



Concept Paper

Project Number: 42179
August 2010

Greater Mekong Sub Region: Capacity Building for HIV/AIDS Prevention in Lao People's Democratic Republic and the Socialist Republic of Viet Nam

I. THE PROJECT

A. Rationale

1. The proposed Project focuses on HIV prevention and control among high risk populations along the Greater Mekong Subregion (GMS) transport and economic corridors (Northern, Central and East West Economic Corridors) in Lao People's Democratic Republic (PDR) and Viet Nam. The Project aims to mitigate HIV risks associated with improved connectivity resulting in increased mobility and migration. The project will strengthen provincial and district HIV prevention and control responses through improved knowledge of the epidemic, protocol, standards, accessibility and quality of health services (service packages) in the project areas specifically along the Viet Nam—Lao PDR transport and economic corridors and in conjunction with ADB's ongoing investments in the infrastructure and transport sector. Particular attention will be given to migrant populations, mobile and high risk populations along these corridors and cross-border towns. The basic project information is provided in Appendix 1.

2. Mobility, migration and transport connectivity are closely interrelated and are significant factors in the spread of HIV throughout the GMS. The development of transport and economic corridors in the GMS has led to improved physical connectivity and increased mobility and migration. Improved transport networks combined with large infrastructure projects such as the building of railways, ports, power stations, etc, has provided new economic opportunities attracting migrant workers, commercial retailers and entertainment industries to previously remote and rural communities. New patterns of internal and cross-border migration have emerged. Separation from families, boredom, and the lack of alternative entertainment opportunities, coupled with disposable income, encourage people on the move to engage in high-risk behaviors, such as unprotected sex, and alcohol and drug use. While these developments have brought new economic opportunities they have also created new risks especially, the spread of HIV. Local markets, ferries, road stops, construction sites, border crossings, ports and other economic hubs become “hot spots” of sexual entertainment and services. Wives of migrant workers and local communities living along the transport corridors, especially women are vulnerable and at risk, as they often lack the skills and knowledge to protect themselves from HIV infection.

3. According to the AIDS Commission for Asia¹ a focus on geographic ‘hot spots’ and high disease burden localities must be given priority when expanding coverage of HIV prevention activities. In the GMS, Lao PDR is considered as a low prevalence (0.2%) country but with a steadily growing HIV epidemic² with particular vulnerability in transport corridors and cross-border areas. Heterosexual transmission accounts for 87% of all new infections among mobile populations, farmers, laborers and women. About 79% of all registered HIV cases in Viet Nam are in the age group of 20-39 years and people living with HIV are getting younger. In Viet Nam the HIV prevalence is 0.53%³ and the virus is primarily driven through unprotected sex⁴. Epidemiological information indicates that the number of if HIV cases among men is as high as 75% meanwhile women carry 25% of the total number of HIV cases⁵. Although men outnumber women among the newly infected, this does not take into account that heterosexual transmission is on the increase, putting younger women and spouses of migrants at significant risk.

¹ Report of the Commission on AIDS in Asia-Redefining AIDS in Asia, March 2008

² Global Fund Proposal Round 8. July 2008.

³ UNAIDS. Second Independent Evaluation 2002-2008. January 2009.

⁴ While sexually transmitted HIV infections are more likely to be reported in the South and Central Viet Nam, IDU transmitted cases are more concentrated in the Northern provinces

⁵ ADB Joint Study Report. 2009. *HIV Transmission in Vietnam-Laos Border Areas*. Hanoi.

4. The proposed Project will contribute to reducing HIV infections among mobile, migrant and local populations. The Project will target ‘hot spots’, particularly along major transport routes and corridors⁶, in cross-border areas, and in regions with high seasonal and long-term population mobility. Investments in national preventive HIV services and surveillance in one country will maximize benefits for these services in neighboring countries and at the same time create synergies between health, infrastructure and transport programs⁷. The Project is in line with Viet Nam’s National Strategy on HIV/AIDS Prevention and Control (2004 – 2010) with a vision to 2020, and the objectives of the new Lao PDR’s National Strategy and Action Plan on HIV/STI (2011 – 2015).

5. ADB’s GMS and HIV Strategy⁸ recognizes that the GMS program and priorities with its focus on connectivity, competitiveness and community clearly intersects with some of the key risk factors and features of the HIV epidemic in the sub-region. Hence, the GMS HIV Strategy articulates that ADB has both an obligation to mitigate the HIV risks associated with transport and other infrastructure and an opportunity, to contribute strategically to the response to HIV and poverty in the sub-region. ADB’s Country Strategies and Programs for Lao PDR and Vietnam emphasize the need for continued support to communicable disease control including the containment and prevention of the spread of HIV in transport and economic corridors. A recent ADB study⁹ on HIV Transmission in Vietnam-Laos Border Areas recommended options to reinforce access and quality of HIV/STI services. While different countries in GMS present similar contexts, the specific nature of each transition station should be considered in the development of strategies and actions that help reduce vulnerability.

