



# Technical Assistance Consultant's Report

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## Socialist Republic of Viet Nam: HIV/AIDS Prevention Among Youth (Financed by the Asian Development Fund Grant)

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**Asian Development Bank**

# Final Report

## HIV/AIDS Prevention among Youth



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## ABBREVIATIONS

ADB	— Asian Development Bank
AIHI	— Australian International Health Institute
ARV	— Anti-retroviral
BCC	— Behavior Change Communication
CBO	— Community Based Organization
CPFC	— Commission for Population, Family and Children (Provincial level)
DoLISA	— Department of Labor, Invalids and Social Affairs
EA	— Executing Agency
FHI	— Family Health International
FU	— Farmer's Union
GAD	— Gender and Development
GDP	— Gross Domestic Product
GoV	— Government of Viet Nam
GSO	— General Statistics Office
HIV/AIDS	— Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
IDU	— Injecting Drug User
IEC	— Information, Education, Communication
ILSSA	— Institute of Labor Science and Social Affairs
INGO	— International Non-Governmental Organization
IPC	— Interpersonal Communication
JFPR	— Japan Fund for Poverty Reduction
KAP	— Knowledge, Attitude and Practice
MDG	— Millennium Development Goal
MoCI	— Ministry of Culture and Information
MoET	— Ministry of Education and Training
MoH	— Ministry of Health
MoLISA	— Ministry of Labor, Invalids and Social Affairs
MSI	— Marie Stopes International
NGO	— Non-Governmental Organization
PE	— Peer Educator
PEPFAR	— The United States President's Fund for AIDS Reduction
PLWHA	— People Living with HIV/AIDS
PMU	— Project Management Unit
PPMU	— Provincial Project Management Unit
PSC	— Project Steering Committee
PSI	— Population Services International
RH	— Reproductive Health
SAVY	— Survey Assessment of Vietnamese Youth
SDP	— Sector Development Program
STI	— Sexually Transmitted Infection
SW	— Sex Worker
TA	— Technical Assistance
ToR	— Terms of Reference
TWG	— Technical Working Group
UNAIDS	— Joint United Nations Programme on HIV/AIDS
UNDP	— United Nations Development Programme
UNFPA	— United Nations Population Fund
UNFPA	— United Nations Population Fund
UNICEF	— United Nations Children's Fund
UNODC	— United Nations Office on Drugs and Crime
VAAC	— Viet Nam Administration of HIV/AIDS Control
VCPFC	— Viet Nam Commission for Population, Family and Children

VCT — Voluntary Counseling and Testing  
VINAFFPA — Viet Nam Family Planning Association  
WHO — World Health Organization  
WU — Woman's Union  
YU — Youth Union

This report was prepared by a team consisting of Eileen Darby (Team Leader), Hoang Thuy Lan (Deputy Team Leader), Peter Annear, Dang Nguyen Anh, Dao Huy Dap, Martha Morrow, Pham Thi Mai Chi, Ken Swann, and Vu Pham Nguyen Thanh.

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## 1) Introduction

1. The Government of Viet Nam (GoV) has identified the HIV/AIDS epidemic as a significant threat to population health, economic development and social order. The Government considers prevention and control efforts as investments in the nation's future socio-economic well-being, and as evidence of Viet Nam's commitment to the international agreements to which it is a signatory. It also considers youth as a priority target for successful national development, and recognizes youth vulnerability in relation to HIV/AIDS. In 2004, the Prime Minister approved a major new Strategy on HIV/AIDS Prevention and Control to 2010 and beyond. It is in the context of the new Strategy, and the nature of the current epidemic, that the ADB Technical Assistance (TA) has undertaken its consultations and prepared this document. The following summarizes key features of the Vietnamese epidemic, its responses to date, the significance of the new Strategy, the socio-economic setting, and the request to the ADB for assistance.

### a. Project Objectives and Scope

#### Overall Objective (Goal)

2. The Project goal is to achieve Millennium Development Goal (MDG) 6 (Target 7) to have halted and begun to reverse the spread of HIV/AIDS by 2010.

#### Specific Objective (Purpose)

3. The Project purpose is to reduce HIV-infection risk among youth aged 15–24 through BCC programs.

#### Scope of Project

4. The Project will be implemented at the national level and potentially in 15 selected provinces over a five-year period. The Project will be administered from the ADB as a Sector Development Program (SDP) which means that implementation will occur in phases and that tranches will be released by ADB to the PMU on successful completion of the milestones for each phase and on the submission of an Action Plan for the next phase. In this phased approach, the Project activities will commence at the national level and in an initial five provinces in the north. Another five provinces selected from the central and southern regions will be included in the second phase and the final five provinces will be added into the Project in the fourth year. The Project is composed of four components which together form an integrated, interlinked program of activities to reduce HIV-infection risk among youth through BCC programs.

