport to remote areas. At the same time, the financial sustainability of these activities can be enhanced by choosing intervention models that are cost-effective, and prioritising activities which are likely to have the greatest impact, or that can be maintained at low ongoing running costs.

Another dimension of sustainability looked at in these types of projects is capacity building. High-cost technical support and capacity building could be a useful strategy towards sustainability if local partners are left with the ability to manage and deliver services on their own at the conclusion of the project. Capacity built within government partners (such as PCCA/DCCA in SP1, Tay Ninh health department in SP 8) was acknowledged by partners. In addition, while sustainability was reported by the sub-project, not as an explicit objective of their TOR, financial and administrative capacity built within local NGO structures in SP5/9 resulted in a collaborative application by the two local NGOS for a bid to implement during-construction interventions for the same section of road.[7]

The ability of peer educators trained by the sub projects to continue their efforts in local communities will be more informal and based on individual interest. Peer educators for sex worker/entertainment worker groups may be difficult to maintain in some areas as the size of the per diem provided was fairly significant ($50 a month in

[7] Unfortunately, the selection process for this intervention partner was managed through the loan project and did not weight prior experience very heavily in the selection process. It appears unlikely that the collaborative application will receive the bid.

Cambodia) and on-going activity without compensation may not be likely. However, the skills developed through the sub-projects in some groups could be taken over if these areas are considered a priority by the broader national prevention efforts providing services for sex workers, or mobile men with money.

A third form of sustainability is engaging the interest of partners and harnessing other resources to extend the benefits of the project. For example, one private sector company (SP1) engaged in social development projects of its own, could see the continuation of activities at a lower level of activity through reinforcement of media such as posters or videos that could be updated periodically. Forging this relationship and strengthening their interaction with local government, may be sufficient to engage this employer in promoting HIV/STI prevention messages to workers. In another case, establishing relationships with border police and arranging the installation of LCD and DVD players at the border crossing at Bavet/Moc Bai (SP8), serves as an ongoing resource that can be used to show a variety of health and social service messages, beyond the HIV prevention materials developed specifically through the sub-project.

A similar example of sustainable effects is in the area of advocacy and influencing policy makers. A measure of success of the sub-projects would be the commitment of national AIDS programmes to work together to address risk associated with cross-border migration. Entertainment areas where casinos owned by foreigners, which employ large numbers of both local and foreign staff and which are important areas for HIV prevention interventions, are a no-man's land in terms of which government is responsible for providing services. Sub-projects under this RETA stimulated cross border collaboration to address these populations, and provide useful models for governments of all GMS countries to sustain and even extend these partnerships. The degree to which these efforts will be continued by GMS governments remains to be seen.

Many of the efforts of the sub-projects could be enhanced with a more concrete definition of what sustainability of different aspects of the project might look like, and could then have conducted activities specific to fostering sustainability. Part of the constraint on the sub-projects was the short period of implementation, which did not afford separate periods of start-up followed by a transition to more of a maintenance or sustainability mode. Sustainability issues could have been addressed more up-front by discussing expectations in a post-construction project that are distinct from a pre or during construction project. The role of government and the plan for post sub-project funding might have been addressed with partners as part of the project inception process. This may also have affected the model for the style and approach to prevention activities that could more easily transition to a phase in programming without sub-project funds.

The actual cost of service delivery is relatively small compared to the overall size of the grants made to each sub-project. Securing sufficient funding from the government might be plausible to sustain activities where deemed necessary and high priority. Linkages to national AIDS programme activities would have made these sub-project innovations more sustainable. For example, the condom and STI revolving fund concept was an opportunity to assess the impact of small infusions of money. The revolving fund concept is not new to the field of HIV, but the implementation in GMS settings could have been designed to demonstrate their effect and to use the data to advocate for these methods as part of larger national programmes or funding from other donors. Potentially other funds could have been leveraged to use the sub-project as an opportunity to test or scale up the revolving fund concept in Lao PDR.

2.5. Gender equality

2.5.1. Equal access to project benefits

- ***Are the subprojects advancing gender equality and promoting more equal access to the subproject's benefits for women?***

Gender action plans developed with the support of gender consultants, including the development of gender-based indicators, were systematically produced for the project. ADB managers acknowledged there were some difficulties in engaging a suitable international gender consultant to support the sub-projects and local consultants were used instead. The gender action plans and indicator sets documented by the gender consultants were not concretely defined or specific to sub-project activities. This may have been due to the expectation that the sub-project consultants would generate the more specific indicators and examples as implementation progressed.

Approaches to gender equality and gender equitable access manifest differently in interventions for different target populations. In HIV prevention projects, most at risk populations are generally already delineated by gender – for example, female sex workers, male clients of sex workers. So, the primary issue is not usually whether participation is proportional by gender or whether peer educators are matched by gender. The more important issue is whether the framing of behaviour change messages and the general style of the intervention is gender sensitive and addresses broader inequalities in male-female relationships. For example, the decision to engage entertainment establishment owners to promote condom norms among clients, rather than focusing on distributing free condoms to female sex workers can be seen as a more gender sensitive approach.

Adopting these types of structural interventions acknowledges that norms about condom use are influenced by the unequal power relationships among men and women in sexual decision-making. Several of the large INGOs already have great sensitivity to issues around gender and the role of gender stereotypes of discrimination in increasing the risk of sex. Programmes such as *'Smart Girl*' and '*You are the Man*', developed by FHI for other HIV prevention activities, but adopted for the sub-projects 5 & 9 activities, have strong components that address gender norms. The *Smart Girl* campaign engages young women who are selling sex and motivates and empowers them to make smart decisions such as using condoms with clients, by building their self-esteem and acknowledging the important contributions to family income afforded by selling sex. Similarly, the *You are the Man* campaign attempts to shift the perception of what manhood is about, promoting concepts of taking responsibility for risk activities and caring/respecting their female partners.

Within interventions for the community, gender equality and equal participation becomes more relevant. For example, it may not be socially acceptable for women in village settings to discuss sex or condom use openly. During field mission meetings with commune committee members in SP8, there was evidence that the project has opened the space for women to talk openly about these topics. Domestic or sexual violence, sexual decision making, alcohol use, addressing infidelity are challenging topics that can affect HIV prevention and could be important to address to make messages in these community settings relevant and useful. It is not clear whether peer educators/outreach workers were trained or prepared to engage all such topics with their beneficiary populations.

These limitations may have been a deliberate choice of sub-projects due to the small scale and short duration of the sub-projects, or the lack of sensitivity of sub-project teams as to the salience of gender to HIV mitigation. Clearly, gender equality and sensitivity have benefits to community extending much beyond HIV prevention. As described earlier, with a broader view of the project scope, the HIV mitigation interventions could serve as an entry point to the broader goal of changing community gender-biased norms about sexual and reproductive health.

2.5.2. Developing capacity to promote gender equality

- ***Is the project helping develop capacity in implementing partners and communities to understand and promote gender equality?***

It is difficult to assess the degree to which sub-project teams explicitly built the capacity of local NGOs and communities to promote gender equality, rather than trained local implementers to provide interventions that implicitly incorporated gender sensitive approaches. The scope and scale of individual sub-projects is limited and may not realistically make big headway in changing deep-seated gender attitudes, norms, and behaviours. However, the gender-balance among leadership staff, the engagement of local groups such as the Women's Unions (in Cambodia and Lao PDR), and the content of the intervention, were likely effective in promoting gender sensitivity among implementing partners. On the whole, the RETA can do more to consolidate these gains. In particular, making these efforts more explicit and documenting concrete examples of how and why the promotion of gender equality is an end in itself as well as being an essential strategy for preventing HIV.

2.6. Monitoring and evaluation

- ***Are the overall project monitoring and evaluation system, and the individual subproject monitoring and evaluation systems, effectively measuring progress towards meeting objectives?***

There are significant weaknesses in the monitoring and evaluation system established at both project and sub-project level. Mid-way through the project period an effort to revise the DMFs at both project and sub-project level was attempted. The changes are well documented and were intended to refocus the DMFs on more specific, measureable indicators and better reflect that the projects were designed for pre- and post-construction phase prevention interventions, rather than during-construction projects. Nonetheless, the revised DMF did not address a number of key weaknesses in terms of 1) the selection of core indicators not reflecting all the objectives of the project; and 2) a lack of targets for all indicators and documentation on the definition of each indicator and rationale for the targets set. A broader weakness of the M&E system relates to the design and use of data collection systems by the sub-projects, both the baseline/end-line assessments and the routine monitoring systems established.

2.6.1. Selection of core indicators

The purpose of a DMF is to summarise the expected results of the project and the intermediate signs of progress, through a selection of indicators and targets that reflect the project approach. At the level of the overall project DMF, the selection of the MDG 6, target 7 impact indicator was not appropriate given the small scale of the activities, in the context of overall HIV/AIDS programming and the relatively small contribution of mobile populations and affected communities to the underlying HIV epidemic in the GMS countries. As a project with the main thrust of mitigating harms attributable to infrastructure development, the impact indicator should have reflected the scope of this goal.

Similarly, the outcome level indicator is related only to HIV/STI transmission, and does not reflect the important objective of sustainability: building the capacity of affected communities to address potential negative social/health related harms as the result of development or government adoption of a strategy or policy to address these types of harms related to development more broadly. This objective is particularly important in the context of post-construction interventions where the project has a defined implementation period, but the effects of the infrastructure project (in terms of increased mobility and traffic through affected areas) are on-going.

Given that the RETA was intended to explore different approaches to pre and post construction interventions and the sub-projects were diverse in their implementation strategies, it did not make sense that the majority of the indicators were a simple aggregation of indicators from the individual sub-projects. This is especially true since the DMF of the sub-projects were not standardised or necessarily have common elements or indicators. Some aggregate indicators may be appropriate, but alternative indicators for the overall project might have included the development of models or approaches for cost efficient interventions; models for addressing gender inequality in HIV prevention interventions, indicators of sustainability, or building of local capacity. The latter two issues are particularly important given that more than 75 per cent of the budget for each sub-project was spent on management and technical assistance, rather than service delivery. While these indicators at this level are not numeric they more clearly set the expectations of what principles should guide each sub-project. Numerical indicators of coverage, or changes in behavioural outcomes at the sub-project level can be expected as part of the measures of cost efficiency.

Ultimately a well-conceived M&E plan and DMF depends on having a clear conceptualisation of the project design, including clear objectives and a well-developed approach for carrying out the intervention. That the original sub-project DMFs had indicators referencing workers constructing the road, and that the DMF for SP5 - a post-construction project, and the DMF for SP9 a pre-construction project are nearly identical, suggests that this level of conceptualisation was not available at the start of the RETA. A key area of lessons learned is in distinguishing the expectations of different phases of such interventions and identifying the critical indicators that reflect these differences.