B. Impact, Outcome, and Outputs

6. The impact of the proposed Project will contribute to achieving the Millennium Development Goal (MDG) 6, Target 7: to have halted and begun to reverse the spread of HIV/AIDS by 2015 in Lao PDR and Viet Nam. The outcome will be reduced incidence of HIV transmission and prevalence of STIs, especially among high risk groups and mobile populations in and along the transport corridors. The draft design and monitoring framework is in Appendix 3. Subject to further dialogue on the design, the Project will deliver four specific outputs:

- Output 1 – strengthened surveillance systems (routine and laboratory surveillance) to improve overall epidemiological analysis in the Project border provinces, support HIV prevention programs, and reinforce cross-border collaboration with a focus on HIV/AIDS/STI with neighboring countries, regional networks and technical partners.
- Output 2 – enhanced delivery of complementary package of services including (i) strengthened provincial and district capacity through the development of training systems for planning and management of human resources and institutional capacity building for provincial systems; (ii) provision of laboratory testing and medical equipment for prevention; (iii) and strengthened linkages between facility-based and outreach services to reach at risk groups. Effective interventions in the area of prevention will be explored, scaled-up and or replicated. The role of the private sector will be explored in providing specific service inputs, wherever possible.

⁶ Quang Tri Quang Binh province is Viet Nam’s primary link with Lao PDR.

⁷ In 2002, ADB and United Nations Development Program developed the Strategy on Mobility and HIV Vulnerability Reduction in GMS⁷. The Project is in line with Viet Nam’s National AIDS Strategy 2020, the objectives of Lao PDR’s National Strategy and Action Plan on HIV/STI (2006-2010), and ADB’s Regional Cooperation Business Plan (RCOBP) for GMS (2009-2011). Communicable disease control including HIV/AIDS prevention has been identified as a regional public good by ADB’s Strategy 2020.

⁸ ADB. 2007. *HIV and the Greater Mekong Subregion, Strategic Directions and Opportunities*. Manila.

⁹ ADB. 2009. *HIV Transmission in Viet Nam-Laos Border Areas: Current Status and Solutions: Joint Study Report*. Manila.

- Output 3 – strengthened behavior change communications (BBC) to include both at-risk groups and mobile populations¹⁰ through strategies such as community-based awareness programs and peer education targeted at risk groups.¹¹ The output will complement ongoing BCC of the infrastructure and health sector.
- Output 4 – improved regional planning, coordination and implementation for managing HIV prevention. Establish support mechanisms to increase regional cooperation with a focus on HIV/AIDS/STI prevention in the project areas.

7. The Project will utilize lessons learned from the cross border collaborations and community-based interventions from the ongoing CDC 1¹² and JFPR 9006,¹³ which strengthened the integration of HIV/AIDS prevention, treatment and care. It will complement (i) the proposed CDC 2 with regard to supporting (national) surveillance, (ii) VIE- Loan: HIV/AIDS Prevention among Youth Project in Viet Nam in reducing risk behaviors among vulnerable young people, and (iii) RETA 6467 - HIV Prevention and Infrastructure Mitigation Risk in GMS and RETA 6321 Fighting HIV/AIDS in Asia and the Pacific. Details on each outcome will be further determined during the project preparatory assistance (TA).

C. Investment and Financing Plans

8. The indicative project investment cost is estimated at \$20.50 million. The Project was included in the GMS RCOBP (2010-2012) for \$20 million comprising (i) a loan of \$15 million for Viet Nam from ADB's Special Fund Resources and (ii) a grant of \$5 million for Lao PDR from ADB's Special Fund resources. The governments of Lao PDR and Viet Nam will allocate tentatively \$ 0.1and \$ 0.4 million respectively, for counterpart funds mainly to cover taxes and duties. The tentative financing plan is in Table 1.

Table 1: Tentative Financing Plan

Source	Amount (\$ million)	Share of Total (%)
		97.56%
Asian Development Bank	20.00	0.49%
Government Lao People's Democratic Republic	0.10	1.95%
Vietnam	0.40	
Total	20.50	100.00

Source: Asian Development Bank estimates.

¹⁰ According to ADB's study HIV Transmission in Vietnam Laos Border Areas (December 2009), mobile populations in the Vietnam-Lao PDR border have limited access to HIV care and antiretroviral (ARV) treatment services and therefore have limited knowledge and attitudes toward HIV prevention.

¹¹ Lessons learned from CDC 1 show that the gradual feminization of HIV suggests that the surveillance approach must be widened to prevent infection and provide testing and counseling to all sexually active men and women.

¹² ADB. 2005. *Report and Recommendation of the President to the Board of Directors: Proposed Grant Greater Mekong Subregion Regional Communicable Diseases Control Project (Cambodia, Lao People's Democratic Republic, and Viet Nam)*. Manila.

¹³ ADB. 2001. *Proposed Grant Assistance to the Kingdom of Cambodia, Lao People's Democratic Republic, and Socialist Republic of Viet Nam for Community Action for Preventing HIV/AIDS*. Manila.