5. At the policy level the project has designed a program of advocacy activities to raise awareness and influence decision making of leaders at national and provincial levels in relation to youth and HIV/AIDS prevention programs. The advocacy activities in Component 1 are aimed at creating a supportive environment for implementation of the National HIV/AIDS strategy in relation to issues affecting youth and HIV/AIDS prevention. Having leaders at all levels that are sensitive to the needs of young people and are willing to support specific policies and programs that focus on youth and their needs in relation to HIV/AIDS prevention will lay the foundation for the other Project activities.

6. The Mass Media and Interpersonal Communications (IPC) Materials component (Component 2) is the centerpiece of the project and will have nationwide reach. Through the contracting of a professional agency capable of developing a high quality, entertaining and influential TV drama series that is broadcast over a three-year period the Project will aim to influence the knowledge, attitudes and behaviors of young people and their families in relation to a number of social issues, including sexuality, HIV/AIDS prevention, stigma and discrimination, gender, etc. The drama series will be linked to provincial radio phone-in pro-

grams and web site. A wide range of IPC materials will be developed for distribution through Project IPC activities at the community level and nationwide by other organizations who wish to use the materials.

7. The Projects community based activities to reduce the transmission of HIV/AIDS among youth will be implemented under Component 3. Voluntary counseling and testing centers in community settings will increase the opportunity for young people to access youth friendly services for information, counseling and early detection of Sexually Transmitted Infection (STI) and HIV status. This will increase the opportunity for young people to take preventative measures and especially encourage the use of condoms for safe sex.

8. The strategy of developing peer education programs among the various vulnerable groups (injecting drug users [IDUs], street youth, service industry workers and factory workers) provides a large community-based network of youth who, through IPC initiatives, will reach their peers with HIV/AIDS prevention messages and provide them with condoms. These peer educators will be the network through which the IPC materials developed in Component 2 will be widely distributed. Peer educators will also conduct regular discussion groups using the IPC materials to generate dialogue on the topics raised in the TV drama series. Similar networks will be established through the community collaborators of VCPFC and civil society organizations who will also receive Project IPC materials and conduct adult discussion groups.

9. The relationship between the mass media outputs (television and radio programming), IPC materials and the community based IPC interventions results in an integrated program linking mass media and interpersonal communications. It is anticipated that ultimately this integrated approach will increase the awareness of HIV/AIDS among youth, empower them to prevent HIV transmission, decrease the stigma and discrimination that exists toward IDUs, SW and PLWHA and increase the use of condoms for safe sex.

## 2) Rationale — Sector Performance

### a. Current HIV/AIDS Situation in Viet Nam

#### **Viet Nam and the Spread of HIV/AIDS**

10. Viet Nam is considered to have made substantial progress towards meeting the Millennium Development Goals. However, the increasing prevalence of HIV/AIDS presents a major challenge to meet MDG 6, which is to reverse the spread of HIV/AIDS by 2015. From its first case diagnosed in December 1990 in Ho Chi Minh City (HCMC), the epidemic has spread to all provinces (UN 2004). A study by ADB and the Joint United Nations Program on HIV/AIDS (UNAIDS) of the socio-economic impact of HIV/AIDS in Viet Nam predicts that households of people living with HIV/AIDS face a 34–41% decline in consumption expenditure and that poverty reduction in Viet Nam could be slowed by 2% annually between 2003 and 2015 (ADB/UNAIDS 2004).

11. As of 31 March 2005, 93,402 cases of HIV infection had been officially reported.<sup>1</sup> The Viet Nam Technical Working Group (TWG) on HIV Estimates and Projections estimates the actual number of People Living with HIV/AIDS (PLWHA) is nearly three times that (approximately 263,470 – in the medium scenario) for a national prevalence rate of 0.51% in the 15–49 years age group (MoH 2005a). The Group further estimates that by 2010 these rates will rise to 311,500, or 0.544% in the 15–49 years age group. UNAIDS (2004) offers prevalence estimates ranging from 0.2%–0.8%, and attributable death estimates ranging from 4,500 to 16,000 in 2003.