At the sub-project level, there were four components, two crosscutting issues (advocacy/capacity building and monitoring and evaluation); and two service delivery areas (IEC and STI services/condom distribution). Measures of coverage are fundamental indicators for any intervention, but the measure of coverage must reflect the type of service each beneficiary is expected to receive. Each sub-project addressed three to four different target populations (such as entertainment workers/sex workers, transport workers, male and female villagers in communities affected by new road construction, and so on). Each target population required a different set of prevention objectives and styles of outreach, key messages, and commodity distribution, or clinical service. Clear, well-defined coverage indicators and targets for each risk population should be included in every sub-project DMF. For example, outreach to entertainment workers may require weekly or monthly contact, depending on whether condom distribution is a primary objective of outreach.

Additionally, the indicator for coverage may reflect the percentage of estimated EWs contacted one-on-one on an at least monthly basis. Information provided to affected communities may be planned as a series of four interactive group sessions addressing different issues. Additionally, the indicator for coverage should reflect the percentage of targeted villagers who attend all four sessions.

These differences in indicators require different methods of tracking and collating routine monitoring statistics, but are much more useful for day-to-day project managers to determine whether services are being provided as expected.

In general the sub-project level DMF has many indicators related to training, but not as many indicators related to the outputs of training and capacity building (such as better quality services, better uptake of services) or sustainability (such as adoption of best practices to other intervention areas, training or supervision practices taken up by government partners). Efforts to capture achievements in advocacy and collaboration are challenging, and sub-projects should be given credit for consistently including these aspects in the narrative section of their progress reports. Good examples of indicators and presentation of these data should be provided to recognise these achievements and continue the development of M&E for these important objectives.

Gender action plans and indicators were developed as part of all sub-projects, with additional technical support from gender consultants engaged by ADB. The suggestion to disaggregate coverage and training indicators by gender was not well thought through, as many of the target populations are gender specific or skewed by gender. For example, disaggregating the number of workers participating in education sessions by gender is not interpretable unless the proportion of factory workers who are male and female is documented and the gender equality target is put in terms of coverage being proportional to the gender mix of workers. As discussed in the previous section, gender issues in the context of HIV prevention go much beyond issues of equal coverage. IEC materials and behaviour change communication approaches that effectively address these issues may need to be described qualitatively, rather than through quantitative indicators (for example, number of gender sensitive materials developed).

Gender sensitive or appropriate IEC material can be assessed with standardised checklists or rating sheets by gender specialists. Measuring outcomes of empowerment or changes in discriminatory attitudes through the quantitative surveys used to assess changes in HIV knowledge/awareness or risk behaviour was a missed opportunity of the completed sub-projects.

2.6.2. Defining indictors and targets

A key weakness of project and sub-project DMFs is the manner of target setting for core indicators. In some cases, this reflects a lack of conceptualising how to make the intervention efficient and effective. Many sub-projects did not provide numerical targets for various indicators of coverage. Additionally, those that did provide targets did not always provide a clear rationale for why specific targets were chosen. One example, is the decision to aim for only a 10 percentage point change in knowledge among many sub-projects, given a fairly low baseline (for example, 20-30 per cent); knowledge being a relatively attainable change, even over a short period of time. It is important to question whether the resources of the project are justified for such small gains in the primary outcome. This suggests a flaw in the logic of the programme and the DMF. If the expected change is small with the chosen intervention model, the model should be re-thought and potentially intensified for a smaller group of higher risk individuals, for whom a larger change can be expected and with a greater potential impact on preventing new infections.

Another example of unclear rationale for targets is that although the two FHI sub-projects had very clear and consistent targets for numbers of mobile populations and affected communities to reach, the basis for these targets were unclear. Did the targets reflect the total target population that existed, or was the target 80 per cent of the estimated population, or was the target calculated on the basis of available

resources, e.g. number of outreach staff multiplied by the number of hours worked, and so on. Progress reports note that estimating the size of mobile populations moving through an area was difficult. However, without a better understanding of the pattern of movement of these groups, it would be difficult to design an appropriate intervention that would have substantial effects.

A related issue to lack of targets and rationale for targets is a lack of indicator definitions. For example, was the ability to reach a much larger number of mobile population, specifically those who were deported migrants, related to a change in the type of 'contact' made with deported migrants. During the review mission, the implementation team noted that every day, hundreds of migrants were being deported. With collaboration from the border police, the team was able to conduct a short information session with large groups of deportees, at the border before being released. The impact of education sessions on this group may have been very different than sessions conducted with day labourers who passed through the border regularly. By counting all contacts the same, it is difficult to discern the potential contribution this type of education session may have on preventing HIV risk behaviour.

A more fundamental issue about definitions relates to clearly describing the target population. Mobile populations can include many different groups, and for many their risk of HIV is not related to paying for sex. Yet the FHI definition of MMP is not male mobile population but mobile and migrant population and can be either male or female. The interventions for a female migrant would be expected to be fairly different for a male migrant and by combining this group together and not distinguishing the types of contacts for each indicator is difficult to interpret.

In general, the definitions used for coverage indicators based on routine monitoring data should be compatible with what exists in the country, and as much as possible what is used across sub-projects. This is both for the purposes of being able to integrate the intervention activities with the broader national prevention strategy as well as to reinforce best practices and standards of quality in both prevention interventions as well as monitoring and evaluation.

2.6.3. Data collection systems

A critical aspect of the sub-project design phase is conducting a baseline assessment, which is the basis of the implementation report detailing the activities and work plan of the intervention. The baseline assessment should serve two functions:

1) To describe the geographic area covered by the intervention, identifying the highest priority risk populations, and justifying the selection of target groups and specific intervention sites; and

2) To collect data about the baseline knowledge, attitudes and behaviours of the target populations that are expected to change as a result of the intervention.

While several sub-projects presented baseline assessments that addressed both functions (SP5, 9), other sub-projects had a baseline assessment which did not provide a broader assessment of the geographic area surrounding the road project or justify the choice of target populations and geographic focus areas. ADB management raised this issue in the review mission of the sub-project, but the sub-project consultant provided no subsequent report addressing these issues. The description or mapping of the broader geographic area is a critical aspect of assessing the denominator of who exists and who will be targeted by the intervention.

An important implication of measuring changes in knowledge, attitudes, or behaviours, is that these data must be collected in a way that allows the results from an end-line

assessment to be compared directly to the baseline data. In practice, this entails conducting a quantitative survey with a systematic approach to sampling that can be repeated in both the baseline and end-line rounds of data collection. The design of such a survey can be complex given the mobile nature of the populations being targeted, and the different types of groups that are part of the intervention. These types of data collection activities are time consuming and resource intensive, and in several cases delayed the start of an already short field implementation period.

While it is comforting to have these types of quantitative data on behavioural outcomes, it may not be practical or cost effective to conduct these types of studies, in all sites of all HIV mitigation interventions. For example, in most countries, interventions for MARP take place in dozens or hundreds of sites, but a relatively small number of sites are selected for formal surveys to measure intervention outcomes. The majority of intervention sites rely on routine monitoring data to assess achievements, or alternative methods for obtaining behavioural data. The lack of survey data in most areas of a country also makes the reliance on national surveillance systems, as described in the DMF, inappropriate as measurement tools for assessing the impact of the sub-projects.

These types of surveys are particularly hard to conduct with mobile populations, such as truck drivers, or those with high levels of turnover. If the percentage of such populations covered is small compared to the total number passing through, it is unlikely that a single contact IEC based intervention will make an impact, much less for a survey to capture a sample that is likely to be able to measure this.

Routine monitoring systems were also difficult to assess for effectiveness. During the field mission, sub-projects appeared to use appropriately simple monitoring tools to track the numbers of people who were contacted or provided with services. However, the collation and analysis of these data appeared to be a weak area of most sub-projects. In particular, without clearly defined targets, projects are not able to assess whether they are making steady progress or how they need to adjust their activities. Discussion with deputy team leaders and programme officers of the consultant, as well as implementing agencies and outreach staff, suggest that a primary focus of the projects have been in engaging and training field teams to conduct activities, with less orientation toward whether the intervention is having the intended effect or whether the activities are conducted efficiently. Examples include, engaging large numbers of peer educators (~20 per village) to cover relatively small villages (~80 youth in a village); or sending teams of four outreach staff, instead of 1-2 staff, to conduct education sessions. In some cases, letting government implementing partners make these decisions may have been a purposeful decision to engage government ownership over service delivery. However, even in this case, using the routine monitoring data to help managers to identify these types of inefficiencies was not a priority of the project.

Part of the challenge of these types of multi-layered management structures is that not all routine monitoring data should flow to higher levels of management. For example, SP5 and SP9 maintained detailed quarterly reports of a longer list of indicators used for FHI management of local implementing agencies. Examples of these reports were shared with the team on the review mission. There was insufficient time to understand in detail how these detailed reports were used to guide local NGOs, though it is clear that data quality audits were conducted periodically to assess the accuracy of the data reported. However, the presentation of their routine monitoring data by the local NGOs suggests some confusion about how the indicators should be interpreted and what definitions should be used for counting individuals vs. contacts, or for assessing uptake of referrals. Certainly a culture of data collection was cultivated by these NGOs. The interpretation and use of these data were less in evidence.

2.6.4. Integrating lesson from M & E

- ***How well has learning from previous project monitoring and evaluation exercises been taken into account in implementing the project and its subprojects?***

To some extent sub-projects were encouraged to draw upon the experience in conducting assessments from earlier transport projects in the GMS portfolio. Although not entirely appropriate, indicators from during-construction projects implemented earlier were used for the DMF for post-construction projects in this RETA (these indicators were later adapted to be more appropriate for the type of populations targeted). However, issues related to defining denominators, setting targets, and establishing routine monitoring systems, remain.

3. Recommendations

Based on the assessment of the implementation of RETA 6467, this review provides recommendations for both more immediate next steps to make the last eighteen months of the project more effective as well as the form of future projects addressing HIV mitigation associated with large infrastructure projects.

3.1. Recommendations for the remainder of RETA implementation

3.1.1. Experience sharing between ongoing sub-projects

Through the course of implementation, teams can benefit from interacting with each other, sharing best practices and problem solving strategies for tackling specific problems. While ongoing communication and learning is ultimately up to the interest and level of effort of project implementation teams, this process can be facilitated in several, low cost ways:

- Circulating contact information of different levels of managers/partners engaged in implementation (such as international NGO teams,
- Organising periodic phone/video conferences to address specific topics raised by project teams
- Establishing an electronic bulletin board or listserv for teams to post questions/share ideas and products.
- At annual meetings, to organise fora which bring together partners from different sectors to come together to discuss
- Standardising summary sections of regular progress reports and posting them so other projects can see how other teams are progressing and what issues they have encountered in implementation.

Many of these strategies were initiated during the course of the RETA, but not all efforts to develop communication channels seemed successfully executed. Additional investment in this area may be valuable, in particular, this type of facilitation may be helpful for ongoing sub-projects under the RETA (such as SP6, 7, and 10). Additionally, some of the fora for sharing and problem solving can be broadened to other projects/partners who are implementing similar projects outside the RETA. Moderator responsibilities for some fora can be rotated to avoid creating a workload issue for a single project or manager.