D. Indicative Implementation Arrangements

9. The ministries of health (MOHs) in Lao PDR and Viet Nam will be the executing agencies (EAs). In Lao PDR, the Center for HIV/AIDS/STI (CHAS) and the Viet Nam Administration of HIV/AIDS Control will be the implementing agencies (IAs). The national project steering committee (PSC) composed of key stakeholders will provide guidance to ensure effective and timely implementation and supervise strategic planning and review. A project management unit (PMU) will be established under the respective IA and composed of at least 4 full-time staff including the project coordinator, experienced in the management of loan projects in the health sector with a focus on HIV/AIDS. The PMUs will be responsible for overall planning, administration, financing, procurement, and training activities, and for liaising between the provinces, MOH and ADB. The PMUs will be supported by national and international consultants with expertise in institutional capacity building, training, and behavior change communication. The provincial project management units (PPMUs) will be established in the project provinces to provide technical guidance, monitor implementation and coordinate with key stakeholders in the sector to synchronize activities which includes donor coordination for national and regional HIV prevention.

II. DUE DILIGENCE REQUIRED

10. Due diligence required under the project preparatory TA will include (i) assessment of economic and financial viability and sustainability of investment components; (ii) assessment of policy and legal, capacity and other institutional issues and mechanisms related to financial management, procurement, and anticorruption; (iii) preparation of a poverty, social, and gender analysis, and (iv) assessment of social safeguard issues including indigenous peoples and involuntary resettlement. The initial poverty and social analysis is in Appendix 4.

III. PROCESSING PLAN

A. Risk Categorization

11. The proposed Project is categorized as *low risk* because (i) the total loan and grant amount will be \$20 million (less than \$200 million); (ii) ADB has sound previous experience in the implementation of HIV/AIDS projects, and (iii) EAs have successfully implemented HIV/AIDS projects and gained experience in working with ADB. None of the safeguard categorizations are categorized as A.

B. Resource Requirements

12. A project preparatory TA is required to (i) prepare a comprehensive feasibility study on prevention and service delivery gaps and required investments to reach most at risk groups in the proposed project areas; (ii) determine cost-effective interventions; (iii) determine scope and detailed implementation arrangements for the national and regional level; (iv) preparation of the project administration manual; (v) conduct overall financial and economic analysis as well as any safeguard-related due diligence. The outline of TA requirements is in Appendix 5.

C. Processing Schedule

13. The major milestones up to loan effectiveness are listed in Table 2.

Table 2: Proposed Processing Schedule

Milestones	Expected Completion Date
Intradepartmental circulation of Concept note	11-16 March 2010
Departmental meeting	19 March 2010
Reconnaissance mission (VIE/LAO)	24 March- 2 April 2010
Peer review meeting	June 2010
VP concept clearance	August 2010
Start of project preparatory TA	October 2010
TA Draft final report	February 2011
Loan fact-finding mission	April 2011
Peer review	May
Staff review meeting	May
Loan negotiations	June
Loan approval	July
Loan signing	September

IV. KEY ISSUES

14. Most donors invest in HIV/AIDS care and treatment rather than prevention. Preventive services in the border areas are almost non-existent. Mechanisms for cross-border collaboration in terms of HIV program implementation need to be identified. The Viet Nam Administration for HIV/AIDS Control (VAAC) has requested loan proceeds to be utilized mainly for the procurement of medical and laboratory equipment. Prior to loan effectiveness, resources should be allocated to assist the EAs, IAs and project implementation units with project readiness and smooth start-up of the Project.