12. HIV/AIDS in Viet Nam is not a generalized epidemic. It is concentrated among young injecting drug users (IDUs) and sex workers (SWs), and in particular geographic “hot spots”, including Quang Ninh, Hai Phong, Ho Chi Minh City, Ba–Ria Vung Tau, An Giang and Hanoi (Government of Viet Nam 2004). In March 2004, IDUs accounted for 57% of reported cases. The national prevalence among IDUs was about 33%, and among female sex workers was 6%. Estimated prevalence among SWs in HCMC was 25%, while in Hanoi it was 15% (UN 2004). In Quang Ninh province, over 60% of IDUs are infected. Increasing use of injecting drugs has been found among SWs in most of these “hot spots”. Given findings that SWs who inject are also those most likely not to use condoms (MoH et al, n.d.), this associated risk merits attention. There is epidemiological evidence that HIV is at risk of moving into the general population, with infection rates of over 1% found in four provinces among women attending ante-natal care (UNAIDS Country Level Progress Report, n.d.), and national prevalence among military candidates at 0.93% in 2001 (GoV 2004). Sexual transmission of HIV is expected to increase, as it has in other Asian countries with similar profiles at early stages (UNDP 2003).

#### **Stigma and Discrimination**

13. The UN Country Assessment for Viet Nam (2004) found discrimination against PLWHA exists in relation to employment and health services, and cited reports that some affected/infected children have been refused school entry. A UNICEF (2005) report on the situation of affected families and children in 2003 noted that some family businesses were boycotted, some families moved to start new lives where their HIV status was not known, children had been attacked by peers, and some suffered isolation, depression and grief. Although prevention programs have provided information about how HIV is not transmitted, misunderstanding remains rife, with a high proportion of target groups at the end of the previous ADB–Japan Fund for Poverty Reduction (JFPR) project stating they would not wish to share a meal with an infected person (ADB JFPR 2005). Urban myths abound about the

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<sup>1</sup> General Department of Preventive Medicine and HIV/AIDS Control, Ministry of Health, GoV.

dangers of infection via manicures and ear-piercing, with such unlikely routes mentioned frequently by youth during the TA team's provincial visits, and by at least one health official.

### **Youth and HIV/AIDS in Viet Nam**

14. Viet Nam has a very young population, with about 53% under 25 years, and nearly 30% aged 12–25 (UN 2004). About 16 million of the country's population is aged 15–24. Youth aged 15–24 are increasingly represented in the HIV/AIDS statistics, comprising about 10% of those infected in 1994, but about 40% today. About 62% of those infected are between 20 and 29 years of age. Males make up about 70% of all infected people, which is attributed to the much higher rate of injecting drug use among males than females. Youth considered at particular risk are those who migrate for work, as well as the unemployed and unskilled.

### **HIV/AIDS and the National Youth Development Strategy**

15. In 2003, the Government approved the Youth Development Strategy to 2010. Like many concurrent documents, the key focus is on socio-economic development and poverty reduction, with special reference to education, vocational training and employment. It is not a youth health strategy, and does not specifically cite HIV as a youth issue, but one of its targets states: to "improve health, spiritual life, build the cultural life, suppress the social evils and law breaching among the youngsters." It also calls for rehabilitation of 50% of IDUs by 2005, and 90% by 2010. The Strategy does not directly mention any particular concepts or theories of 'youth development', such as the World Health Organization (WHO) concept of 'healthy youth development', which is based on building protection and reducing risk (discussed below). The Strategy also does not refer to dangers facing youth, such as exploitation, violence and trafficking.

### **Government-led Responses to HIV/AIDS Prevention and Control**

16. Viet Nam has adopted a variety of approaches in efforts to prevent HIV transmission since the early days of the epidemic. Unlike some neighboring countries, Viet Nam openly acknowledged that circumstances were favorable to transmission in the early 1990s, and established the National AIDS Committee in 1993. Over the years, the placement and organization of this unit has changed; until recently it was situated in the Ministry of Health (MoH) General Department of Preventive Medicine and HIV/AIDS Control. On 20 May 2005, the Prime Minister decreed that all activities henceforth should be headquartered in the Viet Nam Administration of HIV/AIDS Control (VAAC), a free-standing structure within MoH. The decree also stipulated the establishment of higher level Provincial AIDS Bureaus to implement and support the national system.