Because the consultant for SP10, Burnet Institute, also implemented SP1, there should be many concrete, practical lessons learned that can be shared with the SP6 & 7 teams, even in the very early stages of planning and roll out. The upcoming GMS workshop in October (2011) will be another important opportunity for SP 6, 7, & 10 teams to meet with and learn from teams of completed sub-projects. Key topics to share experiences on may include:

1) Effective management team structures and field supervision/support schedules
2) Strategies in building IEC capacity among local implementation teams
3) Effective partnering with condom social marketing agencies
4) Costs and efficiency of service delivery strategies
5) Working effectively with government partners
6) Strategies for establishing and maintaining active cross border collaboration.

3.1.2. Clarifying management arrangements for SP 6 & 7.

At present the management and administration of sub-project 6 & 7 rests with AusAID representatives at the Cambodia and Laos in-country office because the financing is integrated into the respective loan projects. However, as sub-projects listed under the RETA, there needs to be greater clarity between ADB and AusAID as to the responsibility for monitoring the progress of the sub-projects 6 & 7, ensuring they are consistent with the intention of the RETA, and facilitating the learning between sub-projects. Written clarification and concurrence between AusAID and ADB as to the management roles and responsibilities should improve effectiveness and provide a clear communication/decision making structure to external partners such as government and consultants.

3.1.3. Integrating lessons learned into National AIDS Programmes

A key strategy for sustaining gains of the RETA is to integrate essential elements of the project into government programming. Examples of integration would include:

- Adoption of policies for establishing cross border collaboration, working with mobile populations, or addressing the impact of economic development on local communities into the national strategic plan of the national AIDS programme.
- Adoption of tools and protocols for elements of the interventions developed under the sub-projects as part of national programme guidelines (e.g. MOU templates for cross-border collaboration, referral system to increase STI clinic utilization, interpersonal communication techniques for peer education, mapping intervention areas, training curriculum for outreach, IEC, STI management, etc.)
- Expansion of sub-project activities to other geographic areas using government funds or through leveraging funding from other donors.

As the ongoing sub-projects span Vietnam, Laos, and Cambodia, there is a continued opportunity to have discussions with national AIDS programme partners to identify project elements that offer value and can extend the benefits of the project. These discussions may be facilitated by sub-project Consultants, as well as ADB project management staff when conducting review missions or attending meetings with stakeholders. Some funds may be needed to incentivize this process or to test or modify products to ready them for the adoption by the national programme.

3.1.4. Knowledge management

The focus of the last eighteen months of the RETA project period will be on consolidating lessons learned from the sub-project implementation. In particular, synthesising the lessons learned from across the sub-projects could provide important tools for guiding future design and implementation of projects aiming to mitigate HIV related harms associated with infrastructure development.

- Preparation of case studies to highlight specific elements of the sub-projects (in preparation)
- Development of guidance based on lessons learned, concrete descriptions of the model for programming, partnerships, capacity building, gender balance, sustainability, M&E (as outlined in subsequent recommendations below)
- Costing study of various components of the intervention to develop benchmarks for how future projects can be budgeted. As data are available, the costing study should examine the proportion of funds used for management, technical assistance, as opposed to service delivery, and to compare these costs to the types of outputs for different target populations (such as outreach coverage, service uptake, numbers of people trained.)

3.2. Developing models for future projects

Future mitigation projects may offer greater value to the response to HIV as well as operate more efficiently by incorporating a number of lessons learned from the implementation experience of the RETA. Many of these lessons, particularly those in designing the service delivery model, M&E systems, and enhancing sustainability and gender sensitivity are applicable to on-going sub-projects.

3.2.1. Scope of a mitigation project

- The stated objectives and subsequent design of the project must be consistent with the mitigation of HIV related risk associated with an infrastructure project as the primary impetus of the intervention. This constraint sets parameters for the target population and geographic areas where the intervention is implemented.

  The stated expected impact and outcome measures must be realistic given the scope and scale of the intervention. In many areas, the absolute number of new infections that are likely to occur in the absence of an intervention will be small, due to the low prevalence in these rural areas and the long time horizon over which sexually transmitted HIV epidemics develop. The objective of mitigating harms is to create conditions that intervene before harm is incurred and to develop sustainable mechanisms for communities to address on-going risk. Attempting to measure biological outcomes as a direct effect of interventions is not appropriate in this context.

- The justification for an intervention at all, as well as for specific populations, should be based on an assessed need.

  a. There is increased risk of HIV vulnerability related to the infrastructure development project – for example, due to the increased likelihood of people to be trafficked for sex work or for increased numbers of women to become sex workers due to larger numbers of male clients passing through the area. This justification must be further substantiated with the sizes of the populations affected/made vulnerable.

  AND

  b. The increased risk is not addressed by current prevention interventions and there is no plan for expansion of existing services to address the groups that are assessed to be most vulnerable.

  The pre-existing presence of entertainment workers/sex workers or mobile male populations (such as truckers or migrant labourers) in an area near an infrastructure project may warrant prevention interventions, but may not be the specific responsibility, which is to say not be an issue of mitigation, of the infrastructure project and may not be the most cost efficient or sustainable approach to preventing HIV transmission in the area.[8]

[8] Areas already known to be a hotspot for sex work (e.g. border areas with casinos), may see increased traffic related to ease of mobility afforded by new/refurbished roads, however, many of these areas should be prioritized areas under the national strategy rather than be the target of time-limited mitigation-related interventions. Identifying and documenting the presence of MARP (i.e. sex workers) and facilitating national HIV/AIDS programmes to expand coverage to address these populations can be a legitimate cost-effective approach in either mitigating harms associated with infrastructure projects or addressing identified prevention needs.

- Ultimately, the concept of mitigation extends to social/health harms besides HIV risk. An HIV mitigation intervention may be an opportunity to empower and build transferrable skills for affected communities to advocate for resources and organise mitigation efforts. In particular, communities can begin to address harms related to development projects that they perceive to be of highest priority or of greatest concern to their own members. Recognising this broader objective of an HIV mitigation project is key to sustainability and ensuring HIV programming contributes to the broader health and social services system.

- Where need is identified, an intervention can be planned with a variety of objectives depending on the phase of the intervention.

  a. ***Pre-construction project objectives*** **(**focusing on communities affected by the road):

     - Assessing and documenting the potential vulnerability of populations affected by the infrastructure development project (both HIV, trafficking, and other social/health harms; and those identified by technical experts as well as community members);

     - Identifying and developing sustainable organisational structures in local communities to respond to social/health harms (such as village councils, youth groups, local NGOs, women's union/youth union, provincial health officers, and so on);

     - Piloting sustainable IEC mechanisms and training local teams on content knowledge, communication techniques, sourcing information, advocacy, and so on;

     - Facilitating (inter-) government, private sector, and community relationships to address potential harms and collaborative planning in preparation for construction phase of the infrastructure project;

     - Delivering services focused on empowerment of women in sexual decision making (sexual activity, family planning, disease prevention) and having equal opportunities in economic development.

  b. During construction project objectives:

     - (If pre-construction interventions have not occurred, to take up objectives on building community infrastructure);

     - Continuing interventions focused on empowerment of women;

     - Implementing workplace interventions for construction worker;

     - Monitoring and documenting development/changes of geographic risk areas (related to sex work or drug use);

     - Transferring ownership and management responsibilities of implementation to local government and community structures identified in pre-construction phase.

c. Post-construction project objectives

- (If pre or during construction interventions have not occurred, to take up objectives on developing infrastructure, and interventions for empowerment of women)
- Continuing transfer of ownership and management responsibilities of implementation;
- Developing monitoring systems to track and document the shift in vulnerability and high risk populations and geographic areas as related to the completion of the infrastructure project (such as emergence of sex work hotspots or increase in drug availability/use/arrests, village reporting of human trafficking cases);
- Prioritising populations that are most vulnerable and tailoring intervention activities to address their on-going service needs.
- Developing sustainability plans for priority intervention activities, including integrating service delivery into larger national/provincial strategy for HIV prevention or health services; identifying sources of on-going funding, and so on.

3.2.2. Funding mechanisms

A critical aspect of continuing HIV mitigation interventions is developing funding mechanisms that facilitate the effectiveness of the project:

- Funding mechanisms should allow for a consultant to implement the intervention throughout all three phases: pre-, during, and post-construction of activity. Funding that comes out of a loan project can stipulate the funds which should be made available during the planning/preparation phase of the infrastructure project, with the remainder of funds disbursed during the construction phase. Potentially if sustainable local systems and ownership are built during pre- and during construction phases, the amount of money needed for the post-construction phase could be minimal (such as costs of local implementing agencies rather than international NGO). Continuation of the contract with consultants can be re-evaluated at different phases of the programming in the case of under-performance or changes in the assessed need of the affected communities. Different funding mechanisms, such as designated RETA or trust funds, may be required when interventions are implemented only in the post-construction phase;
- Funding for HIV mitigation projects must also be flexible to fit the schedule of the larger infrastructure project. For example, if there are delays in construction, HIV mitigation interventions during the construction periods must adjust their timelines accordingly, and be given flexibility in extending project timeframes, or anticipating staff loss or additional time needed to re-engage partners due to delays in construction;
- Funding allocations should be adjustable according to needs assessments conducted periodically. By definition, the HIV mitigation interventions take place in a context where the socio-economic context is changing and subsequently changes the risk environment. This requires flexibility in the intervention planning and funding. For example, needs assessments conducted periodically may identify that the risk profile has changed, or anticipated increases in vulnerability did not occur, or are being addressed by other interventions or contextual changes. In these situations, consultants should be incentivised and supported to

reprogram funding and intervention activities toward other community capacity development or mitigation of other related social/health harms.

3.2.3. Management structures

Roles in management between donor/co-financier, ADB (as management agency), consultant, sub-contractor, and government partners needs to be more streamlined. The budgets for these interventions are relatively small compared to the infrastructure projects themselves, yet warrant a disproportionate amount of management time and cost on the part of ADB. Some of these costs are related to the intensive financial administrative system used by ADB and cannot be reduced easily. However, some of the technical management burden could be relieved by:

1. Establishing clearer models for intervention in different phases of infrastructure projects and establishing corresponding standards in M&E. These will be particularly important to guide project managers who are not from the social/health sector.

2. Selecting international NGOs with experience in both delivering HIV prevention interventions for the specific target groups, strong government partnerships and country track records, and an orientation towards building capacity of government partners and local NGOs may obviate the need for intensive technical oversight by ADB staff/consultants and allow roll out to occur more quickly.

3. International NGOs should be encouraged to work with partners with existing experience working with local communities or government partners. These pre-existing relationships can help implementation run more smoothly, and anticipate what local resources and structures can be used to facilitate project activities. Capacity built among these local structures is also a critical aspect of sustainability and transferability to address ongoing or related social/health issues.

4. With more appropriate indicators and targets and more systematically presented M&E data, ADB managers may be able to spend less time assessing the performance of consultants and intervene when gross under performance is identified.