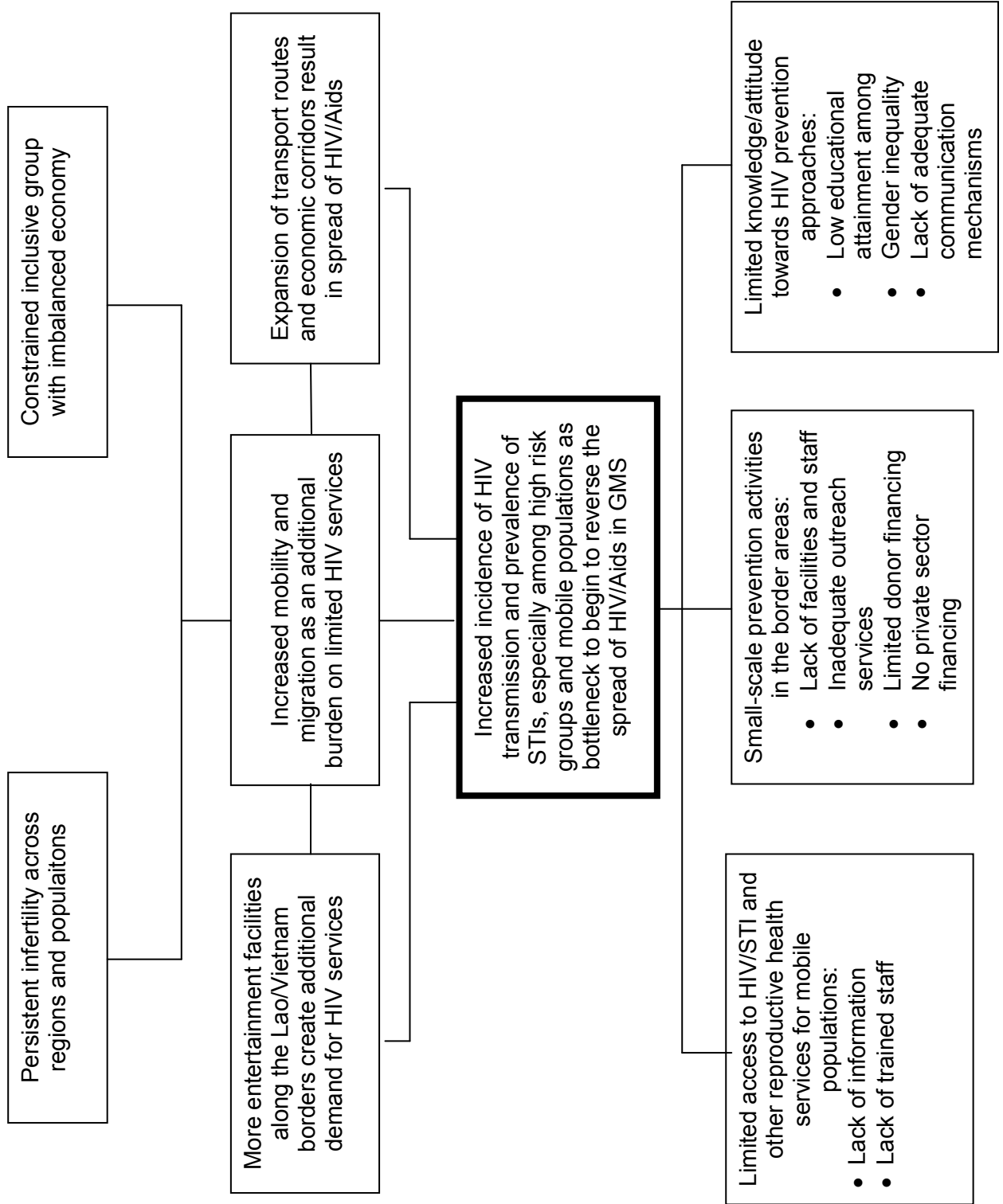
BASIC PROJECT INFORMATION

Aspects	Arrangements
Modality	Project Loan/Grant
Financing	ADF Loan: \$15 million equivalent ADF Grant ^a : \$5 million
COBP/RCOBP Classification	GMS Regional Cooperation Business Plan Sector: Health and Social Protection. Subsector: HIV/AIDS programs Themes: Social development; capacity development; gender equity Subthemes: human development, other vulnerable groups, institutional development, gender equity in empowerment Targeting classification: Millennium development goals (TI-I) Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS Location impact: The project will have rural (high), urban (high), national, and cross country impacts (medium). Safeguards: Category C for environment, resettlement and indigenous people
Risk categorization	The Project is considered as <i>low risk</i> .
Partnership(s)	The Project will complement investments and activities of the Global Fund for AIDS, TB and Malaria, PEPFAR,
Use of a PBA	n/a
Parallel PIU	n/a
Department and division	Southeast Asia Regional Department Social Sectors Division
Mission leader and members	Barbara Lochmann Indicative list of members: Emiko Masaki (Social Sector Economist, SESS) , V.de Wit (Lead Health Specialist, VRM), Rikard Elfving (HIV/AIDS Specialist, RSGS), Uzma Hoque (Gender Specialist, SESS), Hayman Win (Social Sector Specialist, LRM)

ADB = Asian Development Bank, ADF = Asian Development Fund, COBP = country operations business plan, PEPFAR = president's emergency plan for AIDS relief, PBA = programmatic based approach, PIU = project implementation unit, RCOBP = regional cooperation operations business plan.

^a An ADB member's eligibility for ADF grants under the revised grant framework is determined by its risk of debt distress. The latest debt sustainability analysis determined that Lao PDR had a high risk of debt distress and was therefore eligible to receive 100% of its ADF allocation as grants.

