

PROPOSED GRANT ASSISTANCE
(Financed from the Japan Fund for Poverty Reduction)

TO THE

KINGDOM OF CAMBODIA,

LAO PEOPLE'S DEMOCRATIC REPUBLIC,

AND

SOCIALIST REPUBLIC OF VIET NAM

FOR

COMMUNITY ACTION FOR PREVENTING HIV/AIDS

April 2001

ABBREVIATIONS

ADB	–	Asian Development Bank
AusAID	–	Australian Agency for International Development
CIDA	–	Canadian International Development Agency
EA	–	executing agency
HIV/AIDS	–	human immunodeficiency virus/acquired immunodeficiency syndrome
IA	–	implementing agency
JFPR	–	Japan Fund for Poverty Reduction
Lao PDR	–	Lao People's Democratic Republic
NGO	–	nongovernment organization
SOE	–	statement of expenditure
STI	–	sexually transmitted infection
TA	–	technical assistance

NOTES

In this report, "\$" refers to US dollars.

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I. INTRODUCTION

1. The Asian Development Bank (ADB) is financing health sector projects¹ in Cambodia, Viet Nam, and Lao People's Democratic Republic. These projects focus on strengthening infrastructure for primary health care and improving the quality of health services. The Community Action for Prevention of HIV/AIDS Project (the Project) will be implemented in the three countries in conjunction with these ongoing health projects. The Project will enhance the poverty reduction impact of the ADB health projects by reducing the incidence of HIV/AIDS,² a health condition that disproportionately affects the poor and pushes the nonpoor into poverty. The Fact-Finding Mission was fielded from 27 November to 6 December 2000. This report is based on the understanding reached with the three governments during the Mission, consultations held with nongovernment organizations (NGOs) and interested development agencies in workshops held in the three countries, and project preparatory work undertaken by staff consultants. The Government of Japan approved financing of the Project from the Japan Fund for Poverty Reduction (JFPR) on 18 October 2000. The Project Framework is available in Appendix 1.

II. BACKGROUND AND RATIONALE

2. HIV/AIDS infection is one of the major public health problems in Cambodia, Lao PDR, and Viet Nam. The HIV epidemic covers almost all provinces and population groups in these countries. The share of HIV/AIDS-related illnesses in the total burden of disease in the subregion is expected to triple in the next 20 years, unless stronger preventive measures are undertaken.

3. Cambodia has a population of 11 million, composed mostly of ethnic Khmer, who are involved in complex relationships with large populations of Thai and Vietnamese on either side of their country. The recent history of the country has been marked by civil war and only in the last few years has a fragile parliamentary democracy emerged at the level of the national Government. Cambodia has a severe, heterosexually transmitted, generalized³ HIV epidemic, driven by brothel-based commercial sex. Injecting drug use is rare. Over 3 percent of those in the sexually active population are infected. In 1999, aggregate HIV seroprevalence was 33 percent among brothel-based sex workers. Rates among sex workers in the hospitality industry are lower, at 19 percent. About 4.7 percent of policemen were infected. About 170,000 people in Cambodia were living with HIV/AIDS in 2000. Internal seasonal migration, external migration, and Vietnamese immigration play a major part in HIV vulnerability. Studies find strong links between HIV/AIDS and the employment-driven migration of construction workers, factory workers, both brothel-based and hospitality industry sex workers, seasonal agricultural workers, and traders.

4. The Lao PDR has a population of 5 million, about half are ethnic Lao and the others are from several ethnic minority groups. The five largest ethnic minorities—the Hmong, Katang, Khmu, Leu, and Phutai—number 1.5 million. The extent of HIV transmission in the Lao PDR is not yet known; a seroprevalence survey is being planned. However, several factors make the population vulnerable to HIV/AIDS. The country borders Cambodia, Myanmar, Thailand, Viet

¹ Loan 1447-CAM(SF): *Basic Health Services Project* for \$20 million, approved on 20 June 1996; Loan 1749-LAO(SF): *Primary Health Care Expansion Project* for \$20 million, approved on 24 August 2000; and Loan 1460-VIE(SF): *Population and Family Health Project*, for \$43 million, approved on 19 September 1996.

² HIV/AIDS = human immunodeficiency virus/acquired immunodeficiency syndrome.

³ A generalized HIV/AIDS epidemic refers to an epidemic in the general population as opposed to certain vulnerable groups.

Nam, and Yunnan province of the People's Republic of China, where HIV/AIDS prevalence rates are high. Seasonal migration to northeast Thailand and Bangkok is large; a significant proportion of migrants are sex workers. A recent ADB study⁴ identifies hospitality workers, transport workers, traders, construction workers, and migrant factory workers as vulnerable groups. As the Lao PDR becomes more economically integrated with neighboring countries, its vulnerability to HIV/AIDS will increase. Two major roads are planned to link the country to Yunnan province, Thailand, and Viet Nam. The construction of these roads will attract many migrant workers. After the construction is completed, the mobility of trucks and workers through the country will increase. Large dams for hydroelectricity are also planned and their construction will attract many construction workers. The country clearly faces a substantial challenge from HIV/AIDS.

5. Viet Nam, with a population of 77 million, has a Viet ethnic majority with over 10 million ethnic minority people in the Mekong Delta, Central Highlands, and Northern Uplands. The country has enjoyed over 20 years of internal peace under government by the Communist Party of Viet Nam. At present, Viet Nam has a concentrated HIV epidemic, mostly transmitted through the sharing of needles during injecting drug use. About 120,000 Vietnamese are infected with HIV; the number is likely to increase to 197,000 by 2005. The three major subepidemics are among (i) young male injecting drug users in the north; (ii) young and older men and young women sex workers in some large cities; and (iii) a few women who have practiced sex work in the south. Viet Nam does not have a generalized, heterosexually transmitted epidemic. HIV seroprevalence is high for injecting drug users including those who are also sex workers. Among women who practice street-based sex work and do not admit to injecting drug use, rates vary from 1 percent to 12 percent. Rates among sex workers in the hospitality industry are much lower. Military recruit applicants have prevalence rates of 0.41 percent, although some of them inject drugs. Informal internal migration is extensive, with Vietnamese sex workers and laborers working in both Cambodia and the Lao PDR, as well as in other Asian countries. Those with highest vulnerability are debt-bonded Vietnamese women from the lower Mekong Delta provinces who work in brothels in Phnom Penh and provincial towns in Cambodia. Other migrant workers on construction sites in Cambodia and the Lao PDR are also vulnerable.