### **HIV Prevention for the Community: Campaigns against "Social Evils"**

17. Until very recently, the principal approaches taken in Viet Nam to prevent and control transmission have been campaigns and policies to suppress so-called 'social evils', which include drug trafficking, drug use and sex work. Some have interpreted 'social evils' to include PLWHA. However, new guidance from the Party and Government, including the new Strategy (see below) directly seeks to de-link 'social evils' from HIV infection. The UN Country Assessment (UN 2004) notes the 'social evils' campaign has raised awareness of HIV, but also generated fear, contributed to stigma, delayed the introduction of harm reduction measures, and did not contribute substantially to behavior change.

18. Overwhelmingly, HIV prevention in Viet Nam for the community has consisted of information, education, communication (IEC) programs via mass media, posters and leaflets, and school text books. The focus has been on transmission via needle-sharing and unprotected sex (especially with SWs), with some reference to mother-to-child and blood transfusion routes. Condoms have been promoted more openly than in many countries, however, attitudes towards them are largely negative (due to their use as "evidence" of prostitution), and their use remains low among many risk groups, and even lower among mainstream

groups. Male-to-male sex has been almost completely ignored, and studies have found very low rates of knowledge, and high rates of unprotected sex, among men who have sex with men (MSM) (MAP 2004)<sup>2</sup>.

19. The TA team's provincial consultations revealed the 'social evils' campaign remains very active and widely accepted, and also that it has alarmed the general population. Many prevention materials are fear-based, e.g. posters that show a needle and syringe against a backdrop of a skull and cross-bones. School and university-based youth (at low risk) revealed exaggerated fears of personally becoming infected. Reasons given included: 'I might step on a needle'; 'An HIV+ person might attack me with a broken bottle'; 'I might suddenly change and become a drug-user'; 'I might not be able to resist pressure to try drugs'; 'My boyfriend might have another partner and then push me to have sex'.

20. Civil society organizations such as the Women's Union (WU) and Youth Union (YU) have mainstreamed HIV/AIDS into a variety of their programs. A notable approach is the Women's Union 'Cultural Family' and 'Cultural Commune' campaigns, which involve obtaining signatures from the community under pledges that their family/commune will include no IDUs or SWs (and, some say, no PLWHA). Some suggest the campaign is not taken seriously by individuals, and others fear it may drive illicit activities underground, making at-risk people harder to reach with preventive strategies. Secondary school children also sign pledges covering a number of socially-undesirable behaviors, including drug use, and in many schools are asked to inform (anonymously) on 'drug users'. School principals and teachers met during provincial visits declared their schools "drug-free" solely on the basis of pledges taken by students.

#### **HIV Prevention and Rehabilitation Efforts Aimed at IDUs and SWs**

21. Sex work and injecting drug use, along with drug trafficking, are illegal in Viet Nam, and many of those found to be involved in these activities go voluntarily or compulsorily, for varying periods of time, to '05/06' centers (UNODC 2003). These "Rehabilitation and Education Centers" are found in nearly every province and by late 2004 housed an estimated 34% of the country's 126,946 'registered' IDUs (MoLISA 2004a). Residential programs for sex workers tend to be shorter than for IDUs, and may be required only after the 3<sup>rd</sup> infringement. In 2003, around 5,438 women were held in 05 Centers (for sex workers) and 19,477 were held in 06 Centers (for IDUs) (MoLISA 2003). Some are large and overcrowding is a problem. There are plans to build additional Centers in many provinces.

22. Centers are mandated to offer detoxification (by abstinence, sometimes together with sedatives or axiological or traditional drugs), rehabilitation by psychological and moral supervision, vocational training, and behavioral correction and relapse prevention (UNODC 2003). Some use residents for agricultural labor. Funds for vocational training are limited, meaning that unless residents or their families can pay by themselves, they are unlikely to get sufficient training to enable them to take on new jobs after release.

23. Unfortunately, drug use continues inside some 05/06 Centers, with a high likelihood of needle-sharing. Male-to-male sex undoubtedly occurs but condoms are not supplied. The recent World Bank HIV/AIDS Prevention Project background document states plainly, "The current management of HIV within Rehabilitation centers is failing to prevent transmission." Given the Centers do not offer drug substitution or anti-retrovirals (ARVs), they are failing to implement harm reduction for the group at highest HIV risk (who will eventually return to their communities), and also not meeting specific targets within the National Strategy (see below). Provincial consultations revealed different ideas about the best approaches to

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<sup>2</sup> A Voluntary Counseling and Testing facility in Ho Chi Minh City in 2001-2 found 25% infection rates among MSM who presented (Thinh et al 2003).

harm reduction and rehabilitation, with some staff open to condom distribution, but others firmly opposed; however, all wanted ARVs to be supplied.