PROBLEM TREE



PRELIMINARY DESIGN AND MONITORING FRAMEWORK

Design Summary	Performance Targets and Indicators	Data Sources and Reporting Mechanisms	Assumptions and Risks
<p>Impact Contribute to achieving Millennium Development Goal (MDG) 6, target 7: halt and begin to reverse the spread of HIV/AIDS by 2015 in Greater Mekong Subregion (GMS)</p>	<p>Reduced HIV prevalence among Female Sex Workers (FSW), mobile populations and young people (15-24 years)</p> <p>Reduced prevalence of Sexually Transmitted Infection (STI) among men and women 15-49 years</p>	<p>Integrated Biological Behavioral Survey (IBBS), MOH</p> <p>United Nations General Assembly Special Session (UNGASS) country reports</p>	<p>Assumption Enabling policies and sustained financing for HIV/AIDS prevention and control by the Government and donor agencies</p>
<p>Outcome Reduced incidence of HIV transmission and prevalence of STIs, especially among mobile populations and high risk groups in the project areas</p>	<p>Percentage of condom use at last high-risk sex increased from ___% in 2012 to ___% by 2017</p> <p>Proportion of entertainment facilities with HIV policies and programs increased from baseline in 2011 to _ _ _ _</p>	<p>IBBS</p> <p>National and provincial annual HIV reports</p> <p>UNGASS country reports</p> <p>Project baseline and endline surveys</p>	<p>Assumption Government policies and budget will focus on evidence-based HIV/AIDS prevention and control interventions</p> <p>Risk Local governments may not honor their commitments to the creation of an enabling environment for HIV prevention and control for high risk groups</p>
<p>Outputs Output 1. Strengthened local surveillance systems for STI and HIV monitoring</p>	<p>Developed Monitoring and Evaluation (M&E) indicators used by provincial health authorities in standard M&E</p> <p>HIV and STI surveillance will include cross-border areas</p>	<p>National HIV surveillance reports</p> <p>Provincial health department's reports</p>	<p>Assumption Improved information system is used for better targeting of at risk groups and evidence based budgeting</p> <p>Risk Surveillance data are not analyzed</p>
<p>Output 2. Strengthened capacity of HIV/STI services to provide better access and quality services to high risk groups and mobile populations</p>	<p>Percentage of FSWs and mobile populations who had HIV testing increased from ___% in 2012 to--% in 2017</p> <p>Percentage of women and men with STIs are appropriately diagnosed and treated</p>	<p>HIV and STI sentinel surveillance</p>	<p>Assumption Districts provide STI and HIV related services</p>
<p>Output 3. Reduced HIV/AIDS infection risk behavior</p>	<p>Increased percentage of male and female workers who correctly identify ways of</p>	<p>IBBS</p> <p>Project-supported surveys to assess impact</p>	<p>Assumption</p>

Design Summary	Performance Targets and Indicators	Data Sources and Reporting Mechanisms	Assumptions and Risks
	preventing HIV transmissions Percentage of FSWs and young people are engaged as peer educators increased from ___% in 2012 to ___% in 2017		
Output 4. Enhanced capacity of HIV/AIDS/STI programs institutionalized in the project areas	Established mechanism for intra and inter country coordination, implementation, monitoring and evaluation	Project reports	Assumption Enabling legislation to reinforce inter country policy dialogue and program implementation
Activities with Milestones Output 1 : Strengthened Local Surveillance Systems 1.1. Revise current surveillance and response at the province/district level/ border areas 1.2. Identify new approaches for improving surveillance and response in project areas 1.3. Develop mechanisms to enhance local capacity to utilize surveillance data for evidence-based planning and budgeting Output 2: Strengthened Capacity of Services to Provide Better Access and Quality Services to High Risk Groups 2.1. Identify strategies (e.g. mobile services) to increase access to HIV Voluntary Counseling and Testing (VCT) and care and treatment for mobile population groups 2.2. Undertake needs assessment for medical and laboratory equipment for Sexually Transmitted Disease (STD) diagnosis and VCT in "underserved" areas 2.3. Conduct training needs assessment Output 3: Reduced HIV/AIDS Infection Risk Behavior 3.1. Develop strategies to expand peer education and mobile services to reach at risk groups in both countries 3.2. Prepare strategy to scale-up Information Education and Communication (IEC) for harm reduction Output 4: Enhanced Capacity for HIV/AIDS/STI Programs 4.1. Recruit consultants 4.2. Conduct baseline, midline and endline surveys and develop M&E framework 4.3. Conduct training needs assessment for project implementation units			Inputs ADB: ADF Loan: \$15 million equivalent ADF Grant: \$5 million RCIF: \$0.450 million TASF- IV: \$0.300 million Government counterpart funds: International and national consultants Equipment Private sector TBD Others

FSW = female sex workers; GMS = greater Mekong subregion; IBBS = integrated biological behavioral survey; IEC = information education communication; M&E = monitoring and evaluation; MDG = millennium development goals; MOH = ministry of health; STD = sexually transmitted disease; STI = sexually transmitted infection; UNGASS = united nations general assembly special session; VCT = voluntary counseling and testing

Shireen Lateef
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INITIAL POVERTY AND SOCIAL ANALYSIS

Country/Project Title:	Greater Mekong Subregion: Capacity Building for HIV/AIDS in Lao People's Democratic Republic and the Socialist Republic of Viet Nam		
Project Number:			
Month/Year	May 2010		
Lending/Financing Modality:	Project	Department/ Division:	SERD SESS