6. The response to the HIV/AIDS epidemic in the three countries has been uneven. Although all three countries have established national and provincial organizational structures to develop a multisectoral strategy for HIV/AIDS, these organizations require further strengthening, especially at provincial and district levels. Viet Nam and the Lao PDR are still in the process of developing their surveillance systems. HIV testing facilities are available only in a few large cities. HIV prevention activities are being carried out in all three countries, but need to be mainstreamed into primary health care programs. Awareness about HIV is still low, especially among the poor and people living in remote areas. Perhaps the biggest constraint the HIV/AIDS programs face is the lack of financial resources. The annual per capita investment for HIV/AIDS prevention activities ranges from about \$.05 per capita in Viet Nam to \$.15 per capita in Cambodia, which is significantly lower than that required for an effective response; for example, Thailand invests about \$1 per capita annually in HIV/AIDS programs.

7. Although the histories, ethnic composition, political systems, stages of the epidemic, and national responses of the three countries differ, the high level of mobility within and among the three countries strongly justifies a regional response to HIV. Mobility continues to increase in response to greater economic integration and heterogeneity in economic opportunities. Due to the regional nature of the epidemic, national efforts are inadequate. The level of migration

⁴ Chantavanich, S., Beesey, A., and Paul S. 2000. *Mobility and HIV/AIDS in the Greater Mekong Subregion*. Manila: ADB.

between the three countries is high, involving sex workers, construction workers, and people from fishing communities. The migration increases vulnerability and risk, and is the major contributing factor for the spread of HIV/AIDS in the entire region. Prevention efforts are required at points of origin, along the migration routes, and at points of destination. Since these focal points are spread all over the region, national projects cannot comprehensively tackle the issue. Moreover, no direct incentives are available for one country to work on HIV/AIDS issues involving people from other countries. A regional approach is required to effectively address this issue.

8. The ADB-financed regional technical assistance (TA)⁵ Preventing HIV/AIDS among Mobile Populations studied mobility patterns and vulnerability related to mobility in the Greater Mekong Subregion. The study yielded the following key findings in the three countries:

- (i) Risk behaviors of mobile people and migrants are heavily influenced by the risk situations they are in. Some groups are very vulnerable to HIV infection because of their typical work situation, living conditions, and lack of social support in their daily lives. Examples are people in fishing communities, transport workers, sex and hospitality workers, police and military personnel, state officials, and some other groups of migrant workers.
- (ii) Areas where people are at high risk for HIV (referred to as hot spots) emerge from the convergence of mobile populations and the rise of a service industry for them. Many ports, truck stops, provincial towns, and some border crossing points fit the definition of a hot spot and most lack well-targeted HIV prevention activities.

9. This TA is being implemented by World Vision, an international NGO. One of the major TA outputs will be toolkits for organizing HIV/AIDS prevention activities for selected vulnerable groups. These toolkits are proposed to be used in the current Project.

10. HIV/AIDS infection is closely related to poverty. While HIV infection push individuals and households into poverty, widespread poverty and extreme income inequities favor the spread of AIDS. The poor are more likely to yield to the practice of high-risk behavior such as commercial sex work and IDU, they are also less likely to negotiate safer practices like condom use or take effective preventive measures like prompt and proper treatment of STIs. HIV/AIDS infection is an added burden for the poor, which can be avoided by early and effective prevention. Given the particularly high gender disparities in the region, heterosexual women are one of the most vulnerable groups. In general, women in the region—especially those living in rural areas or in marginalized communities, such as the ethnic minorities—have significantly lower literacy rates, lower rates of access to health care, lower access to information, and lower decision making power at the household level. Unequal gender relations mean women's relative inability to negotiate safe sex with their partners. Low social status of women ensures lack of attention to their health problems, including HIV infection, and their lower access to timely care. High rates of TB among rural women increase the chances of co-infection. The care burden, as is well-documented in Africa and increasingly in Asia, falls mostly on poor women, a group that ADB is concerned about.

11. Despite substantial support from international agencies, a significant financing gap exists for organizing effective HIV/AIDS prevention activities nationally and regionally. Several

⁵ TA 5881-REG: *Preventing HIV/AIDS among Mobile Populations in the Greater Mekong Subregion*, for \$800,000, approved on 16 December 1999. The TA is likely to be completed by 31 January 2002.

international agencies—including the Australian Agency for International Development (AusAID), Canadian International Development Agency (CIDA), German Agency for Technical Cooperation, United Nations agencies, and United States Agency for International Development—implement some regional activities for HIV/AIDS prevention. Most of these activities relate to situation analyses and capacity building of national HIV/AIDS programs. AusAID and CIDA are currently preparing their regional strategies and investment plans for HIV/AIDS prevention and care in Southeast Asia. While several agencies are supporting the capacity building and policy research aspects of HIV/AIDS control, little support is available for organizing actual preventive and control interventions.

III. THE JFPR PROJECT

A. Objectives

12. The goal of the Project is to reduce HIV transmission among mobile groups of people, migrants, and source and host communities in the three countries in order to decrease the impact of the HIV epidemic in the region. The Project will fund community-based activities in areas that send or receive a significant number of migrants and have a relatively high prevalence of HIV/AIDS. The Project's objectives are

- (i) to support a comprehensive set of HIV/AIDS prevention activities in strategically important areas (also referred to as hot spots) for the transmission of HIV in the region; and
- (ii) to strengthen the capacity of national and local HIV authorities and selected NGOs to develop community-based prevention and care programs.

13. While a few activities will be implemented nationally in the three countries, the Project will primarily support community-based HIV/AIDS prevention activities in selected provinces. The provinces have been selected on the basis of (i) HIV prevalence; (ii) poverty; (iii) presence of mobile people, migrants, and those vulnerable to HIV infection; and (iv) mobility links with the other project countries. Accordingly, the Project will cover the following areas (Appendix 2): (i) Cambodia: Battambang, Kho Kong, Prey Veng, Svay Rieng; (ii) Lao PDR: Khamoune, Oudomxay, Savannakhet; (iii) Viet Nam: An Giang, Dong Thap, Kien Giang, Lai Cau, and Quang Tri.

14. Within these provinces, the Project will focus on:

- (i) sites and areas that receive many transient mobile populations or long-term migrants,
- (ii) large construction sites, and
- (iii) source communities of migrants.

B. Scope

15. The Project will have three components

1. Community-Based HIV Prevention Activities

16. The Project will aim to provide a comprehensive set of activities that can effectively prevent the transmission of HIV/AIDS in the project area. Provincial AIDS authorities and offices

will be involved in planning and implementing all activities. The following community-based activities will be implemented:

- (i) behavior change communication activities for host communities and mobile populations,
- (ii) condom promotion using social marketing,
- (iii) care and management of sexually transmitted infection (STI).

17. **Behavior Change Communication.** Since a cure for HIV infection is unavailable, prevention is the most cost-effective strategy, even in countries with generalized epidemics such as Cambodia. The Project will work through communities to provide information about HIV prevention to mobile people, migrants, and their host communities to change social norms and behaviors to reduce vulnerability to HIV infection. In each country, the Project will: (i) identify high priority areas; (ii) develop a strategy specific to local needs in a participatory manner; (iii) organize community action; and (iv) continuously refine the strategy based on the experience, and modify the activities.