24. A number of challenges remain in relation to these Centers. Residential rehabilitation is extremely costly for the Government. Because the number of residents is large, and Viet Nam's resources are limited, funding per capita is low and must be supplemented by family support and/or income-generating activities by residents (e.g. embroidery). In one provincial program, only VND180, 000 is allocated per year for medications per resident, making it difficult to treat sexually transmitted infections (STIs) and opportunistic infections. Purchase of ARVs is beyond the scope of current budgets. Centers often lack sufficient trained medical personnel. Medical issues are a concern due to high HIV rates inside the Centers (an estimated 70–90% of residents in 2004) (UNODC 2003). HIV testing is not available for all residents (due to cost), meaning that infection rates are often extrapolated from Centers where sentinel surveillance takes place.

25. Another challenge is mental health. Centers have few staff trained in counseling for drug addicts undergoing rehabilitation. This specialized capacity is rare in many countries, including Viet Nam, and means that Center staff have only a limited range of techniques to deal with people who are depressed, possibly psychotic, and anxious about their health, isolated from the support of family, and compulsorily detained for up to two years. Ministry of Labor, Invalids and Social Affairs (MoLISA) officials recognize these problems and want support to enhance the skills base of Center staff.

26. Finally, it is of particular concern that some Centers house minors under age 18 (with some as young as 12). The lack of specialized staff is even more relevant for this highly vulnerable group, who may experience intimidation and sexual abuse by older, possibly HIV-infected, residents. The UN Country Assessment (2004) mentions the need for improvements in Viet Nam's juvenile justice system.

27. The Centers have drug relapse rates estimated at 70–90%. This can be directly attributed to the lack of social and community resources to support re-entry and rehabilitation, the lack of drug substitution services and discrimination related to employment. A UNODC (2003) report found that most residents wanted credit schemes to enable them to become self-employed. Methadone was trialed for drug substitution in the 1990s (UNODC 2003). The question of future piloting was discussed recently (June 2005) at the Harm Reduction Conference in Hanoi, where its small-scale use in China was reported by a participant.

### **A Turning Point: Viet Nam's 2004 National HIV/AIDS Strategy**

28. Despite the high visibility of public campaigns, an increasing budget allocation and a very large number of programs, activities and players, HIV prevalence has steadily increased, and remains a significant threat to health and to the economy in Viet Nam. In light of this, in March 2004 the Government released a new National Strategy on HIV/AIDS Prevention and Control in Viet Nam till 2010 with a Vision to 2020 (hereafter, National HIV/AIDS Strategy). The Strategy (GoV 2004) document summarizes activities undertaken to date in Viet Nam, highlighting the varied and large-scale involvement of all major State and Party groups, including civil society organizations and most Government departments, as well as 'social, religious and community organizations...especially in providing care and support for HIV/AIDS-infected people' (p. 23). It notes the wide reach of IEC campaigns (28.7 million people contacted nationally in 2002). While 'great efforts' have been made, the document notes 'the effectiveness...has been limited in some aspects, for example, there is no solution for activities to reduce harm among [IDUs and SWs]' (p. 22). The National HIV/AIDS Strategy broke new ground by endorsing harm reduction as a key approach. Its targets are considered very ambitious, in particular the goal of controlling national prevalence to below 0.3% by 2010, with no rises thereafter (UN 2004:29). The National HIV/AIDS Strategy commits to

targets of up to 100% coverage (e.g. safe injecting and condom use), and 90% for care and treatment of PLWHA. Its 'priority activities...in the coming time' are:

- i) Intensifying behavior change communication (BCC) to prevent transmission;
- ii) Stepping up Harm Reduction interventions;
- iii) Promoting counseling, care and treatment for those affected by HIV/AIDS; and
- iv) Strengthening program management, monitoring, supervision and evaluation capacities.

### **Funding for AIDS Prevention**

29. The direct budget from the Government in 2004 was about USD5 million, a 25% increase on the previous year. This is sourced from central (37%) and local (58%) government budgets, reflecting the country's policy of decentralization. Substantial additional funding comes from local sources and, in particular, the international community, which is giving approximately USD70 million for the period 2002–2005. Because some funds are given directly to provinces, it is difficult to obtain accurate estimates of total resources (CCRD and ILSSA 2003).

### **ADB and HIV/AIDS Prevention**

30. The Long-Term Strategic Framework of the ADB commits it to supporting the pursuit of the Millennium Development Goals (MDGs) in the region. MDG 6 aims to halt and begin to reverse the spread of HIV/AIDS by 2015. ADB's Operational Principles related to HIV/AIDS include, 'evidence-based targeting and capacity building...to ensure all resources are used for maximum impact and efficiency', and 'a commitment to flexibility and innovation...but linked with rigorous and timely monitoring and evaluation...'