I. POVERTY ISSUES
<p>A. Links to the National Poverty Reduction Strategy and Country Partnership Strategy</p> <p>1. Based on the country poverty assessment, the country partnership strategy, and the sector analysis describe how the project would directly or indirectly contribute to poverty reduction and how it is linked to the poverty reduction strategy of the partner country. Progress toward poverty reduction has been achieved along the major transport routes including Northern, Central and East West corridors (Lao PDR and Viet Nam) corridors. However, the health status of populations in the border areas of these provinces lagged behind. While these corridors help increase connectivity and economic growth through trade and tourism, through transport corridors HIV/AIDS and communicable diseases are spread in GMS. The Project will help contain the spread of HIV/AIDS through strengthening information systems and STI/HIV services for mobile populations and at-risk groups in the border areas, which suffer from an increasingly higher burden of STI/HIV. The Project will focus its investments in border areas and along economic corridors where communities and mobile populations have little access to prevention and care.</p>
<p>B. Targeting Classification</p> <p>1. Select the targeting classification of the project:</p> <p><input type="checkbox"/> General Intervention</p> <p><input type="checkbox"/> Individual or Household (TI-H) <input type="checkbox"/> Geographic (TI-G) <input checked="" type="checkbox"/> Non-Income MDGs (TI-M1, M2, etc.)</p> <p>2. Explain the basis for the targeting classification: Interventions will focus on hot spots in urban and rural areas in the economic and transport corridors and border areas</p>
<p>C. Poverty Analysis</p> <p>1. If the project is classified as TI-H, or if it is policy-based, what type of poverty impact analysis is needed? N/A</p> <p>2. What resources are allocated to the project preparatory TA and due diligence? The team will comprise of a team leader and HIV/AIDS expert, community development, gender specialist, finance/procurement specialist and institutional development specialist.</p> <p>3. If GI, is there any opportunity for pro-poor design (e.g., social inclusion subcomponents, cross subsidy, pro-poor governance, and pro-poor growth)? N/A</p>
II. SOCIAL DEVELOPMENT ISSUES
<p>A. Initial Social Analysis</p> <p>Based on existing information:</p> <p>1. Who are the potential primary beneficiaries of the project? How do the poor and the socially excluded benefit from the project? The economic impact of HIV/AIDS on households is severe and the poor are particularly at risk both to the infection itself and to its economic effects. Migrant and mobile populations tend to be poorer since they are searching for economic opportunities. Hot spots are not necessarily among the poorest provinces, however, households recently rising out of poverty and are also at risk of HIV infection are often just above the poverty line.</p> <p>2. The provision of effective HIV services will be one focus including well targeted outreach for people engaged in high risk behaviors (FSWs, mobile populations etc) and those vulnerable to adopting high-risk behaviors, thereby increasing the likelihood of preventing infections and poverty.</p> <p>3. What are the potential needs of beneficiaries in relation to the proposed project. The provision and access to preventive services such as volunteer counseling in the project areas is challenging. Further details will be determined through the PPTA.</p> <p>4. What are the potential constraints in accessing the proposed benefits and services, and how will the project address them? Local appropriate approaches will be identified through the PPTA.</p>

B. Consultation and Participation			
1. Indicate the potential initial stakeholders. A stakeholder analysis will be conducted during the PPTA. Primary stakeholders include at-risk groups and young people, as well as the ministries of health as executing agencies, VAAC in Viet Nam and CHAS in Lao PDR.			
2. What type of consultation and participation (C&P) is required during the project preparatory TA or project processing (e.g., workshops, community mobilization, involvement of non-government organizations and community-based organizations, etc.)? Workshops, involvement of donor organizations including NGOs.			
3. What level of participation is envisaged for project design? <input type="checkbox"/> Information sharing <input checked="" type="checkbox"/> Consultation <input type="checkbox"/> Collaborative decision making <input checked="" type="checkbox"/> Empowerment			
4. Will a C&P plan be prepared? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Please explain.			
C. Gender and Development			
1. What are the key gender issues in the sector and sub-sector that are likely to be relevant to this project or program? Men account for more than 80% of the infection in Viet Nam. As more men become infected it is inevitable that the number of (non risk group) women (wives or girlfriends) infected will increase. Transport sector workers and truck drivers as well as FSW are spreading HIV. Further women living along the road side with limited information and little control over their reproductive health are most affected. In addition, returning male workers transmit HIV/AIDS to women. As more women migrate in search of better economic opportunities, trafficking of women and girls increases and thereby their vulnerability. General vulnerability of women to HIV infections is due to the lack of negotiating power over the use of condoms, which derives from a lack of economic power. Women's vulnerability to HIV is also strongly associated with gender-based violence and should be addressed in HIV programs.			
2. Does the proposed project or program have the potential to promote gender equality and/or women's empowerment by improving women's access to and use of opportunities, services, resources, assets, and participation in decision making? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Please explain. A gender action plan will be prepared during the project preparatory TA.			
3. Could the proposed project have an adverse impact on women and/or girls or widen gender inequality? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Please explain			
III. SOCIAL SAFEGUARD ISSUES AND OTHER SOCIAL RISKS			
Issue	Nature of Social Issue	Significant/Limited/ No Impact/Not Known	Plan or Other Action Required
Involuntary Resettlement		Type of investments require no resettlement	<input type="checkbox"/> Full Plan <input type="checkbox"/> Short Plan <input type="checkbox"/> Resettlement Framework <input checked="" type="checkbox"/> No Action <input type="checkbox"/> Uncertain
Indigenous Peoples		To be assessed during the PPTA	<input type="checkbox"/> Plan <input type="checkbox"/> Other Action <input type="checkbox"/> Indigenous Peoples Framework <input type="checkbox"/> No Action <input checked="" type="checkbox"/> Uncertain
Labor <input type="checkbox"/> Employment Opportunities <input type="checkbox"/> Labor Retrenchment <input type="checkbox"/> Core Labor Standards		n/a	<input type="checkbox"/> Plan <input type="checkbox"/> Other Action <input checked="" type="checkbox"/> No Action <input type="checkbox"/> Uncertain
Affordability		No revenue generating Services	<input type="checkbox"/> Action <input checked="" type="checkbox"/> No Action <input type="checkbox"/> Uncertain
Other Risks and/or Vulnerabilities <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Human Trafficking		Investigation on possible risks will be conducted during the PPTA	<input type="checkbox"/> Plan <input type="checkbox"/> Other Action