18. The Project will support communication programs aimed at the following groups: (i) hospitality service providers, such as beer girls, karaoke singers, and masseuses; (ii) brothel-based sex workers; (iii) freelance sex workers; (iv) mobile male populations such as construction workers, truck drivers, and seafarers; (v) men in uniform; and (vi) the general population. In some provinces, women employed in industries, such as garment and electronics, may also form a separate focus. Since these different groups have different communication needs and are linked with different communication channels, a distinct communication strategy will be required for each group. The Project will use existing channels and infrastructure to reach these groups. For example, usually health facilities are located near construction sites to provide basic and emergency health care to construction workers. These facilities will be strengthened through training, and provision of behavior change communication materials and condoms for distribution. Peer education will be used for hard-to-reach groups.

19. **Condom Promotion.** The Project will use social marketing to promote condom use. This process applies commercial marketing skills and techniques to the marketing of socially desirable products for the social good through nongovernment, for-profit channels. The social marketing of condoms will not replace the existing free distribution, but will be done in addition to it. The social marketing will (i) generate demand for condoms by using modern marketing techniques to raise brand awareness, and (ii) increase the availability of condoms through commercial channels such as grocery shops, pharmacies, tea shops, beer outlets, hotels, and restaurants. Transport hot spots and construction sites will receive special attention. Several forms of outlets for condom sales and free distribution will be developed in each community. As condom social marketing can only be effectively implemented through nongovernment channels, condom social marketing organizations will be contracted for this.

20. **Care and Management of Sexually Transmitted Infections.** Since early detection and treatment of STIs can substantially reduce the incidence of HIV transmission, the Project will support community-based activities to encourage symptomatic STI care. Facilities for STI diagnosis and treatment need strengthening in terms of provider skills and equipment. Also, demand must be strengthened and social barriers to using STI services reduced. The Project will build bridges between vulnerable communities and user-friendly STI care services and will strengthen health facilities providing these services. The Project will strengthen laboratory services, treatment facilities, and training of health workers.

21. The Project will give due attention to STI care for men. The diagnosis and treatment of STIs is relatively easy and effective and uses a syndromic approach. However, since men are reluctant to access public sector STI services, the Project will involve private pharmacies, and work with vulnerable groups such as police and military personnel to provide STI care. Although the development of public sector facilities is a priority, private-sector service delivery points will also be employed.

2. Capacity Building

22. The Project will support the following four capacity building activities:

- (i) development of models for AIDS care in Cambodia that can be adapted for use in the other two countries,
- (ii) support for behavioral sentinel surveillance for second generation HIV surveillance in all three countries,⁶
- (iii) training of teachers and other community workers on HIV/AIDS prevention and control, and
- (iv) advocacy with policymakers and facilitation of the learning of lessons from the Thailand experience.

23. The Project will support home-based AIDS care activities in Cambodia, which will act as models for regional sharing of ideas. Home care, community voluntary testing, and counseling will be emphasized. Limited institutional care will also be developed. These models will be useful for the Lao PDR and Viet Nam as they develop AIDS care models.

24. The Project will support behavioral sentinel surveillance or second-generation surveillance of HIV in all three countries in 2002 and 2003. Support will focus on collection, analysis, and dissemination of surveillance data. In addition, the Project will train about 5,000 teachers and 6,000 community workers in the project area on HIV/AIDS prevention and control. The training will be planned and carried out through NGOs. The Project will also support advocacy with policymakers about the need for investing in HIV/AIDS programs and will provide the opportunity to them to learn from the successful Thailand experience through a study tour.

3. Project Coordination and Monitoring

25. A team comprising an international consultant (based in Viet Nam or Cambodia) and three domestic consultants (one in each country) will support the implementation and monitoring of the Project. Outline terms of reference for the consultants are in Appendix 3. Some basic office equipment and an accountant will be provided to the executing agencies (EAs) in the three countries to support project implementation. A regional NGO will be engaged to undertake a baseline survey and a final survey to evaluate the impact of the Project.

26. The Project will be implemented over 30 months starting in June 2001 and ending in December 2003. An overview of the project activities and scheduling is in Appendix 4.

C. Costs and Financing

27. The Project is estimated to cost \$10 million equivalent. ADB will finance \$8 million equivalent on a grant basis from the JFPR, funded by the Government of Japan. The three

⁶ Behavioral surveillance, also called second generation surveillance, refers to a population-based assessment of knowledge, attitude, and behavior related to HIV risk factors.

governments through the ongoing health-projects will finance \$2 million equivalent for project management and infrastructure development. Appendix 5 provides an overview of the costs and financing.

D. Implementation Arrangements

1. Executing and Implementing Agencies

28. The ministries of health in Cambodia and the Lao PDR and the National Committee for Population and Family Planning in Viet Nam, will be the EAs for the Project. The National Center for HIV/AIDS, Dermatology, and Sexually Transmitted Diseases in Cambodia; the National Committee on Control of AIDS in the Lao PDR; and the AIDS Division of the Ministry of Health in Viet Nam, provincial AIDS agencies, and selected NGOs will be the Implementing Agencies (IAs); the first three will be the national IAs. Appendix 6 contains a schematic presentation of the relationship between the EAs and IAs in the three countries.

2. Community and NGO Involvement

29. The project design is predicated on intensive participation of stakeholders at three levels: institutional, community, and individual. At the institutional level, the Project will involve provincial and district authorities in planning and monitoring project implementation. This will ensure greater ownership and sustainability of project inputs. At the community level, the project interventions are to be implemented mainly by communities and NGOs. For the community-based HIV prevention activities component, the Project will use participatory approaches for community education, promotion of sexually transmitted disease screening and treatment among vulnerable groups, and implementation of safe blood practices. For the capacity building component, the Project will seek to strengthen the capacity of NGOs working on HIV/AIDS issues. The project monitoring and evaluation component will also be carried out by an NGO. At the individual level, the project interventions will engage vulnerable people themselves (such as sex workers, truck drivers, and police personnel) as peer educators to communicate messages about HIV/AIDS. This is important as several issues related to HIV/AIDS are best communicated at the individual level, especially to persons in vulnerable situations.

3. Fund Flows and Disbursement

30. Funds for country-level activities will be disbursed through the three EAs, which will maintain separate JFPR accounts. The accounts will be established with an advance payment provided by ADB. The amount of advance will depend upon the work plan developed by the EAs in consultation with related IAs. Each IA will also maintain a subaccount and will receive advances from the EA of the country based on a written agreement with the EA on the use of funds, reporting, and auditing. These advances to IAs will not exceed \$200,000 in the case of national IAs and \$100,000 for others. Statements of expenditure (SOEs) by IAs will be used by the EA to liquidate and replenish the advance. Any unused balance will be refunded to ADB before the close of the Project.