5. ADB supervision should start with reviewing the available monitoring and evaluation data submitted periodically. At present, progress reports are lengthy and do not succinctly summarise the core indicators or compare milestones against plans.

6. Review missions in the field focus on assessing managerial competence of the implementing agency (for example, does the manager have a good understanding of the field conditions, is the logic of the intervention clearly articulated and reflected in adjustments made to make activities more effective, are the staff clear in the project objectives and targets) rather than get involved in direct problem solving. Supervision checklists can be developed to assist field missions in being more systematic.

7. Consultant team leader positions were designated as half time, due to the cost of engaging international level staff, however, this led to gaps in leadership and unclear delegation of responsibilities to full time national deputy team leaders. Where team leaders oversaw multiple projects or was continually engaged in

country on similar activities funded by other donors, this gap in leadership was less apparent. An alternative approaches would be to have formal transition plans for national staff to develop capacity to take on team leader positions over the course of the project, such as using the pre-construction phase as a training period for national level deputy team leaders mentored by international level staff/team leaders, and transition team leadership responsibility to national staff over the during-construction phase, and so on.

3.2.4. Sustainability and cost effectiveness of intervention models

Sustainability is a guiding principle for designing the HIV prevention interventions that are implemented. Issues of sustainability have been raised in recommendations for defining the scope of the project, including the types of objectives appropriate for different phases of intervention. In general the design of HIV mitigation interventions should adopt best practices for what is known about the effectiveness of different types of interventions for different populations and epidemic settings. For example, structural interventions such as the 100 per cent condom use programme approach may be a more cost effective way to promote condom use than 1:1 or 1:group outreach to sex workers and male client populations.

3.2.5. Intervention models

Based on lessons learned from the projects implemented so far, an intervention model should be outlined that is appropriate for different target populations. The model should address appropriate interventions for entertainment workers, mobile and migrant men, and affected communities. For each population the model should address:

- The selection criteria – how to assess need for intervention and to prioritise the geographic areas and types of populations for intervention;
- The package of service – what type of services should be prioritised for different populations;
- Cost-efficient service delivery strategies – this areas should draw on best practices for interventions for MARPs and mobile male client populations in the region; this section should also discuss approaches for assessing needs and determining how existing services can be built on or extended to meet the needs of target populations, rather than starting up services. Teams should be encouraged to select service delivery strategies based on what is sustainable in the local context;
- Concrete examples of incorporating gender sensitive and balanced approaches into different aspects of service delivery;
- Examples of standardised indicators that can be used to measure effectiveness and efficiency and sample DMF.

The model developed can also address cross cutting issues such as advocacy, cross-border collaboration, monitoring and evaluation systems, and capacity building.

(See Annex 1 for detailed outline of guidance on components of HIV mitigation interventions associated with infrastructure projects.)

3.2.6. Monitoring & Evaluation

- Baseline assessments should include an aspect of mapping and documenting the presence of potential intervention population in different geographic areas and provide a sound rationale for the selection of target populations. These data should include estimated figures on size of different populations that establish the denominator for coverage indicators and inform the determination of targets; this type of assessment may need to be updated at least at the end-line, and potentially in the middle of a project period if substantial shifts in the target population are observed.
- It may not be necessary or cost effective to conduct quantitative formal surveys for all intervention sites. Other more efficient approaches to measuring changes in knowledge or women's empowerment should be explored, coupled with greater reliance on routine monitoring data to demonstrate progress or achievements.
- Indicators selected for the DMF should be standardised as much as possible, be explicitly defined, and have interim and end-line targets, accompanied by documentation on how targets were determined.
- To strengthen monitoring and evaluation systems a number of tools, based on lessons learned from completed projects, can be developed to guide future project teams and managers. These tools may include:
  - Designs for baseline assessments - including timeline, methods, sample data collection tools
  - Indicator selection – appendix menu of indicators for components of interventions for specific populations, as described above.
  - Target setting considerations – issue of defining denominators and documenting rationale for choice of targets, to consider interim as well as end-line targets.
  - Presentation of quarterly/biannual progress reports – examples of standard summary formats for DMF indicators, supplemented by narrative, formats that show progress over time.
  - Establishing benchmarks (such as unit costs for different activities, timeline for establishing infrastructure, and so on.)

  (See Annex 2 for examples of indicators and target setting rules for components of HIV mitigation interventions.)

Annex 1: Guidance on HIV mitigation interventions

The following is a detailed outline of what could be covered in guidance for mitigation interventions based on field experience of RETA 6467 and other similar projects managed by ADB. The guidance suggests what type of programming might be appropriate for different phases of mitigation activities, but presents the options as a menu from which components can be selected based on initial assessment of need. The outline is filled for the section for conducting baseline/end line assessments and entertainment worker interventions in the post-construction phase, as an example of the level of detail that might be included.

Overview of intervention components by phase and target population/activity area

Key areas of Intervention	Timeline		
	Pre-construction	During Construction	Post-construction
Assessment	Mapping of road communities + existing risk areas/ epidemiology	Updated mapping of road communities + risk areas	
Entertainment workers		Intervention in areas related to emergent/growing numbers of construction worker	Intervention in areas related to emergent/growing numbers of mobile client populations
Mobile male population/male client population		Workplace intervention for construction workers	Condom social marketing and entertainment establishment intervention
Affected communities	Capacity building, community organizing education & awareness for anti-trafficking and STI/HIV risk, gender empowerment about sexual & reproductive health. During post-construction, add peer education based outreach as needed.		
Advocacy & capacity building with local authorities/ NGOs	Awareness and capacity building for planning	Continued engagement of partners. Capacity building for management, implementation, and M&E	
Cross border collaboration	Individual governments to develop strategy for CBC and existing models/precedence	Initiate partnership, develop agenda for collaboration. Assessment of need and pilot joint work.	Institutionalize partnership. Ongoing projects. Expansion of agenda.
M&E	Develop DMF, with indicators/targets and routine monitoring tools for capacity building, advocacy, community resilience.	Develop DMF, with indicators/targets and routine monitoring tools for service delivery.	Ongoing collection, analysis and use of data. Integrate into national HIV/AIDS programme

I. Pre Construction Interventions
[To add details for each area of pre-construction interventions listed –
Assessment
Affected communities
Advocacy & capacity building with local authorities/NGOs
Cross border collaboration
M&E]

II. During Construction Interventions
[To add details for each area of pre-construction interventions listed –
Assessment
Entertainment workers
Mobile male populations/ male client populations
Affected communities
Advocacy & capacity building with local authorities/NGOs
Cross border collaboration
M&E]

III. Post Construction Interventions
[Example of more detailed description of what should be included in guidance on the intervention model]

Assessment
Mapping:
The objective of the mapping is to assess how the sex work situation is evolving as related to the completion of the road. Mapping should be conducted to document geographic locations where changes are observed and to characterize the types and approximate size of the sex work establishments/entertainment workers that are present in different areas. Important characteristics to note for specific risk populations include,

- Women who sell sex in different types of settings, general characteristics of age, nationality/place of "origin," linguistic & cultural differences.
- Male client populations in terms of patterns of mobility (local, frequently pass through, infrequently pass through, duration of stay) and types of establishments visited. Opportunities for structural interventions, such as workplaces, industry organizations, etc.

Mapping of affected communities in proximity of the infrastructure project should be updated to determine if new or increased interaction with the road has occurred after the completion of the project (e.g. new villages targeted for recruitment for migrant labour, villages near areas where sex work areas have increased which engage a new group of villagers as potential sex workers or increase the frequency of paying for sex among local male population.

Ideally, assessments of pre and/or during construction periods are available and provide evidence of how the sex work scene has evolved and what changes in the intervention model are needed.

An updated mapping of the intervention at the end of the project can be helpful to determine:

a. whether the social-economic dynamics of the area have stabilized or there continues to be change that should be monitored more frequently;
b. to help interpret the data from end line survey data in a context where the underlying characteristics of the target populations have changed.

Issues that may be identified through mapping that could affect the design of the post-construction intervention may be in terms of:

- Geographic areas prioritized for interventions
- Opportunities to engage structural approaches in the intervention
- The need to prioritize specific sub-groups which are perceived to be at greater risk
- Greater referrals to public sector clinical facilities for services such as STI management and HIV testing and counselling
- Increased cross border collaboration to provide services for an important migrant risk group

Surveys:

When the specific intervention areas and target populations have been determined, it may be necessary to conduct surveys of the target population to be able to assess changes in knowledge, attitudes, or behaviours that are the result of the intervention. These surveys are intended to provide quantitative evidence related to characterizing the population targeted and to assess baseline levels of knowledge, attitudes, or behaviours among those who are covered by the programme. It may not be necessary to conduct surveys for all populations in all areas. A more cost effective strategy may be to select specific areas where the expected outcomes can be measured through surveys, but to collect routine monitoring data to assess whether the outputs suggest that the intervention was implemented as planned.

[To add more about how to prioritize areas for surveys, based on the potential contribution of the risk population to the epidemic, the scale of the intervention/size of the population being covered, and the budget of the overall project.]

Interventions for different populations may change attitudes and behaviours to different degrees and may or may not diffuse effects into the broader population. These differences in expectations should influence the sampling design for the surveys used to evaluate the programme effectiveness. For example, in village settings, changes in attitudes about PLHIV, condom use, women's empowerment and sexual decision making may diffuse beyond people who are directly or more intensively involved in the intervention. For this reason, it may be appropriate to survey a broader set of villagers, to evaluate the effectiveness of the intervention. In contrast, peer education and outreach to mobile male populations may not be expected to effect a broader change in sexual norms and attitudes, so for these groups it may be more critical to survey a group of individuals who have actually been engaged in the intervention.

[To add more about sampling strategies for surveys of entertainment workers, mobile male populations, and affected communities.]

Entertainment workers

Selection criteria:
Assumes the area for the potential intervention has been mapped to identify the specific locations and approximate sizes of different risk groups in different areas. Even though an area had been selected for EW during construction interventions, the selection criteria should be applied before planning post-construction interventions, in case there are different circumstances, which may not warrant an entertainment worker intervention.

Mitigation need	Sex work area that has been established or increased significantly in size due to the proximity of infrastructure development. (Assumes the intervention is for during or post construction period. However, the documentation of the increase or establishment of sex worker areas may require pre-construction period assessment/mapping data.)
Epidemiologic	Size of the sex worker population (various typologies) is equal to or greater than other sex worker intervention areas prioritized by the government
Coordination with other interventions/ national programme	There are no other significant intervention efforts for sex workers in this area.