31. The GoV has requested ADB's support for an HIV/AIDS activity that will focus on youth and behavior change communication (BCC) strategies. The proposed activity offers support for some aspects and target groups identified within the new National Strategy that to date are not well-supported by national or international financial resources.

32. For the purposes of this Project, 'youth' have been defined as aged 15–24. This definition is used by UN agencies and much of the international community. The age range approximates the life phase that lies between near total dependence on parents/adults, and the age at which most young people form their own families and are financially independent. It begins at the approximate age at which puberty begins (and before which risk behaviors are rare). However, this definition is intended to be interpreted flexibly within the Project itself, meaning that spill-over to groups that are slightly younger or older than 15–24 will occur, and simply reflects the complex networks in which young people live. The growing concentration of the epidemic in younger populations is a major justification for selecting this particular cohort.

### **b. Socio-Economic Context**

33. Viet Nam's population is estimated at 82 million, 74% of whom reside in rural areas. About two-thirds of the labor force is in agriculture. Since the adoption of a modified market economy and more international engagement in 1986 (known as "doi moi", or renovation), the country has experienced rapid economic expansion. Gross Domestic Product (GDP) doubled in the period 1990–1999 and has grown an average of 7–8% annually. Poverty has fallen dramatically, particularly from the early 1990s. Using international (World Bank) and Viet Nam's General Statistical Office (GSO) definitions of 'poverty', rates have fallen from 58% in 1993 to 29% in 2002 (MoLISA 2004b). Viet Nam's Human Development Index is relatively high in relation to its GDP; adult literacy in 2002 was 94.3% (GSO 2004 VHLSS 2002) and life expectancy in 2003 was 68.8 years.

34. Economic growth, however, has been uneven, concentrated particularly within large cities and the two major deltas where 40% of the population resides. More isolated zones, especially mountainous/highland regions and the central coast have seen fewer benefits. Ethnic minorities from 54 groups, who make up about 16% of Viet Nam's population, live mainly in these regions, and many experience hardship, with less education and poorer health status and health services. Viet Nam's Development Strategy aims for development with equality, and has identified priority programs and target groups for special assistance.

35. As elsewhere, rapid growth has been accompanied by rapid social change, with dramatic lifestyle shifts for many citizens, particularly in urban centers. It is projected that 45% of Vietnamese will be urban dwellers by 2020 (UN 2004). The benefits of higher living standards are obvious, but these are accompanied by an increase in social problems – including drug use, commercial sex work and family breakdown – which many, including the Government, attribute to a weakening of traditional values (GoV 2004, p. 28).

### **c. Social and Behavioral Aspects of HIV/AIDS**

36. The emergence and spread of HIV in Viet Nam can be traced to a variety of circumstances, social norms, practices and beliefs. Because the epidemic is fuelled largely by injecting drug use and, to a lesser extent, by commercial and non-commercial sex, this discussion will focus primarily on issues relevant to these pathways.

#### **Migration**

37. Migration is increasingly a fact of life in Viet Nam, driven by disparities between regions, the increased mechanization of agriculture, opportunities for employment arising from direct foreign investment, access to employment for those in unregistered households, and the increasing development of transport systems (Dang Nguyen Anh 2005). During the five years prior to the 1999 Census, over 4 million people moved across provincial borders. Migration was most common into the southeastern areas and central highlands, with over 53% into urban centers (particularly Hanoi and Ho Chi Minh City [HCMC]). It was mainly spontaneous and often temporary.

38. As elsewhere, migration has different impacts on different populations. For some it provides productive employment that helps keep them out of poverty, but for others it exposes them to criminality, dangerous workplaces, reduced educational and social services (because many are unregistered) and to environments in which unprotected sex and drug use are more likely. Particular migrant groups are very vulnerable, such as ethnic minorities, due to their poor education and lack of Life Skills for coping with life in new surroundings.

39. Over half of all internal migrants in the late 1990s were less than 25 years old, with the highest rates among those aged 20–24 (Dang Nguyen Anh 2005). Women migrated more than men in that period, reflecting emerging sex-specific employment opportunities. Mobile youth are vulnerable when they leave home (for education or for work) since they are no longer bound by parental constraint and protection. Female migrants working as street vendors and housemaids, etc, may experience sexual exploitation and be lured into the sex industry. Poverty and indebtedness propel other young women into sex work, which offers far more lucrative income than factories or informal sector work (Dang Nguyen Anh 2005).