31. The use of the JFPR account and SOE should be audited annually, and a separate audit opinion on the use of the JFPR account and SOE should be included in the annual reports. All IAs will submit documentation supporting the expenditure to the EA, which will maintain records of all such documentation for ADB's verification. For the third component, funds will be channeled from ADB directly to the regional NGO and consultants.

4. Procurement and Consulting Services

32. Three international (45 person-months) and nine domestic consultants (144 person-months) will be recruited in accordance with ADB's *Guidelines on the Use of Consultants* and other arrangements satisfactory to ADB on the engagement of domestic consultants. The international consultants will be recruited by ADB, while the domestic consultants will be recruited by the EAs. Any procurement under the Project will be conducted by EAs in accordance with ADB's *Guidelines for Procurement*. NGOs to implement certain activities of the Project—such as social marketing, monitoring and evaluation, behavior change communication, and behavioral surveillance—will be selected and engaged by the EAs in accordance with arrangements satisfactory to ADB. In some cases (for example, social marketing of condoms), direct selection procedures may be applied. Direct selection may be justified in cases where one qualified agency is available to undertake a particular activity. However, prior to application of direct selection procedures, ADB's Central Operations Services Office and the concerned division will certify that all other sources of competitive expertise have been reviewed and found unsuitable.

5. Performance Monitoring Indicators

33. A list of objectively verifiable indicators was prepared to assess the impact of the Project (Appendix 7). A baseline survey at the start of the Project and a final survey after project completion will be used to assess changes in these indicators.

6. Reporting

34. The EAs will submit semiannual reports to ADB on physical and financial progress of the Project. The format of the reports will be agreed upon by the governments and ADB before the start of the Project. A detailed midterm review of the Project will take place after one and a half years of implementation; midcourse corrections will be made as required.

E. Impact Assessment

1. Education and Community Development

35. The HIV/AIDS epidemic in the region is a serious health problem and has important economic and social implications. Since young people and children are more likely to be infected by HIV/AIDS, the loss of human capital and earnings potential are staggering. A recent study shows that widespread poverty and unequal distribution of income stimulate the spread of HIV. Driven by despair and due to the lack of knowledge about HIV/AIDS, the poor are more likely to be in vulnerable situations. At the same time, HIV/AIDS infection in households exacerbates poverty and social inequality, creating conditions for a larger epidemic in the subregion. The Project will assist in breaking this vicious cycle and will contribute to improving the quality of life, supporting human development, and reducing poverty. In particular, the Project will educate more than 2 million people, motivate about 150,000 people to use condoms for casual sex, and provide STI services to about 10,000 people. The Project also directly addresses gender equity concerns as it explicitly recognizes that the low status of women makes them more vulnerable to HIV/AIDS. By including men as one of the major groups for interventions, the Project attempts to change male behavior and to encourage males to practice safe sex. This has the potential to reduce women's vulnerability to HIV/AIDS. A discussion on the poverty impact of the Project is available in Appendix 8.

36. The Project will strengthen communities, NGOs, and cross-border surveillance systems: this will improve the effectiveness of the ongoing government responses to HIV/AIDS and enhance the poverty reduction impact of the ADB health projects in the three countries. The strengthened capacity of communities, NGOs, and governments will have long-term payoffs, much beyond the time-period of the Project.

2. Sustainability

37. The Project's major emphasis is on creating HIV/AIDS resilient communities and strengthening national and subnational capacity for organizing effective responses to the epidemic. These improved capacities—community, provincial, and national—will help sustain the activities initiated under the Project. All three governments have shown strong support for the Project and plan to provide significant counterpart funds for project implementation. In all three countries, the present level of spending on HIV/AIDS is low, but it is increasing rapidly. This increased spending on HIV/AIDS in next three years is expected to be sufficient to sustain the project inputs. In addition, the following features of the Project will assist in sustaining the planned activities beyond the project period:

- (i) the actual running cost of investment being provided is quite minimal;
- (ii) the Project will develop and mainstream low-cost approaches for AIDS care, which will be more affordable for the countries compared with the existing approaches; and
- (iii) improved capacity for planning and management will engender efficiencies in implementation that will reduce waste and improve effectiveness of the response.

F. Risks and Assumptions

38. The project design is based on two interrelated assumptions. First, the strong government commitment for supporting HIV/AIDS prevention activities will continue. Second, the governments will be able to mobilize additional resources to continue the activities after the Project is over. All three governments have demonstrated strong political commitment for the prevention of HIV/AIDS. The governments realize that spread of HIV/AIDS, if unchecked, will be a major stumbling block for growth and poverty reduction in their countries. However, early success in controlling the epidemic could lead to complacency and weakening of the political support necessary for mobilizing additional resources for the sector.

IV. RECOMMENDATION

39. The President recommends that the Board approve ADB administering assistance to the Government of Cambodia, the Government of Lao People's Democratic Republic, and the Government of the Socialist Republic of Viet Nam in an amount not exceeding the equivalent of \$8,000,000, to be financed by the Japan Fund for Poverty Reduction on a grant basis, for the purpose of Community Action for Prevention of HIV/AIDS.

APPENDIXES

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PROJECT FRAMEWORK

Design Summary	Performance Targets	Monitoring Mechanisms	Assumptions & Risks
<p>Goal</p> <ul style="list-style-type: none"> Reduce the incidence of HIV/AIDS (human immunodeficiency virus/acquired immunodeficiency syndrome) Cambodia, Lao People's Democratic Republic (PDR) and Viet Nam. 	<ul style="list-style-type: none"> Prevalence of HIV infection will stabilize in the project area by the end of the Project 	<ul style="list-style-type: none"> National HIV surveillance systems. 	<ul style="list-style-type: none"> The three governments will continue to treat prevention and care of HIV/AIDS as a priority policy issue.
<p>Objectives</p> <ul style="list-style-type: none"> Support HIV/AIDS prevention activities in strategically important areas (also referred to as hot spots) for the transmission of HIV in the region. Strengthen capacities of the national and local HIV authorities and selected nongovernment organizations (NGOs) for the development of community based prevention and care programs 	<ul style="list-style-type: none"> Reduction in the incidence of high-risk behavior for HIV infection. <ul style="list-style-type: none"> increase in use of condom with non-regular sexual partners by 50 percent use of sexually transmitted infection (STI) services by vulnerable groups increases by 100 percent Availability of second generation surveillance data in all three countries Availability of trained personnel at national and subnational level Development of cost-effective models for AIDS care 	<ul style="list-style-type: none"> Baseline survey and final survey Behavioral sentinel surveillance (BSS) reports Project reports and review missions 	<ul style="list-style-type: none"> The support will create capacity of the governments for organizing HIV/AIDS prevention activities, which will facilitate the replication of the experience in other similar areas, and will sustain the activities beyond the project period. The governments will use the available data for program management and policymaking Trained personnel will stay in the assigned jobs, which require their new skills
<p>Outputs</p> <p>Component 1: HIV/AIDS Prevention Activities in Hot Spots</p> <p>(i) Behavior Change Communication</p> <ul style="list-style-type: none"> Increase in knowledge about HIV/AIDS transmission mechanisms among vulnerable and general populations in the project area. Decreased incidence of risky behavior that can lead to HIV infection. 	<ul style="list-style-type: none"> Percent of vulnerable people who know how to prevent HIV will increase by 50 percent Percent of vulnerable people who "always" use condoms with nonregular or commercial partners will increase by 50 percent 	<ul style="list-style-type: none"> Baseline survey and final survey behavioral sentinel surveillance data 	<ul style="list-style-type: none"> Vulnerable groups will not be stigmatized and will continue to receive the appropriate social support