[To add more about how to coordinate with existing interventions. Cost efficient options to explore for adding on to areas that may need additional intervention:

- ***Purposeful decision that additional coverage is not necessary***
- ***Agreement by intervention partner (based on assessment data/evidence gathered), to integrate additional EW into current intervention.***
- ***Addition of funds to existing intervention partner to provide services to more EW. Co-financing mechanism may need to be negotiated with other donor and government partners.***
- ***Addition of funds to existing intervention partner to enhance services to EW, e.g. funds for capacity building, material development, additional assessment, etc.]***

Package of services:

Outreach to EE owners	Engagement of entertainment establishment owners to promote condom use and increase condom availability
Peer education and outreach to EW	Peer educators should be assigned to specific geographic areas or establishments at a ratio of 1:20 up to 1:50, depending on capacity and skills of peer educators. 1:1 education sessions should include assessment of risk and referral to public sector STI or VCT services and individual counselling about risk reduction strategies. 1:group sessions should focus on interactive group problem solving around condom use or client negotiation, etc. Peer outreach standards should specify the ideal frequency of contact through 1:1 or 1: group session.
STI clinical services	Services at nearby public sector health systems should be promoted to EW. Health service providers should receive refresher training on anti-stigma and discrimination of EW with multiple sexual partners should be encouraged for
HIV testing	Should be promoted among EW at least every year. Public sector health systems should be promoted for EW.
Condom distribution	Where condom social marketing partnerships can be established, efforts should be made to promote purchase of SM condoms by clients and sex workers. When clients/EW in an area generally identify cost as an issue in not using condoms approaches to provide lower cost or subsidized, or even free condom distribution. Interventions must develop approaches for equitably distributing free condoms based on need and risk.
Local advocacy	Awareness of local authorities about the programme; Getting their support in allowing interventions to operate, for peer educators to work with getting harassed, To get their support in engaging in

Cost-efficient service delivery strategies:

To be cost efficient, entertainment worker interventions should:

- Incorporate structural elements (e.g. engaging owners of establishments in condom promotion/accessibility, and having government authorities to facilitate cooperation from owners; take advantage of condom social marketing efforts that make condoms available in non-traditional outlets, near sex venues.)
- Make use of public sector facilities for clinical services, especially if this is the norm in the country
- Be consistent with national programme guidelines, including the expected market share of socially marketed condoms vs. free distribution vs. other.

In the case, that national programme guidelines do not exist, where possible, infrastructure mitigation interventions should take advantage of tools and norms adopted by other large scale programmes, and participate in/support the process of developing national standards and guidelines.

Gender perspective in programming:

- Programmes should address attitude and behaviour change among male client populations and owners of sex work establishments, not only focus on behaviour change among female EW.
- Group sessions or engagement of opinion leaders/influential persons among the community of EW, male clients, and entertainment establishment owners

that create norms such that women/EW can negotiate condom use without fear of violence or verbal abuse

- Interventions that address general violence, sexual abuse, harassment, or false arrests against EW (e.g. work with local police or authorities, registering incidents or events, establishing mechanisms for redress for incidents of violence or harassment, facilitating problem solving sessions between EW and local police and authorities)
- Promotion and facilitation to help EW to make good decisions about their own health and wellbeing (providing information and education about maintaining good health, group sessions to discuss health concerns in the community, providing information about where to access health services, improving services at facilities where EW can be referred, etc.)
- Activities that prevent or mitigate sex trafficking (in the context of EW who practice sex work against their will or due to false debts incurred by other family members.
- Empowerment of EW to organize and advocate or make changes to unsafe, unfair practices in their work environment (helping EW to form a social network, assessing top priorities/concerns of the EW community, providing examples of how other EWs have addressed similar issues).

Sample indicators for measuring effectiveness:

Outcomes		Data sources/ Definitions	When to use this indicator
Risk behaviour	% of FSW who used condom at last sex with client	Baseline and end line survey of FSW/EW (among those who sold sex in the last month)	If survey of EW is feasible (I.e. project budget and #s of EW who regularly sell sex is large enough)
STI prevalence	% of FSW who have early syphilis OR % of FSW who currently have symptoms of STI	-- Baseline and end line survey of FSW/EW (among those who sold sex in the last month)	If survey is feasible and blood specimens are collected. Self-reported symptoms are a rough substitute if survey is only behavioural. And baseline level is sufficiently high.
Outputs			
Coverage	% of FSW/EW contacted by peer educator in the last month	Numerator: # of individuals contacted by peer educators in the month (routine monitoring) Denominator: estimated # of EW in the intervention area (mapping)	Relevant if peer education based outreach is a key component of intervention.
	% of entertainment establishment owners engaged in intervention	Numerator: # of EE owners engaged at a minimal level in intervention Denominator: estimated # of EE mapped in the intervention area	Relevant if engagement of EE owners is a key component of intervention.

	% of contacts to EW that were 1:1 in the quarter	Numerator: # of contacts made to EW in the quarter through 1:1 (routine monitoring) Denominator: Total # of contacts made to EW in the quarter / Average number of people in each group contact. (routine monitoring)	Relevant if peer education based outreach is a key component of intervention.
	% of condom "need" met by free distribution (in the quarter)	Numerator: # of free condoms distributed in the quarter (routine monitoring) Denominator: Estimated # of EW in the intervention areas (mapping) X # of paid sex acts per quarter per EW (survey data) X % of sex acts expected to be covered by free distribution. (plan)	Relevant if free condom distribution is a key component of intervention
	% of FSW/EW accessing STI services in the last quarter	Numerator: # of individual EW seeking services at STI clinic in the last quarter Denominator: estimated # of EW in the intervention area (Can also be collected through survey)	Relevant if EW are encouraged to do a quarterly STI check-up and STI uptake is a key component of intervention.
	% of FSW/EW accessing HIV testing in the last year	Numerator: # of EW accessing HIV testing in the last year (routine monitoring data) Denominator: estimated # of EW in the intervention area (mapping) (Can also be collected through survey)	Relevant if EW are referred for HIV testing on at least annual basis and referral is a key component of intervention.
Empowerment	% of EW who are aware of risk related to paid sex and feel able to protect themselves from HIV	Baseline and end line survey of FSW/EW (among those who sold sex in the last month)	If survey of EW is feasible (I.e. project budget and #s of EW who regularly sell sex is large enough)
	% of EW who are not able to use condoms as often as they would like because of violence, harassment, or losing clients	Baseline and end line survey of FSW/EW (among those who sold sex in the last month)	If survey of EW is feasible (I.e. project budget and #s of EW who regularly sell sex is large enough)
Efficiency	Ratio of peer educators to EW covered	Numerator: # of peer educators (routine monitoring) Denominator: # of individuals contacted through outreach in the last month (routine monitoring)	Relevant if peer education based outreach is a key component of the intervention

References for guidance on sex worker programming:

- M&E toolkit for sex worker programming (WHO-WPRO/SEARO)
- Baseline assessment CRIP (FHI)
- ***[To include examples from other sub-projects]***

[To fill in
Mobile male populations/ male client populations
Affected communities
Advocacy & capacity building with local authorities/NGOs
Cross border collaboration
M&E]

Annex 2: Examples of indicators and target setting rules

This annex provides an outline of how M&E guidance could be organized to help mitigation activities design simple, functional M&E systems that can help to manage the interventions more effectively. The document could be organized by giving detailed guidance about the types of indicators suitable for different components and different phases of mitigation activities. These indicators would be consistent with the indicators suggested in the intervention guidance (See Annex 1.) but provide more details about the definitions, approaches to target setting, and examples of data sources. These sections are followed on more specific guidance on designing surveys for different target populations and the data collection formats for collecting the routine monitoring data for different indicators. To support use of routine monitoring data to manage the interventions, examples of how these data can be analysed and presented in progress reports can also be given.

I. Indicators

Pre-Construction

Affected Communities:

Indicators, Definitions, Target Setting, Data sources

Capacity building:

Indicators, Definitions, Target Setting, Data sources

Cross border collaboration:

Indicators, Definitions, Target Setting, Data sources

During Construction

Entertainment workers:

Indicators, Definitions, Target Setting, Data sources

Mobile male Populations:

Indicators, Definitions, Target Setting, Data sources

Affected Communities:

Indicators, Definitions, Target Setting, Data sources

Capacity building:

Indicators, Definitions, Target Setting, Data sources

Cross border collaboration:

Post-Construction

Entertainment workers:

Indicators, Definitions, Target Setting, Data sources

Mobile male Populations:

Indicators, Definitions, Target Setting, Data sources

Affected Communities:

Indicators, Definitions, Target Setting, Data sources

Capacity building:

Indicators, Definitions, Target Setting, Data sources

Cross border collaboration:

Indicators, Definitions, Target Setting, Data sources

II. Data Sources

Surveys:

Sampling (by population – EW, MMP, affected communities)

Population definitions

Survey Instruments/Sample questions

Key issues in Analysis and interpretation (including trend analysis)

References/Examples from sub-projects

Routine Monitoring Data:

Data Collection formats – generic forms and samples from sub-projects

Outreach (1:1 and 1: group)

Clinical services

Capacity building

Analysis and presentation of routine monitoring data

Using data by local managers

Annex 3: Terms of reference

**RETA 6467 - HIV Prevention and Infrastructure:
Mitigating Risks in the Greater Mekong Sub-region
Joint AusAID-ADB Midterm Review**

A. Background

A Regional Technical Assistance (RETA 6467) project ('the project') for HIV Prevention and Infrastructure: Mitigating Risk in the Greater Mekong Sub-region (GMS) with the grant amount of AUD6 million was approved in June 2008. The project, funded by the Government of Australia, supports HIV prevention and mitigation programs in ADB-supported infrastructure projects during pre-construction, construction and post-construction phases in Cambodia, Lao PDR and Viet Nam. The overarching project supports a set of distinct subprojects on HIV prevention and mitigation associated with ADB-financed infrastructure projects in Cambodia, Lao PDR and Viet Nam. The project is expected to close in December 2012.

The project's outcome is a reduced incidence of HIV and other sexually-transmitted infections (STIs) in communities and population groups directly associated with ADB-financed infrastructure development. Key outputs include: (i) Leadership support and associated institutional policies for addressing HIV risks in the context of infrastructure development; (ii) Improved awareness of HIV, AIDS, and STI and of human trafficking in communities affected by ADB-financed infrastructure projects; (iii) Ready availability of HIV and STI prevention commodities (e.g., condoms) and associated social-marketing programs; (iv) Improved and expanded HIV and STI testing, treatment, and care services used by affected communities; (v) Improved capacity of local government units and partner institutions for HIV and STI monitoring with M&E indicators in project area; and (vi) Knowledge products and advocacy materials and events related to the benefits from and implementation mechanisms for HIV prevention in infrastructure projects.

B. Purpose of the Evaluation

The main objective of the evaluation is to provide appropriate recommendations based on a careful assessment of the implementation of the project, its components and various subprojects.

C. Scope of the Evaluation

The midterm review will look into:

(i) Consistency, performance and efficiency:

- Is there evidence to indicate the cost-effectiveness of HIV prevention and mitigation activities associated with infrastructure projects in the GMS?
- Are subproject interventions consistent with the overall project objectives?
- Are the interventions based on sound technical analysis and continuous learning?
- Are financial and human resources being used efficiently?
- Has the project design (as subprojects sitting under an overall regional project) provided for optimal use of time and resources? Recognising the limited time before the overall project ends, are there alternative structures that would represent better value for money?