40. Many migrant workers lack permanent registration status, making it difficult for them to organize for their rights under the Labor Code or have any security of employment. Most lack health or social insurance provisions (Dang Nguyen Anh 2005). The TA team encountered such women regularly working seven-day weeks and 10–11 hour days. Exposure to risk and lack of health insurance, coupled with the opportunity costs of seeking care, lead to increased physical (and mental) health risks. Women's greater vulnerability to sexual abuse

and violence means they are at increased risk of STIs and HIV. Many migrants come from poorer families, and often lack Life Skills and knowledge about HIV. They may be lonely and seek connections that lead to risky sex or drug use and they may lack the maturity to perceive risk accurately. UNICEF (2003) notes the connection between increasing rates of migration and the spread of HIV in Viet Nam.

41. There are other implications if migrants are unregistered (UN 2004). They may be harder to reach with HIV prevention programs or anti-poverty strategies (despite the fact that many are poor). In addition, their 'invisibility' means they are not included in statistics on HIV prevalence or, for example, among known drug users, potentially leading to underestimates.

42. The 1997–98 Viet Nam Living Standards Survey found 33.6% of the population had migrated at least once in their lives, mostly from rural to rural areas. Cross-border migration draws some into drug trafficking and sex work, which led the ADB to focus a previous project on this target population. Increasing numbers, including many women, are becoming guest workers in Southeast and Northeast Asia (and further afield), and a portion have ended up in sex work.

43. Large construction and other infrastructure projects are 'pull' factors for migration, particularly for men. The new Ho Chi Minh Highway employs thousands of temporary workers, as will the new Japanese-funded bridge across the Mekong River at Can Tho. In Quang Nam, gold mining is attracting jobless youth. Because some of gold explorations are illegal, workers do not receive services and information through the public system. Provincial informants noted the growth of a sex industry alongside these isolated camps. The ADB is also currently planning and/or implementing large projects that are likely to provide employment for mobile workers, who may be at risk of involvement with sex workers, and so the vulnerability factors of these workers needs to be addressed.

#### **Gender and HIV/AIDS in Viet Nam**

44. As in most countries, gender plays an important role in HIV risk in Viet Nam. Girls and women are vulnerable to infection because of biological factors, which include easier male–female transmission, especially in younger women, and the fact that STIs (which facilitate HIV infection) tend to be less symptomatic (and less treated) in women. Girls and women are more likely to be trafficked and become SWs. The illegality of sex work in Viet Nam means SWs cannot easily insist clients use condoms, despite targets of 100% use in the new Strategy. Refusal and even intimidation were confirmed during the TA team's provincial meetings with SWs. Condoms are unpopular in Viet Nam, even among youth. They are perceived as reducing sensation but are also considered symbols of immorality for anyone who carries them (MoH 2005b).

45. Women and girls bear about 75% of the burden of caring for infected family members (UNDP 2003). Household income spent on health care means less is available for nutrition and education, where girls already lag slightly. Because most PLWHA are male, their deaths often leave behind a female-headed household.

46. Gender roles are quite sharply delineated in Viet Nam. Traditional Confucian values for women and girls are refinement, self-sacrifice and obedience, and a focus on home and family. Men should be active outside, make key decisions, and engage socially with other men (Jamieson 1993). Women's home-based role makes them responsible for family social and moral conduct. A traditional saying asserts that children who become 'rubbish' end up this way because of bad mothering.

47. When women informants were asked during the TA provincial visits why men visit sex workers, nearly all blamed the wives. The following answer was typical:

“In this case, the woman should ask herself why her husband has gone to another woman. Perhaps she has not kept herself attractive, or made the home a warm and welcoming place where her husband feels he wants to spend time. She should take better care of her appearance, and make sure she looks nice.” (CPFC Collaborator, Hai Duong).

48. Alongside this, cultural attitudes inhibit women from becoming well informed about sexuality (UN 2004). There is a perception that SWs are more adept at satisfying men, but discussion of sexual needs by married couples is avoided by the vast majority. Some informants explained that if a woman knows how to use condoms, or suggests new sexual experiences, her husband concludes she has been unfaithful. It is obvious that sustained, innovative approaches will be needed to overcome this dilemma.

49. Other cultural norms require the young to be obedient and to place service of the family above personal desires (Jamieson 1993). Recent studies have found these gender and age-related norms strongly enduring, and clearly associated with various health-related risks (Do Thi Ngoc Nga and Morrow 1999; Morrow et al 2002; MoH 2005b).