Design Summary	Performance Targets	Monitoring Mechanisms	Assumptions & Risks
<p>(ii) Condom Promotion</p> <ul style="list-style-type: none"> Increased availability of condoms Increased use of condom by vulnerable population <p>(iii) STI Care</p> <ul style="list-style-type: none"> Availability of quality care in STI clinics in the project area Greater use of STI clinics, especially by vulnerable groups and men in the project area 	<ul style="list-style-type: none"> Condoms will be regularly available in 90 percent of retail establishments and free distribution points Distribution of condoms will increase by 100 percent STI care services of standard quality will be available in all district health centers in the project area 100 percent of people presenting to facilities with urethral discharge, genital ulcer, and vaginal discharge receive appropriate history, exam, diagnosis and treatment Number of clients attending STI services will increase by 100 percent for both men and women 	<ul style="list-style-type: none"> Baseline survey and final survey Distribution figures Baseline survey and final survey Service statistics Service statistics 	<ul style="list-style-type: none"> The governments will continue to support condom promotion for HIV/AIDS prevention. Wide availability and acceptance of condoms will not increase promiscuity Use of STI care services will not be stigmatized The Project interventions will be able to overcome the inhibitions that men and women face in seeking health care for STI treatment.
<p>Component 2: Capacity Building</p> <p>(i) Behavioral Surveillance</p> <ul style="list-style-type: none"> Availability of HIV/AIDS-related behavioral data across the three countries Use of BSS data for policy and program formulation in the three countries <p>(ii) Training</p> <ul style="list-style-type: none"> Health workers and other key stakeholders working in hot-spots trained in HIV/AIDS prevention and care 	<ul style="list-style-type: none"> Nationally representative behavioral data for HIV/AIDS available for 2002 and 2003 in all three countries National AIDS authorities in all three countries will have been well trained in organizing and analyzing the data National programs and policies will be suitably modified in accordance with the findings of the BSS data 100 percent of all health workers in the project area will have been trained in STI care 	<ul style="list-style-type: none"> Project reports and review missions Project reports and review missions 	<ul style="list-style-type: none"> Turnaround time between data collection, analysis and dissemination of findings will be minimized to ensure their policy relevance The governments will continue with the policy of wide sharing and dissemination of data and will not treat it as sensitive information Health workers and other professionals will be released by authorities on time for training and will receive support for using their skills

Design Summary	Performance Targets	Monitoring Mechanisms	Assumptions & Risks
<p>(iii) AIDS Care</p> <ul style="list-style-type: none"> • Development of cost-effective and efficient models for AIDS care in Cambodia • Dissemination and sharing of Cambodian experience in the other two countries <p>(iv) Study Tour to Thailand</p> <ul style="list-style-type: none"> • Study tour of key policymakers in the three countries to Thailand 	<ul style="list-style-type: none"> • Case-studies and evaluation reports on AIDS care models in Cambodia developed • Policymakers and program managers in the Lao PDR and Viet Nam will have been exposed to the Cambodian model • Key policymakers exposed to the approaches adopted by Thailand for HIV/AIDS prevention and control 	<ul style="list-style-type: none"> • Project reports and review missions • Tour report and review missions 	<ul style="list-style-type: none"> • Policymakers in the three countries will be convinced of the urgent need for devoting resources for AIDS care • Policymakers will be available for the tour
<p>Inputs Components</p> <p>1. Community-based HIV/AIDS prevention activities</p> <p style="padding-left: 20px;">(i) Communication programs</p> <p style="padding-left: 20px;">(ii) STI care</p> <p style="padding-left: 20px;">(iii) Condom promotion</p> <p style="padding-left: 40px;">Subtotal</p> <p>2. Capacity building</p> <p>3. Project management and evaluation and monitoring</p> <p>4. Contingencies</p> <p style="text-align: right;">Total</p>	<p>Cost (\$ million)</p> <p>2.8</p> <p>1.0</p> <p>0.8</p> <p>4.6</p> <p>1.4</p> <p>1.4</p> <p>0.6</p> <p>8.0</p>		



OUTLINE TERMS OF REFERENCE

A. Chief Technical Adviser (24 person-months)

1. The consultant will be an HIV/AIDS expert with experience of working in the Greater Mekong Subregion. The consultant will be based in Cambodia or Viet Nam and will (i) provide support to all three countries for planning, implementing, and monitoring the Project; (ii) work closely with the three executing agencies (EAs) and all implementing agencies (IAs) and help them conceptualize the overall project framework; and (iii) directly supervise and guide the work of the domestic consultants, and be responsible for the collective work of the team. Specifically, the consultant will be responsible for the following:

- (i) Planning: help the EAs prepare detailed plans for implementing the Project, including detailed time-line and procurement plans.
- (ii) Implementation. The consultant will
 - (a) with the help of the domestic consultants, assist the EAs in implementing the Project according to the prepared plans and agreements reached between the Asian Development Bank (ADB) and the governments;
 - (b) ensure that the contracting and fund flow arrangements are in accordance with ADB guidelines; and
 - (c) help the EAs implement the Project without time or cost overruns.
- (iii) Monitoring. the consultant will
 - (a) design and supervise the baseline survey to estimate baseline values of the monitoring indicators;
 - (b) together with the EA, carry out monitoring and supervision of ongoing activities through meetings, field visits, and studies to ensure the quality and of implementation;
 - (c) assist ADB missions in undertaking reviews;
 - (d) prepare all background information for the midterm review and participate in the review; and
 - (e) plan and design the final survey to estimate the final values of the monitoring indicators (actual survey might be undertaken after the term of the consultant expires).
- (iv) Coordination. The consultant will
 - (a) coordinate with ADB to ensure smooth flow of funds for the planned activities;
 - (b) ensure intercountry coordination and that the project interventions are consistent across countries and support each other; and
 - (c) coordinate with other development agencies to avoid overlap with other initiatives and ensure synergies of effort.
- (v) Reporting. The consultant will
 - (a) prepare formats for periodic reporting of physical and financial progress of the Project;

- (b) with the help of the domestic consultants, ensure that reports are regularly sent to ADB; and
- (c) at the end of the term prepare a report on project implementation documenting the major achievements and the lessons learned (the format of the report will be agreed with ADB about six months before the end of the assignment).