(ii) Relevance:

- Is there evidence to indicate the need for HIV prevention and mitigation activities associated with infrastructure projects in the GMS?
- Are the interventions effectively targeted at the most appropriate groups?
- Are the interventions relevant to GMS government and other development partner programs and priorities?
- Has the project been responsive to any relevant changes in the development context?
- What changes, if any, are required in the project to ensure it continues to be relevant?

(iii) Effectiveness:

- Is the project on track to achieve its objectives, as set out in the Design and Monitoring Framework? Given this, what has been the impact of individual subprojects on the progress of the overall project? Have project interventions produced negative changes directly or indirectly? What are some specific examples of adverse impacts, if any?

(iv) Sustainability:

- Have the subprojects been appropriately addressing sustainability so that the benefits of the activity will continue after funding has ceased?
- Do beneficiaries of the project, and/or in-country partners, have sufficient ownership, -capacity and resources to maintain the project benefits after the project has concluded?
- What actions could be taken now, if any, to increase the project's sustainability?
- What options are there for ensuring lessons learned through the project are relevant after the project has concluded? In this regard, what role might there be for the remaining components of the project focused on knowledge products and outreach?

(v) Gender equality:

- Are the subprojects advancing gender equality and promoting more equal access to the subproject's benefits for women?
- Is the project helping develop capacity in implementing partners and communities to understand and promote gender equality?

(vi) Monitoring and evaluation:

- Is the overall project monitoring and evaluation system, and the individual subproject monitoring and evaluation systems, effectively measuring progress towards meeting objectives?
- How well has learning from previous project monitoring and evaluation exercises been taken into account in implementing the project and its subprojects?

Taking into account lessons learned, the midterm review is expected to provide recommendations on:

(i) Institutional arrangements in implementing the project;

(ii) Sustaining the gains from the project;

(iii) Knowledge sharing;

(iv) Critical concerns for the remaining period of project implementation;

(v) Mobilization of additional resources, including use of ADB's operational resources, co-financing opportunities with AusAID and other development partners, if further development partner resources are judged necessary.

(vi) Future policy and implementation implications for mitigating the impact of infrastructure projects on HIV vulnerability and risk.

D. Reporting requirements

The review will produce a final report of not more than 30 pages (not including annexes), addressing each of the questions addressed above, and providing recommendations on the above six points and others identified during the review.

The report will contain a 2-page Executive Summary targeted at senior officials and other key stakeholders. The Executive Summary should be comprehensible as a standalone document.

A concise summary (not more than 4 pages) of qualitative and quantitative information on key results to date of the RETA and its individual subprojects should be annexed to the report. Where possible, this should be drafted in non-technical language.

As a further annex to the comprehensive mid-term review report, the Team Leader will also complete an AusAID Quality at Implementation report (template and guidance to be supplied by AusAID)

The Team Leader shall have final responsibility in preparing the report, with each member of the team contributing to writing sections of the report. A draft of the report will be shared with the team members for comment before being circulated within AusAID and ADB, then to key stakeholders, before being finalized and disseminated. ADB and AusAID will publish a joint management response to recommendations made in the review report.

E. Organization of the Review

Principles

The review will be conducted in a participatory manner and ensure involvement of stakeholders and partners as appropriate, with transparent proceedings and reporting, and dissemination of the findings and recommendations.

Approach

The review will include:

(i) A desk-based component, with key sources being project and subproject progress reports, to be supplied by ADB

(ii) A field component involving visits to subproject sites, with schedule to be determined by ADB

Methodology

The review methodology will be developed by the team leader, in consultation with other members of the review team, including ADB and AusAID. This methodology will be finalized before the review begins.

F. Review Team

The members of the review team will be as follows:

1. Virginia Loo, Team Leader
2. Shireen Lateef, Gender Advisor, ADB
3. Emiko Masaki, Project Officer, RETA 6467, ADB
4. Chris Lyttleton, Project Technical Advisor (consultant)
5. Robyn Biti, HIV Advisor, AusAID
6. Fiona Mcalister, Policy Officer, Effectiveness and Program Performance, AusAID
7. Roger Nixon, Policy and Program Officer, HIV and Health, AusAID

Regional workshop:

The 4th GMS HIV and Infrastructure workshop scheduled in October will be used as a dissemination venue for the MTR findings.

G. Source of Financing for the Mid-Term Review

AusAID will cover the costs of the Team Leader (to be recruited), and the project will fund the cost of a Technical Advisor (Chris Lyttleton) to conduct the review.

H. Qualification of the Team Leader

The Team Leader will have substantive managerial experience in conducting reviews and evaluations of similar magnitude, preferably with multilateral development banks such as ADB and the World Bank. Health sector expertise would be strongly preferred, and experience working on multi-country projects would be an asset. Together, the evaluation team, comprised of the Team Leader, a RETA Technical Advisor, AusAID experts, and ADB project officers. A Review Team should be multi-disciplinary and gender-balanced, and possess experience/experience in the following areas:

- HIV/AIDS policy theories and implementation theories;
- HIV/AIDS issues in the Greater Mekong Subregion (epidemiology and socio-economic impacts);
- International development cooperation (implementation of Three Ones and Paris Declaration Principles);
- Knowledge of methods related to integrating and mainstreaming cross-cutting issues and their application to HIV/AIDS in low prevalent countries (e.g., gender and human rights);
- Substantive experience in management for results and cost-benefit analysis; and
- Dynamics of regional/sub-regional political bodies and country mechanisms (national AIDS coordinating bodies)

I. Terms of Reference of the Team Leader

The Team Leader will be responsible for the overall MTR evaluation and for the preparation for the MTR report. The Team Leader's specific tasks include:

(i) Review all the project reports, documents, IEC materials, and gather relevant qualitative and quantitative data for the MTR evaluation.

(ii) Together with the MTR team, conduct review and prepare a MTR report meeting the scope and requirements set out in Section C above.

(iii) Conduct the MTR mission as a MTR team leader, including field visits to the project sites, interviews with key stakeholders and project beneficiaries.

(iv) Review and evaluate the quantitative performance indicators included in the project design and monitoring framework (DMF) or log frame.

(v) Prepare a draft MTR report (including the annexes and executive summary, as set out above) for review and comments by MTR team, ADB, and AusAID

(vi) Finalize the MTR report incorporating comments received as appropriate.

The Team Leader will be engaged for 32 person days on an intermittent basis from 22 June 2011 to 15 September 2011.

J. Schedule

Timeframe	Activity	Responsible
23 – 31 May	Finalize Mission Itinerary Finalize composition of MTR Team	ADB/AusAID
31 May - 3 June	Send letter informing the implementing partners (national and provincial authorities) and contractors, as the case may be, about the MTR, and requesting government clearance.	ADB
6 -14 June	Firm-up local logistics arrangement/budget for inland travel	ADB
22 June	Consultant-Team Leader on board	AusAID
30 June	Reference documents sent to members of the review team	ADB
8 July	MTR Design and Work plan submitted by Consultant-Team Leader	Team Leader
8 July	Distribution of MTR Design or Work plan to the rest of the MTR Team	ADB/ AusAID
11 July	Comments on the Work plan by MTR team members sent to Consultant	AusAID/ADB
15 July	Revised Work plan sent to MTR Team	AusAID/ADB
20 July	Telecon among the MTR Team, if needed	ADB

23-24 July	Travel time to Siem Reap, Cambodia	
25 July – 4 Aug	Field Review	
8-12 Aug	Preparation of the draft MTR report by the Team	Team Leader
	ADB begins work on draft Dissemination Plan	ADB
22 Aug	Draft MTR Report submitted by Team Leader and circulated to all MTR Team Members (to be reviewed for consistency with TORs, factual accuracy, overall content)	Team Leader
2 Sept	Comments on the Draft MTR from Team Members sent to Team Leader	AusAID/ADB
9 Sept	Final Report submitted by Team Leader to ADB and AusAID	AusAID/ADB
10-30 Sept	ADB begins work on Management Response, agrees Dissemination Plan with AusAID, before finalizing both for internal approval and dissemination of report and management response, as appropriate.	ADB
3rd wk Oct	4th Workshop on HIV Prevention and the Infrastructure Sector in the GMS	ADB

Annex 4: Mission itinerary

First leg: Cambodia Road Improvement Project/Northwest Provincial Road Improvement Project

Time	Activity	Venue/Location	Contact
24 July 2011 (Sunday)			
PM PG 907 BKK-Siem Reap 17:00 -18:10	Travel to Siem Reap Brief MTR Team Meeting (depending on arrival time of the team) Overnight stay in Siem Reap	Hotel: Victoria Angkor Resort Tel: (855) 63 760 428 Ext: 8351 Fax: (855) 63 760 350	Ms. Caroline Francis Dr. Tep Navuth 012 774 797
25 July 2011 (Monday)			
8:00 – 10:30 am	Travel from Siem Reap to Poipet		Dr. Tep Navuth 012 774 797 navuth@fhi.org.kh
10:30 – 11:30 am	Project Briefing on CRIP/NRIP and meeting with Banteay Meanchey Provincial AIDS Secretariat (PAS)	Provincial Health Department, Banteay Meanchey	Dr. Sin Eap: 012 953 244 sineap06@yahoo.com
11:30 – 1:00	Lunch in Sisophon, BMC	TBD	Dr. Tep Navuth 012 774 797
1:00 –2:00 pm	Travel to Poipet and check in	Hotel Holiday Palace	Dr. Uch Thuok 012 777 884
2:00 – 3:00 pm	Meeting with NGOs (SEADO and BIG-C)	SEADO Office, Poipet	Dr. Tep Navuth 012 774 797
3:00 – 5:00 pm	Field Activities at and near Poipet:	TBD	Dr. Tep Navuth 012 774 797
	Overnight in Poipet, Banteay Meanchey	Hotel Holiday Palace	Dr. Tep Navuth 012 774 797
26 July 2011 (Tuesday)			
8:00 – 10:00 am	Travel to Samraong, Oddar Meanchey		Dr. Tep Navuth 012 774 797
10:30 – 11:30 am	Meeting with PHD/PAS Samraong, Oddar Meanchey	Provincial Health Department (OMC)	Dr. Kham Samphos: 012 499 192 paoomc@yahoo.com
11:30 am –1:00 pm	Check in and Lunch	Chh Brakorb Hotel	Dr. Tep Navuth 012 774 797
1:30 – 2:30 pm	Meeting with WOMEN	Women Field Office	Dr. Tep Navuth 012 774 797
3:00 – 5:00 pm	Outreach Activity	TBD	Dr. Tep Navuth 012 774 797
7:00 – 8:00 pm	Dinner		
9:00 – 10:0 0pm	Outreach Activity (Night)	TBD	Dr. Tep Navuth 012 774 797
	Overnight in Samraong		