<input type="checkbox"/> Others (conflict, political instability, etc.), please specify			<input type="checkbox"/> No Action <input checked="" type="checkbox"/> Uncertain
IV. PROJECT PREPARATORY TECHNICAL ASSISTANCE/DUE DILIGENCE RESOURCE REQUIREMENT			
<p>1. Do the terms of reference for the project preparatory TA (or other due diligence) include poverty, social, and gender analysis and the relevant specialist(s)? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain why.</p> <p>2. Are resources (consultants, survey budget, and workshop) allocated for conducting poverty, social, and/or gender analysis, and C&P during the project preparatory TA or due diligence? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain why.</p>			

PROJECT PREPARATORY TECHNICAL ASSISTANCE

A. Justification

1. Based on a number of recent studies on HIV/AIDS in the economic corridors/ border areas, the TA will review studies and develop a Project suitable for ADB financing in terms of technical, financial, economic, institutional, sector policy, and safeguard contexts, in conjunction with the CPS, operational experience and lessons learned from previous health sector projects. The recommendations must complement and add value to existing programs currently being implemented in the region. The suggested interventions must be evidence-based and cost-effective based on the country and regional context.

B. Major Outputs and Activities

2. The TA will (i) prepare a situation and gaps analysis on HIV services and HIV communication/information programs for at risk groups and mobile populations in the 2 countries including border areas; (ii) identify cost-effective strategies for HIV prevention services; (iii) identify evidence-based HIV communication/information methods for reaching most at risk groups and mobile populations in cross-border areas in the two countries; (iii) determine the scope and feasibility of proposed investments in the area of capacity building, behavioral change and small-scale infrastructure and equipments; (iv) prepare cost estimates and financing plan; (iv) assess the financial and economic viability and sustainability, (v) prepare detailed implementation arrangements. Further, the TA will prepare the project administration manual that includes all the information and schedules describing the project implementation.

3. The major outputs and activities are summarized in Table A5.1.

Table A5.1: Summary of Major Outputs and Activities

Major Activities	Expected Completion Date	Major Outputs	Expected Completion Date
A. Inception			
1. Consultant mobilization	October 2010	Contract signed with firm	October 2010
2. Prepare detailed work Program	October 2010		
3. Stakeholder consultations	October 2010		
4. Inception work shop	November 2010		
5. Sector/gaps analysis	November 2010		
B. Midterm			
6. Goal oriented project planning with stakeholders to determine project scope	January 2011	Interim Report	February 2011
7. Determine detailed project outputs	February 2011		
8. Assess institutional constraints	February 2011		
9. Develop institutional capacity building	March 2011		
C. Final			
10. Prepare cost estimates and financing plan	March 2011	Draft final report	April 2011
11. Assess economic and financial viability and sustainability	March 2011		
12. Prepare IPSA, gender	April 2011		

Major Activities	Expected Completion Date	Major Outputs	Expected Completion Date
action plan etc			
13. Develop detailed implementation arrangements	April 2011	Draft final report	
14. Prepare PAM	May 2011	Final report and PAM	June 2011

C. Cost Estimate and Proposed Financing Arrangement

4. The TA is estimated to cost \$980,000 million of which \$750,000 will be financed on a grant basis by the Regional Cooperation and Integration Fund (RCIF), \$450,000 and TASF IV, \$300,000. The detailed cost estimate is in Table A5.2.

Table A5.2: Cost Estimates and Financing Plan
(\$'000)

Item	Total Cost
A. ADB Financing^a	
1. Consultants	
a. Remuneration and per diem	
i. International consultants ({19.5} person-months)	400.0
ii. National consultants ({27} person-months)	80.0
b. International and local travel	51.0
c. Reports and communications	15.0
2. Equipment (computer, printer, etc.) ^b	42.0
3. Workshops, training, seminars, and conferences ^c	
a. Facilitators	30.0
b. Training program	20.0
4. Vehicle ^d	28.0
5. Surveys	40.0
6. Miscellaneous administration and support costs	15.0
7. Representative for contract negotiations ^e	6.0
8. Contingencies	23.0
Subtotal (A)	750.0
B. Government Financing (Viet Nam + Lao PDR)	
1. Office accommodation and transport	100.0
2. Remuneration and per diem of counterpart staff	100.0
3. Contingencies	30.0
Subtotal (B)	230.0
Total	980.0

^a Financed by the Regional Cooperation and Integration Fund (\$450,000) and TASF IV (\$300,000).