B. Domestic Consultants (72 person-months, one each in Cambodia, the Lao PDR, and Viet Nam for 24 person-months)

2. The domestic consultants will be based with the national IAs and will support project implementation. While the consultants will be responsible to the project director of EA and head of IA for their day-to-day operations, they will work under the administrative supervision of the Chief Technical Adviser. The domestic consultants will support the EAs, national IAs, and the Chief Technical Adviser in carrying out the planning, implementing, monitoring, and reporting functions.

C. Team of Consultants in Community-Based Behavior Change Communication (International, 12 person-months; and Domestic, 36 person-months—12 person months in each of the three countries)

3. The team members will have experience in supporting the development and implementation of effective community-based behavior change communication programs in both small urban and rural areas of Viet Nam and documented experience in developing effective behavior change communication materials. The team will be responsible for working with provincial AIDS departments or bureaus in the three countries:

- (i) Develop a detailed communication plan for each country and province.
- (ii) Organize brainstorming workshops to develop messages and material.
- (iii) Develop and implement training, refresher training, and support for up to 4,000 community members in transport hot spots, construction sites, and source communities for migrants.
- (iv) Work with provincial AIDS departments or bureaus to assure that community members receive training in effective interpersonal communication techniques for the prevention of HIV infection and effective use of behavior change communication materials and condoms.
- (v) Assure that the community members receive refresher training that helps them to solve challenges they encounter in talking with mobile groups of people. The team will have responsibility to assure that behavior change communication materials are easily used by community members by being easily understood, small, and mobile. They may include small picture booklets with condoms in a sleeve on the last page, audiocassettes, key chains, hats, stickers, calendars, raincoats, and others.
- (vi) Support two staff member in each of 12 provinces in developing and producing prototypes of five kinds of materials for each of four kinds of mobile groups of people.

- (vii) Make recommendations for levels of production of each kind of material to the project management unit (PMU) at the end of the contract.
- (viii) Monitor and evaluate the impact of the programs and suggest changes if required.

D. Team of International and Domestic Consultants for Sexually Transmitted Infection Case Management Training (International 9 person-months, Domestic 36 person-months—12 person months in each of the three countries)

4. The team members will have documented experience in training health care providers including pharmacists in the provision of syndromic management of sexually transmitted infections for men and documented experience in training health care providers in microscopy for differentiating the three most common reproductive tract infections of women. The team will be responsible for developing training material, training curriculum, and supervising the following training programs:

- (i) training for about 1,000 health care providers including pharmacy staff in the provision of syndromic management of sexually transmitted infections in men;
- (ii) training for about 100 people in microscopy to improve diagnostic accuracy; the skills to be mastered by each microscopy trainee are
 - (a) the use of wet mount to determine the presence of yeast cells found in women with candidiasis or mobile flagellated organisms found in women with trichomoniasis;
 - (b) the use of gram stain to determine a shift in vaginal flora with a decrease in large gram-positive rods and a marked increase in smaller gram-variable coccobacilli found in women with bacterial vaginosis; and
- (iii) training for up to 250 people in diagnosing and managing the three common reproductive tract infections: candidiasis, bacterial vaginosis, and trichomoniasis, based in microscopic differentiation.

5. In addition, the team will be responsible for monitoring the quality of sexually transmitted infection care by trained providers during the duration of the Project.

PROJECT IMPLEMENTATION

Quarter	First Year				Second Year				Third Year	
	1	2	3	4	5	6	7	8	9	10
Activity \ Month										
Component 1 – Community Based HIV Prevention Activities										
A1. Behavior Change Communication										
Identification of sites based on criteria	■									
Contracting of consulting services	■									
Development of BCC materials		■	■							
Production/distribution of BCC materials			■	■						
Training of community members				■	■					
Support of community members					■	■	■	■	■	■
Mass media campaigns in source communities					■	■	■	■	■	■
Monitoring and evaluation	■	■	■	■	■	■	■	■	■	■
A2. Condom Promotion										
Contracting of institution for marketing	■									
Intensive social marketing in provinces		■	■	■	■	■	■	■	■	■
Procurement of condoms	■	■								
A.3. Sexually Transmitted Infection Care										
Contracting of consulting institution	■									
Procurement of equipment	■									
Development of training materials		■								
Training in microscopy and care			■	■						
Training in syndromic management			■	■						
Market testing of urethritis kits				■	■					
Purchase and distribution of medications				■	■	■	■	■	■	■
Component 2 – Capacity Building										
Contracting of consulting services								■		
Behavioral sentinel surveillance								■	■	■
Procurement of office equipment, etc.		■	■							
Field visits for policymakers				■	■					
Field trip to Cambodia									■	■
Study tour to Thailand					■	■				
Component 3 – Project Management, Monitoring, and Evaluation										
Consultants for project management	■									
Monitoring and evaluation	■	■	■	■	■	■	■	■	■	■
Studies				■	■	■	■	■	■	■

BCC = behavior change communication.

COST ESTIMATES**Table 1: Cost Estimates by Components**
(\$'000)

Activities	Cambodia	Laos	Viet Nam	Regional	Total
A. JFPR Financing					
1. Community-based HIV/AIDS Prevention Activities					
(i) Communication Programs	839	580	1,425	0	2,845
(ii) STI Care	232	150	430	0	812
(iii) Condom Promotion	250	235	500	0	985
Subtotal (1)	1,321	965	2,355	0	4,641
2. Capacity Building	689	245	455	0	1,389
3. Project Management and Evaluation and Monitoring	190	190	190	850	1,420
Contingencies	0	0	0	550	550
Total (A)	2,200	1,400	3,000	1,400	8,000
B. Government Financing					
1. Community-based Prevention Activities	400	200	1,000	0	1,600
2. Capacity Building/Project Management	100	100	200	0	400
Total (B)	500	300	1,200	0	2,000
Total	2,700	1,700	4,200	1,400	10,000

HIV/AIDS = human immunodeficiency virus/acquired immunodeficiency syndrome, JFPR = Japan Fund for Poverty Reduction, Lao PDR = Lao People's Democratic Republic, STI = sexually transmitted infection.

Source: Staff estimates.