Time	Activity	Venue/Location	Contact
27July 2011 (Wednesday)			
7:00am	Travel to Siem Reap (by road)		
11:15am – 12:00pm K6 102	Flight from Siem Reap to Phnom Penh		
12:00 – 1:30 pm	Airport to Hotel/Check-in/Lunch	Hotel: Himawari Hotel	Tel: (855) 23 214555 Fax: (855) 23 217111
2:00 – 3:00 pm	Debriefing with FHI	FHI Office No. 1, Street 302 Boeung Keng Kang I, Chamkarmon, Phnom Penh, Cambodia	Dr. Tep Navuth 012 774 797
3:30 – 5:00 pm	Meeting with NAA	NAA office No 16, St271 corner 150, Sankat Toek Laak II, Khan Toul Kork, Phnom Penh, Cambodia	Dr. Teng Kuthy 855 23 885279 Mobile: 855 12 456956 kunthy@yahoo.com Dr. Ros Seilavath Mobile: 012 518 393 seilavathmd@yahoo.com
5:30 – 6:30 pm	Debriefing with the ADB Country Director	Cambodia Resident Mission Asian Development Bank 29 Suramarit Blvd. (St. 268), Phnom Penh Tel: + 855 23 216 417 Ext 224, Fax: + 855 23 215 807	Sovathavy Hel Operations Assistant Cambodia Resident Mission Tel: + 855 23 216 417 Ext 224, Fax: + 855 23 215 807 Email: shel.contractor@adb.org
	Overnight in Phnom Penh	Hotel: Himawari Hotel	Tel: (855) 23 214555 Fax: (855) 23 217111

Second leg: Phnom Penh - Ho Chi Minh Highway

Time	Activity	Venue/Location	Contact
28 July 2011 (Thursday)			
8:00 am	Depart Phnom Penh	16 seater van	
10:30 – 11:30 am	Visit to a project area of PADEK (Partnership for the Development of Kampuchea)	Kraing Svay Commune Preah Sdach District Prey Veng Province	Kong Villa Project Officer, Cambodia 855 97251 4444 kongvilla@gmail.com Le Ngoc Hai Deputy Team Leader Email: lehai52@gmail.com Phone: (84 66) 381 5999 Mobile: 84 903 734 573
12:00 – 1:00 pm	LUNCH		
2:00 – 3:00 pm	Meeting with Svay Rieng Provincial AIDS Secretariat (PAS) Dr. Pen Sona, Director Provincial Health Department and PAS Chief	Provincial Health Department, Svay Rieng	Kong Villa Project Officer, Cambodia
3:00 – 4:00 pm	Travel to Bavet		Le Ngoc Hai Deputy Team Leader
	Overnight in Bavet	Las Vegas Sun Hotel	Mai Thi Kim Hoang Program Officer, Viet Nam
29 July 2011 (Friday)			
9:00 – 10:00 am	Crossing MocBai Gate Activity at the border gate	Watching SP 8 short film thru SP 8 TV/DVD players run by Health Quarantine Unit	Mai Thi Kim Hoang Program Officer, Viet Nam kimhoangagg@gmail.com Phone: 84 903 734 573 Mobile: 84 907 845 691 Le Ngoc Hai Deputy Team Leader
10: 00 – 11:00 am	Meeting with Tay Ninh PHD and Women's Union at Border Gate Facility	4 participants from Tay Ninh Provincial Health Dept. 1 participant from Tay Ninh Women's Union	Mai Thi Kim Hoang Program Officer, Viet Nam Le Ngoc Hai Deputy Team Leader
11:00 – 1:00 pm	Travel to HCMC	16 seater van	Mai Thi Kim Hoang Program Officer, Viet Nam
	Overnight in HCMC	Caravelle Hotel	Tel: (848) 3823 4999; Fax: (848) 3824 3999

3rd leg: Northern Economic Corridor (Lao PDR)

Time	Activity	Venue/Location	Contact
30 July 2011 (Saturday)			
AM/PM VN840 SGN-VTE 15:00 – 18:00	Travel from HCMC to Vientiane (direct flight if available or via BKK)		
	Overnight in Vientiane	Hotel: Lao Plaza Hotel	Tel: (856) 21 218800; Fax: (856) 21 218808
31 July 2011 (Sunday)			
AM/PM	Team Meeting Aide Memoire Preparation		
1 August 2011 (Monday)			
8:30 – 9:00	Meeting with Mr. Pascal Steiner, UNAIDS Country Coordinator, Lao PDR	CHAS Office Km 3, Thadeua Road, Sisattanak District, Vientiane, Lao PDR	Dr. Niramonh Chanlivong Tel (856 21) 250 853 Fax (856 21) 250 854 Email: niramonh@burnet.edu.au
9:00 – 10:00am	Meeting with CHAS	CHAS Office Km 3, Thadeua Road, Sisattanak District, Vientiane, Lao PDR	Dr. Chansy Phimphachanh Director, Center for HIV/AIDS/STI (CHAS) Tel: 856 21 315500 / 856 21 354014 Mobile: 856 20 551 8282 Email: Gfachas.chansy@gmail.com
12.30 – 1.30 pm Fly to Luang Namtha QV 601	Travel Vte -Namtha Meeting with Mr. Somlith Senvanpan Deputy Director Provincial Health Department and Mr. Air Keomitda Acting Head Disease Control Division Provincial Committee on the Control of AIDS (PCCA)	Provincial Health Department Luang Namtha Province	Mr. Somlith Senvanpan Tel: 856 86 312037 / 312287 Mobile: 856 20 55686055 Fax: 856 86 211 978 / 312037 senvanpan@yahoo.com Mr. Air Keomitda Tel: 856 86 211978 Mobile: 856 20 56645149 Fax: 856 86 21 1978
Travel to Namtha district	Meeting with Ms Monekham, PWT member, who provides STI treatment	Namtha District Hospital near the Luang Namtha Airport	Mr. Somlith Senvanpan Tel: 856 86 312037 / 312287 Mobile: 856 20 55686055 Fax: 856 86 211 978 / 312037
	Sleep at Luang Namtha	Thoulasith guesthouse	

Time	Activity	Venue/Location	Contact
2 August 2011 (Tuesday)			
Morning - TBD	Travel to Nam Ngeun /Vieng Poukha, meet with the village leader	Village meeting hall	
Mid-morning – TBD	Visit to Nam Ngeun village: time with village youth (peer educators)	Village meeting hall	
	Lunch		
Afternoon - TBD	Visit to Viengphoukha coal mine company - meeting with coal mine manager and staff	Coal mine company	
Mid-afternoon	Travel to Bokeo (Ton Pherng)	TBD	
Evening	Sleep at Casino Area	Keopaseuth guesthouse (Tonpheng Casino) Mobile: 020 554 84345 OR Chaluensak guesthouse (Tonpheng Casino) Mobile: 554 74 872	This can be decided when the team sees the guesthouses. There should be rooms available.
3 August 2011 (Wednesday)			
8.00am-9.00 am	Travel from Ton Perng to Houayxai		
9:00am - 9:30 am	Meeting with Dr Khamphaya, Head of the Bokeo Health Department	Bokeo Health Department	Dr. Khampaya Mobile: 856 20 557 83666 khampagn@yahoo.com
-11:00am	Meeting with PCCA/DCCA, head of the Provincial/District Hospital, representative from the Core Provincial Working Team (PWT), representative from the District Youth Union	Bokeo Health Department	
2:00 pm	Land travel to Chiang Rai		
4:20 – 5:00 pm	Check-in	Hotel: Le Meridien Chiang Rai	Tel: (66) 53 603 333 Fax: (66) 53 603 330
5:00-6:00 pm	Team Meeting Aide Memoire Preparation		
4 August 2011 (Thursday)			
AM	Aide Memoire Preparation Wrap-up Meeting		
PM	Return flight		

Annex 5: List of persons met

CAMBODIA

National Government Agencies

H.E. Teng Kunthy, Secretary General, National AIDS Authority (NAA)
Dr. Ros Seilavath, Deputy Director, NAA
Mr. Sokeheng Song, Assistant to the Secretary General, NAA

Provincial Government

Dr. Chum Vanarith, Deputy Governor, Banteay Meanchey
Dr. Eap Sin, Manager, Provincial AIDS Office, Banteay Meanchey
Ms. Le Changsavath, Deputy Director, PUD, Banteay Meanchey
Dr. Kham Samphos, Chief of Technical Bureau, Provincial Health Department, Oddar Meanchey
Mr. Seng Sanylan, Deputy Director, Provincial Health Department, Oddar Mencheay
Dr. Pen Sona, Director, Provincial Health Department, Svay Rieng
Dr. Ung Soeung Kang, Deputy Director, Provincial Health Department, Svay Rieng

Local NGO Partners

Mr. Kong Sammang, Executive Director, Social, Environment, Agricultural Devt. Org'n (SEADO)
Ma. Sameath, Deputy Coordinator, Border Issue Group for Children (BIG-C)
Chea Sarith, President, Women Organization for Modern Economic and Nursing (WOMEN)
Ony Savannara, staff, WOMEN
Nhek Sophy, Program Manager, WOMEN
Nhem Chantha, Project Officer, WOMEN
Bo Raksa, Staff, WOMEN-CRIP
Chhith Phaly, Staff, WOMEN-CRIP
Phuok Vichith, Staff, WOMEN-CRIP
Chhoy Sam Eth, Project Officer, WOMEN-NRIP
Bun Sarann, Staff, WOMEN-NRIP
Kem Rithy, Staff, WOMEN-NRIP
Ouy Sovanara, Staff, WOMEN-NRIP
Ly Sopheary, Staff, WOMEN-NRIP
Sok Sokunthea, Program Support Officer, Partnership for the Devt of Kampuchea (PADEK)
Kuth Sophea, Commune Development Facilitator, PADEK
Yous Chheng, Chief Resource Officer, PADEK, Prey Veng
Cong Kin, Health focal person, PADEK, Prey Veng
Sab Linh, Agriculture focal person, PADEK, Prey Veng
Dim Leu, Fisheries focal person
Lea Chantha, Village Vice-Leader
Poy Meng, Health support, PADEK
Sam Phorn, Village leader
Warwick Miles, Advisor, SEADO and WOMEN

Subproject Team – FHI Cambodia

Caroline Francis, Team Leader for CRIP/NRIP, Family Health International (FHI)
Tep Navuth, Deputy Team Leader for CRIP/NRIP, FHI
Em Malea, Technical Program Officer, FHI
Uch Thuok, Project Officer, FHI
Kong Neath, Technical Program Officer, FHI

Family Health International (FHI) Cambodia
Peter Cowley, Director, FHI-Cambodia
Steve Penfold, FHI-Cambodia

VIETNAM

National Government Agencies
Dr. Chu Quoc An, Deputy Director General, Vietnam Administration for AIDS Control (VAAC)