^b Equipment

Type	Quantity	Cost
Desktop computer with software	4	\$ 16,000
Laptop computer with software	4	\$ 18,000
Laser colour printer	2	\$ 2,000
Photocopying machines	2	\$ 5,000
Set of office furniture (2 meeting tables with chairs, 8 work tables and chairs, 8 filing cabinets)	2	\$1,000
		Total \$ 42,000

^c Workshops, training, seminars, and conferences

Purpose	Venue
Inter-country workshops	TBD
Inception, mid-term and final workshop	Hanoi/Vientiane

^d Vehicle

Justify the use of and the need to purchase or lease a vehicle Expected length of use

Consultants will require to lease a vehicle for field visits and consultation meetings in 8 months the two countries.

^e In accordance with the project administration instructions on recruiting consulting firms for TA assignments, the user division, in consultation with COSO, will decide on the mode of negotiation. Negotiations are usually conducted by correspondence when the assignment budgets are equal to or less than \$600,000. ADB. Recruiting Consulting Firms for Technical Assistance Assignments. *Project Administration Instructions*. PAI 2.02D. Manila.

Source(s): Asian Development Bank

D. Consulting Services

5. Consultants will be engaged through a firm. The TA will require 19.5 person-months (pm) of international consulting services, and 27 pm of national consulting services. ADB will select and engage consultants in accordance with *ADB's Guidelines on the Use of Consultants* (April 2010 as amended from time to time). The quality-based selection (QBS) will be followed. The consultants may procure equipment through shopping in accordance with *ADB's Procurement Guidelines* (April 2010 as amended from time to time). Upon completion of the TA, equipment procured under the TA will be transferred to the implementing agencies (IAs).

Table A5.2: Summary of Consulting Services Requirement

International Name of Positions	Person-months	National Name of Positions	Person-months
HIV/AIDS Specialist/Team Leader	8	Public Health Specialist/Deputy Team Leader	8
Institutional development Specialist	2	Institutional Development Specialist	4
Behavior Change and Communications Specialist	4	Health Promotion Specialist	6
Social Development/Gender Specialist	2	Community Development/Gender Specialist	3
Health Economist	2	Finance Specialist	3
Procurement specialist	1.5	Procurement specialist	3

6. The outline terms of reference for the TA consultants are described in Paras. 7-10

7. The international HIV/AIDS specialist, team leader and deputy team leader will be a public health specialist with at least 10 years working experience on prevention, preferably in the Asian region, familiar with the AIDS Commission Report for Asia and GMS regional programs and responsible for (i) coordinating technical assistance activities with government counterparts and civil society representatives; (ii) oversee participatory planning workshops and assist in facilitation of all workshops and consultation meetings to define objectives, scope and methodologies for the proposed project; (iii) ensure adequate coordination between country coordinating mechanisms, technical committee and the TA team; (iv) timely preparation and submission of required progress reports and ensuring quality and completeness of progress reports, including the preparation of a detailed work plan; (v) preparing a detailed project proposal, including the design and monitoring framework, a monitoring and evaluation framework, with measurable indicators and a detailed project administration memorandum in order to ensure that the proposed project is ready for ADB and Government appraisal.

8. The international institutional development specialist will (i) determine the capacity of relevant public and private institutions including NGOs to plan, manage and finance interventions and propose strategies for the project areas; (ii) work with the team leader to identify suitable linkages between the public and private sector and recommend strategies to build or strengthen services and communications to reach high risk groups and mobile populations; (iii) recommend institutional levels where outreach and or mobile services to reach at risk groups/ mobile populations should be placed; (iv) assess willingness and ability of the private sector to support financing and management of interventions in the target areas; (v) prepare an institutional development plan for both public and private sector, including recommendations for capacity building to address needs of the target group through adequate services and communications, and (vi) prepare an implementation framework that defines roles of central and local government's institutions involved in the provision of HIV prevention, treatment, care and communications. The national institutional specialist will work in close cooperation with the international consultant.

9. The international social development and gender specialist will (i) prepare poverty and social analysis and strategy; (ii) gender action plan; (iii) participatory strategy and (iv) ethnic minority development plan.

10. The international health economist and the national finance specialists will (i) prepare the economic analysis; (ii) project costs and financing; (iii) calculation of disability adjusted life years; (iv) assess affordability and sustainability of interventions, and (v) prepare project financing, fund flow and disbursement mechanisms.

11. The international and national procurement specialists will (i) conduct the procurement assessment for medical and laboratory equipment; (ii) prepare the procurement plan including specific advance actions with funding sources, time frame and responsibilities and the (iii) PAM.

E. Implementation Arrangements

12. The ministries of health in Lao PDR and Viet Nam will be the EAs, VAAC and CHAS will be the IAs. The project management unit (PMU) in Lao will be established in the EA and in Viet Nam in the IA. The Governments will provide qualified counterpart staff, office administrative support services and logistics for the consultant team. The TA consultants will be based in VAAC, as lead coordinator, will provide an office accommodation. For the work in Lao PDR, the EA will provide office space for the consultants.

13. The proposed PPTA processing and implementation schedule is listed in Table 5.3

Table 5.3: Proposed Technical Assistance Processing and Implementation Schedule

Major Milestones	Expected Completion Date
TA inception	October 2010
Inception workshop	November 2010
Inception report	November 2010
Draft midterm report	January 2011
Midterm workshop	March 2011
Draft final report	May 2011
Final report	June 2011
TA financial closure	September 2011

Source: Asian Development Bank