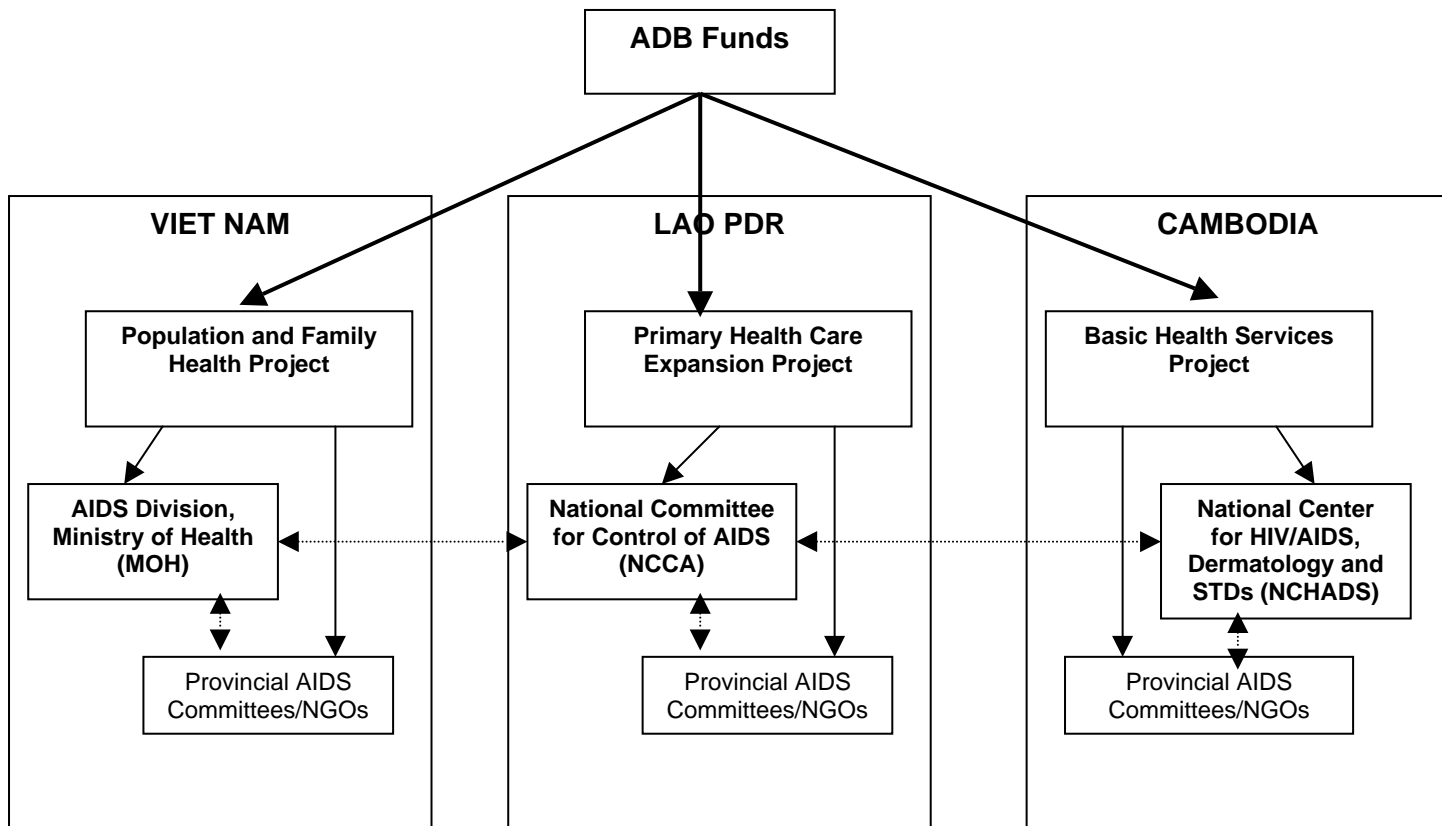
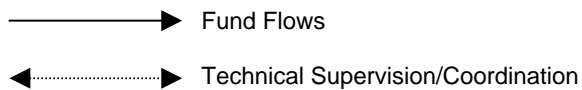
Table 2: Cost Estimates: ADB Financing
(\$'000)

Inputs	Component 1			Component 2	Component 3	Total
	Community Based HIV/AIDS Prevention Activities			Capacity Building	Monitoring & Evaluation	
	BCC	Condom Promotion	STI Care		Project Management	
1. Equipment	0	0	68	0	0	68
2. Communication Vehicles	0	0	0	75	0	75
3. Drugs and Supplies	0	215	110	0	0	325
4. Office Equipment	0	0	0	70	0	70
5. Communication Activities	1,860	200	0	0	0	2,060
6. Training and Study Tours	435	0	234	140	0	809
7. Consulting Services	270	0	60	150	580	1,060
8. Surveys and Studies	30	0	0	300	0	330
9. Pilot Studies	0	0	340	654	0	994
10. Social Marketing	0	570	0	0	0	570
11. Monitoring and Evaluation	60	0	0	0	750	810
12. Administrative Costs	189	0	0	0	90	279
Contingencies						550
Total	2,844	985	812	1,389	1,420	8,000

BCC = behavior change communication, STI = sexually transmitted infection.

Source: Staff estimates.

PROJECT IMPLEMENTATION ARRANGEMENTS AND FUND FLOWS



ADB = Asian Development Bank, HIV/AIDS = human immunodeficiency virus/acquired immunodeficiency syndrome, Lao PDR = Lao People's Democratic Republic, NGO = nongovernment organization, STD = sexually transmitted disease.

BENEFIT MONITORING AND EVALUATION INDICATORS

Objectively Verifiable Indicators	Targets
A. Prevalence	
1. Prevalence of HIV in the project area	Prevalence will not increase
B. Knowledge	
2. Percent of vulnerable population that know how to prevent HIV	Increase by 50 percent
C. Condom Use	
3. Use of condom with nonregular or commercial partners	Increase by 50 percent
4. Availability of condom in retail establishments	Increase to 90 percent
5. Number of condoms used	Increase by 100 percent
D. STI Services	
6. Number of people using STI clinics	Increase by 100 percent
7. Proportion of health workers trained in STIs	Increase to 100 percent
8. Use of STI services by vulnerable population	Increase by 100 percent
9. Number of clinics/health centers equipped with STI care	All district health centers

HIV/AIDS = human immunodeficiency virus/acquired immunodeficiency syndrome, STI = sexually transmitted infection.

POVERTY IMPACT ASSESSMENT

1. In the early stages of the AIDS¹ pandemic, when its cause and manner of transmission had not yet been understood, the infection affected the rich as much as the poor. Rich countries were as likely to be affected as poor countries, and in each country, rich people were as likely to get infected as poor people. AIDS seemed to affect the rich and the poor alike, unlike most other infectious diseases like malaria, tuberculosis, diarrhea, and others that ravage the poor much more than the rich.