Provincial Government
Dr. Nguyen Van Cuong, Deputy Director, Tay Ninh Provincial Health Department
Dr. Tran Phuoc Doan, Director, International Health Quarantine Unit, Moc Bai, Tay Ninh
Ms. Nguyen Phu Hoai Dung, Secretary, HIV/AIDS, Tay Ninh Provincial People's Cmtt.
Ms. Le Thi Doi, Women's Union, Tay Ninh

Subproject Team, World Vision Australia (WVA)
Le Hai Ngoc, former Deputy Team Leader, Subproject 8
Mai Thi Kim Hoang, former Project Officer for Vietnam, Subproject 8

LAO PDR

National Government Agencies
Dr. Chansy Phimphachanh, Director, Center for HIV/AIDS and STIs (CHAS), Lao PDR
Dr. Beuang Vang Vanh, Project Coordinator, CHAS

Provincial Government
Mr. Somlith Senvanpan, Deputy Director, Prov'l Health Department, Luang Namtha Province
Mr. Air Keomitda, Head, Secretariat of the Provincial Committee for the Control of HIV/AIDS (PCCA), Luang Namtha Province
Dr. Nuanta Si Bone Meuang, Deputy Director, Namtha District Hospital, Luang Namtha Province
Dr. Huth Phanh, Namtha District Hospital, Luang Namtha Province
Mr. Khome Sone, Namtha District Hospital, Luang Namtha Province
Mr. Somsanith Chanthakam, Namtha District Hospital, Luang Namtha Province
Nang Mon Kham Chanhadala, Namtha District Hospital, Luang Namtha Province
Nang Sing Phon, Namtha District Hospital, Luang Namtha Province
Nang Koe on Keo, Namtha District Hospital, Luang Namtha Province
Nang Kham Kheuang, Namtha District Hospital, Luang Namtha Province
Dr. Novchanh Visouthiphania, Deputy Director, Bokeo Provincial Health Department
Mr. Ounla Meunphonh, Member, Bokeo Project Working Team
Ms. Pakaythip Keokangpheng, Member, Bokeo Project Working Team
Ms. Khammanh Silipanya, Member, Bokeo Project Working Team
Mr. Kittiphoun Somphanith, Member, Bokeo Project Working Team
Ms. Aksone Keomuhavong, Member, Bokeo Project Working Team
Ms. Southaphone Phiouphasok, Member, Bokeo Project Working Team

Subproject staff – Burnet Institute
Ms. Niramonh Chanlivong, former Deputy Team Leader

Private sector partners and volunteers

Mr. Boon Ya Wong, Head Public Relations Department, Viengphoukha Coal Mine LTD
Mr. Noubane Panethachack, Community Development Staff and peer educator, VPK Coal Mine
Mr. Vandy, Peer Education Leader, Nam Nguen Village, Viengphoukha

Donor Agencies

Pascal Steiner, Country Coordinator, UNAIDS, Lao PDR

Annex 6: List of documents reviewed

Overall Project Documents

Regional Technical Assistance Report. Project # 41363. HIV prevention and infrastructure: Mitigating Risk in the Greater Mekong Subregion. May 2008.
Aus AID Progress Report and Appendices. July-December 2008.
2nd AusAID Progress Report and Appendices. January-June 2009.
3rd AusAID Progress Report and Appendices. July-December 2009.
4th AusAID Progress Report and Appendices. January-June 2010.
5th AusAID Progress Report and Appendices. July-December 2010.

Gender
Final Report (by M. Wegelin)
Gender Action Plan and monitoring indicators
Gender Updates Jun 2011

M&E
Design and Monitoring Framework (DMF) overall RETA and sub-projects
Original overarching RETA DMF
Revised Overarching DMF

Knowledge Dissemination
Summary proceedings 3rd GMS Workshop 18 Oct 2010.
Summary Proceedings MOU workshop – Final 7-8 Apr 2011.
Transport Forum presentation (R. Elfving)
MPWT La PDR Final (E. Masaki)
Transport Forum 2010 (F. Torneiri)

Subproject 1

Mission Reports

SP1 Informal Review Technical Notes 13 Jan 2009
SP1 Post Mission Technical Note 13 Jan 2009.
SP1 Review Aide Memoire 31 Mar to 3 Apr 2009.
SP1 Review Aide Memoire 8-16 Nov 2009.
SP1 Review Aide Memoire 27 Sep to 1 Oct 2010.

Consultant Reports

Formatted Inception Report
Qualitative Baseline Assessment
Baseline Quantitative Survey Report
Implementation Report
MTA report
End-line Assessment Report
SP1 2nd Quarter Progress Report
SP1 3rd Quarter Progress Report
SP1 4th Quarter Progress Report
SP1 5th Quarter Progress Report
SP1 6th Quarter Progress Report
SP1 7th Quarter Progress Report
SP1 Revised DMF
SP1 Achievements against DMF 10 June 2011

Presentations

3rd GMS Workshop Presentation
Programs for Route 3 Sep 2010
Strengthening Provincial and Local Capacities in Responding to HIV/AIDS Closing Workshop
End-line Assessment Findings
Project Overview
English translation mini booklet

Subproject 2

Mission Reports

SP2 Aide Memoire – Inception Mission. 4-8 May 2009.
SP1 Review Mission Technical Notes. 12-16 Oct 2009.
SP1 Review Aide Memoire 12-16 Oct 2009.
SP1 Field Notes. 5-6 July 2010.

Consultant Reports

Inception Report
Baseline Survey
Baseline Quantitative Survey Report
Implementation Report
Mid term report
Draft Final Report
SP2 2nd Quarter Progress Report
SP2 3rd Quarter Progress Report
SP2 6th Quarter Progress Report
SP2 7th Quarter Progress Report
SP2 DMF_20 Oct final version
SP2 DMF with accomplishments

Presentations

SP2 Introduction September 2010.
SP2 Closing Workshop March 2011.
SP2 Owen Wrigley presentation Closing Workshop Marh 2011.

IEC/Training Materials

Radio Drama – Return of Tingtong (Lao)
Radio Drama – Tingtong Melody (Lao)
DVD – Joined Patches of Life (Vie)
DVD – Love in the Modern Time (Vie)
DVD – Love Stories of the Mountain (Vie)

Subproject 3

Comparative Analysis of Risk Settings in Infrastructure Projects – Report. 2010.

Subproject 4

Comparative Analysis of Risk Settings in Infrastructure Projects Cross Border Transport Agreement Report. December 2008.

Subproject 5

Mission Reports

SP5 Review Aide Memoire 27-30 Apr 2009.
SP5 Review Aide Memoire 19-23 Oct 2009.
SP5 Review Review Mission Technical Note 19-23 Oct 2009.

SP5 Informal Review Consultant's Report 12-14 Jul 2010.
SP5 Review Aide Memoire 28 Feb- 4 Mar 2011.

Consultant's Report

Inception Report 8 May 2009.
Baseline Assessment Report 1 Sep 2009.
Implementation Bi-annual Report Mar-Nov 2009.
Midterm Report with the 3rd Bi-annual progress report Mar 2009-Sep 2010.
SP5 2nd Bi-annual progress report. Mar 2009-Mar 2010.
Status report of SP5 CRIP Jun 2011.
SP5 Revised DMF
SP5 Achievements against DMF 10 June 2011

Presentations

SP5 Pre & Post Construction Projects in Cambodia. Mar 2009 – Dec 2010.
SP5 CRIP Project Presentation (by SEADO) 28 Feb – 4 Mar 2011 review
SP5 Project Implementation CRIP & NRIP 28 Feb – 4 Mar 2011 review

IEC/Training Materials

ADB statement cards
'My Way' Referral Slip
'My Way' Drinking Safe Card
'My Way' Drinking Safe Facilitation Guide
Risk Assessment Guide 001
Risk Assessment Card
Service Directory
Volunteers' Shirts

Sub-contracts

WOMEN subgrant
SEADO subgrant

Subproject 8

Mission Reports

SP8 Review Aide Memoire Inception Mission 7 Jul 2009.
SP8 Review Aide Memoire 25-28 Jan 2010
SP8 Technical Note Review Mission 25-28 Jan 2010.
SP8 Consultants' Report Informal Review Mission 8-11 Jul 2010.
SP8 Review Aide Memoire 9-11 Feb 2011.

Consultant Reports

Inception Report Aug 2009.
1st Bi-annual progress report Jun-Nov 2009.
Baseline Survey Report May 2010.
SP8 Qualitative Research Report Jul 2010.
Implementation Report Sep 2010.
2nd Bi-annual progress report Dec 2009 – May 2010.
Midterm Report with the Bi-annual progress report Jun 2009-Dec 2010.
SP8 Demand Resarch Report
SP8 Revised DMF
SP8 DMF with final achievements 12 Jul 2011

Presentations

SP8 3rd GMS LAOS Presentation
SP8 GMS Workshop Safe Mobility in a cross-border setting
ME presentation SP8 end-line survey - final

Sub-contracts

Subcontracting agreement with PADEK
Subcontracting agreement with Women's Union

Subproject 9

Mission Reports

SP9 Review Aide Memoire Inception Mission 20 Jan – 2 Feb 2009.
SP9 Consultants' Report Informal Review Mission 12-14 Jul 2010.
SP9 Review Aide Memoire 28 Feb- 4 Mar 2011.

Consultant Reports

Inception and Implementation Report 16 Apr 2010.
Baseline Assessment Report 12 May 2010.
Midterm Report with the 1st Bi-annual progress report Nov 2009- May 2010.
Midterm Report with the 2nd Bi-annual progress report Nov 2009- Nov 2010.
Status report of SP9 CRIP Jun 2011.
SP9 Revised DMF
SP9 Achievements against DMF 10 June 2011

Presentations

SP9 Pre & Post Construction Projects in Cambodia. Mar 2009 – Dec 2010.
SP5 Project Implementation CRIP & NRIP (by WOMEN)

IEC/Training Materials

(See SP5 list)

Sub-contracts

WOMEN subgrant
Ministry of National Defense Scope of Work

Subproject 10

Indicative terms of reference for the pre-construction HIV prevention associated with the second northern GMS transport network.

HLSP Disclaimer

The Health Resource Facility (HRF) provides technical assistance and information to the Australian Government's Australian Agency for International Development (AusAID). The Health Resource Facility is an Australian Government, AusAID funded initiative managed by Mott MacDonald Limited trading as HLSP in association with International Development Support Services Pty Ltd (IDSS), an Aurecon Company.

This report was produced by the Health Resource Facility, and does not necessarily represent the views or the policy of AusAID or the Commonwealth of Australia.

This document has been prepared for the titled project or named part thereof and should not be relied upon or used for any other project without an independent check being carried out as to its suitability and prior written authority of HLSP being obtained. HLSP accepts no responsibility or liability for the consequences of this document being used for a purpose other than the purposes for which it was commissioned. Any person other than the Commonwealth of Australia, its employees, agents and contractors using or relying on the document for such other purpose agrees, and will by such use or reliance be taken to confirm his agreement, to indemnify HLSP for all loss or damage resulting therefrom. HLSP accepts no responsibility or liability for this document to any party other than to the agency and agency representatives or person by whom it was commissioned.