2. Today the global pattern of HIV/AIDS (footnote 1) infection is similar to those of other infectious diseases in the sense of prevalence being closely related to poverty. The following facts emphasize the link between poverty and HIV/AIDS:

- (i) Of the global population infected with HIV/AIDS, about 90 percent live in poor countries.
- (ii) Poorer countries tend to have less success preventing an HIV/AIDS epidemic from starting, and in controlling the epidemic once it has started.
- (iii) In every country regardless of income level where a sizeable number of HIV/AIDS infected people live, infection rates among the poor are significantly higher than those among the nonpoor.

3. Throughout the Greater Mekong Subregion, those at greatest HIV risk are all considered to be socially marginalized. They engage in socially unaccepted, and often illegal, behavior. Poverty and HIV/AIDS have been shown to be related through both cause and effect. HIV/AIDS deepens the poverty of households and nations, and poverty favors the spread of HIV/AIDS by increasing the vulnerability of households and decreasing their inability to take preventive actions. An HIV/AIDS epidemic will have macroeconomic, sectoral and household, and individual impacts.

A. Macroeconomic Impact of HIV/AIDS

4. Studies show that as HIV prevalence rates rise, both total national income and incomes per capita fall significantly. Of the three countries in the project area, the HIV prevalence is estimated to be the highest in Cambodia, which will result in a significant impact on the gross domestic product growth rate in the country. Joint United Nations Programme on HIV/AIDS estimates that over the next five years, the impact of HIV/AIDS will be translated into a cumulative reduction in the country's output of between 2 and 5 percent.

5. Even if a highly successful campaign against AIDS is mounted from today, the negative economic impact will continue to reverberate for many years to come. The hundreds of thousands already infected in the region will inexorably proceed to develop HIV-related illnesses and ultimately die of AIDS, leaving behind faltering households, communities, and economies. HIV/AIDS affects the adult working-age population. The illness and premature deaths of critically large numbers of the adult working population as a result of AIDS, typically when they have started to form their own families and have become economically productive, will reduce economic output in the region. Those left behind are the young and the very old, those least able to contribute to the economy.

¹ AIDS refers to acquired immunodeficiency syndrome, HIV refers to human immunodeficiency virus.

B. Sectoral Impact of HIV/AIDS

6. All the major sectors of the economy will begin to feel the negative effects of the AIDS epidemic. Consider the following:

- (i) AIDS patients are starting to fill more and more hospital beds throughout the region, especially Cambodia where AIDS patients are likely to overwhelm the capacity of public health system.
- (ii) Labor intensive businesses such as garment factories will be severely affected by HIV/AIDS, with companies' profits being reduced due to higher absenteeism, health care costs, death benefits, and retraining costs.
- (iii) In other countries, farm production has decreased by 40-60 percent for households experiencing an AIDS illness or death

C. Impact of HIV/AIDS on Households and Individuals

7. The most visible impact of HIV/AIDS will be borne by households and individuals. Most of these household and individuals will be poor. Even if the households are not poor before contracting HIV, loss of employment and high cost of treatment will push the households into deep poverty. An explanation of the close linkage between poverty and HIV/AIDS follows:

8. **Poor people are more likely than rich people to be exposed to higher risks of HIV infection.** In the Greater Mekong Subregion countries, especially Cambodia and the Lao People's Democratic Republic, the initial pool of HIV infection emerged among commercial sex workers. Poor people tend to be overrepresented among commercial sex workers and poor clients of commercial sex tend to unduly patronize the highest risk areas, i.e., high-volume, low-cost brothels, and freelance street-based sex workers.

9. In provinces where unsafe injections or blood transfusions are an important channel of HIV transmission, such as Lai Cau in Viet Nam, poor people tend to be more exposed to re-used needles, transfusions of untested blood, and unsafe injecting drug use.

10. Undiagnosed and/or untreated sexually transmitted infection (STI) is a risk factor in HIV infection. Poor people who contract an STI tend to remain undiagnosed or untreated due to their preexisting problems with access to basic health care. Thus the higher chances of having an untreated STI expose poor people to higher probability of HIV infection.

11. AIDS-infected mothers who do not obtain proper treatment are at a higher risk of transmitting their infection to their children. Since poor women who are infected with AIDS tend to have limited means to obtain proper drug treatment, rates of mother-to-child transmission among such women would be higher.

12. **Poor people are less likely than rich people to do something to reduce the risks of HIV infection that they face.** Poor people in all three countries tend to be less educated and have more limited access to knowledge and information than rich people. Poor people thus have lesser opportunities to obtain critical knowledge essential for avoiding the risks of HIV infection.

13. In the context of commercial sex, poor people involved may also be in a much weaker position to negotiate safer sex practices, including the use of condoms. In this sense, poor

people may have lesser ability to adopt practices that can reduce the risks of HIV infection inherent in commercial sex transactions.

14. Among the many problems that poor people face, an STD may simply be one of the lower priority issues they need to solve. Thus poor people with STDs may not sufficiently seek proper care thereby passing up one more opportunity to reduce the risks of HIV infection.

15. **Poor people are more likely than rich people to be devastated by AIDS infection, and being infected with AIDS is also likely to lead people into deeper poverty.** Poor people largely depend on their labor for income. AIDS can reduce their ability to work and eliminate their only source of income. Death from AIDS can often eliminate the income earning members of poor families. In addition, the high costs attendant to care of the AIDS-infected and the large funeral expenses from an AIDS death can devastate a poor family already living on the edge of survival even under normal circumstances.

16. Even in coping with the financial consequences of HIV/AIDS infection, poor people may have much more limited options as their circle of community support tends to also be other poor families and discrimination may cut them off from traditional family support networks at the moment of their greatest vulnerability.

D. How will the Project Benefit the Poor

17. The Project will address all these three categories of linkages between HIV/AIDS and poverty. By targeting HIV/AIDS prevention to those at highest risk of infection, the Project is likely to benefit poor people in the highest risk groups. By increasing the means available for reducing the risks of HIV infection among the highest risk groups, the Project will probably increase the likelihood that poor people would reduce their own risks to infection. By piloting the care of AIDS-infected people in Cambodia, the Project will demonstrate cost-effective means to help poor people cope with AIDS.

18. The project area has been identified based on the following criteria:

- (i) strategic importance of the area for regional spread of HIV/AIDS, i.e., close linkages with the neighboring countries;
- (ii) significant presence of mobile people, migrants, and those vulnerable to HIV infection;
- (iii) HIV/AIDS prevalence; and
- (iv) poverty incidence.

19. These selection criteria will ensure that the Project (i) assists the three governments in stemming the regional spread of HIV/AIDS; (ii) helps the mobile populations that are normally not covered by national programs and yet constitute one of the major vulnerable groups for HIV infection; and (iii) provides direct assistance to the poor.