50. While girls and women do face certain risks related to HIV, the overwhelming number of infections in Viet Nam is among boys and men. As elsewhere (Courtenay 2000), concepts of masculinity promote risk-taking and discourage self-care. Vietnamese males are more likely to use drugs, which largely explains the disparity in infections. Moreover, males are clients of SWs, and often do not use condoms with casual partners or with wives. Unemployed young men spend more time outside the home with friends and make easier targets for drug pushers, as well as for pressure from peers, which many lack the skills to resist. Unemployed young women spend most of their time at home, largely to do housework, but also because parents give them less freedom; therefore, they are less likely to engage in risky behavior.

51. Despite its key role in HIV transmission in Viet Nam, gender is almost completely absent from prevention programs. While awareness of gender equity is high, there is little awareness of the risks for both sexes from normative gender roles. There is a great need for more public discussion of these norms and for programs for youth that address gender-related risks.

#### **d. Youth and HIV/AIDS Risk in Viet Nam**

52. This Project will focus on ‘youth’, which means it is important to explore the mechanisms and pathways to HIV/AIDS risk for this large population sub-group.

##### **Achieving ‘Healthy Youth Development’**

53. Since the mid-1990s, the international approach to youth health has moved away from the concept of ‘risk behaviors’, which led to medicalised approaches and the stereotyping of young people as sources of problems and social breakdown (Blum 1998). Most youth lead healthy lives and make good decisions; a small minority undertake risk (and this minority are more likely to undertake other risks). This ‘clustering’ of risk behaviors suggests a need to target more precisely and to develop more realistic profiles of young people, but, importantly, to investigate new ways of responding to vulnerability.

54. For the last decade, WHO and other organizations have been compiling evidence showing that improved youth health can be obtained if the emphasis is shifted to the development of youth skills, resilience and self-esteem, and to the building of safe, protective settings in which youth can experiment within reasonable limits (WHO 1999). Evidence that youth do not always perceive risks, and, moreover, may prioritize social relationships above

health concerns, offers further rationale for a healthy development framework (Rugkasa et al. 2001). This model is grounded on understandings about stages of child and youth psychological development, and on observations that young people do better when surrounded by adults who care about them, make them feel worthwhile, value their ideas and involvement, and can discipline effectively without relying on beating or intimidation. If children start doing something risky, or are being exploited, bullied or sexually abused, they may not want to confide in their parents (and thus seek help) if they cannot communicate with them openly. Good communication can enable problems to be dealt with early, and also fosters warmer family environments, which benefit all members. The 2004 Survey Assessment of Vietnamese Youth (SAVY) adopted this model, noting:

“Many worldwide programs that strive to prevent dangerous youth behaviors utilize the risk and resilience model, which focuses on reducing factors known to increase the potential for problem behaviors (‘risk factors’), while emphasizing those factors known to promote resilience, or young people’s capacity to cope in difficult times (‘protective factors’).” (MoH 2005b:16).

55. The Healthy Youth Development model differs in some ways from typical approaches to youth health and well-being in Viet Nam. There are clear contrasts between the individualism which underpins western culture—and the focus on individual development—and traditional norms that have served Viet Nam well over the centuries. Vietnamese norms place great emphasis on the duty of children to work and study hard, serve parents and the family unit (Jamieson 1993) and the modern state considers all citizens as responsible for the development of the nation. These traditional ways of parenting are not working as smoothly in some families due to social change, and some parents know few tools apart from criticism and corporal punishment. Recently, the Viet Nam News featured the problem of youth depression and suicide, which are sensitive issues in Viet Nam. The article reported instances where parental criticism and false accusations had led youth to drink insecticide. A recent UNICEF survey noted in the UN Country Assessment (2004) found over 30% of youth injuries are self-inflicted. At the same time, there is now a greater interest in human psychology, early childhood development, and related fields, which provides an opening from which to build discussions about youth well-being.<sup>3</sup> Parents everywhere want happy homes and good relationships, but in rapidly changing times they may not know how to achieve these aims.

### **Youth: A Focus of Hope and Worry in Viet Nam**

56. In Viet Nam, as elsewhere in today’s world, youth are recognized as ‘the future’. However, at the same time they are seen by some in negative ways, and blamed for social problems and moral decay. This ambivalence emerged in a recent account of a National Assembly debate on a proposed ‘Law on Youths’, where delegates described ‘the increasingly decadent lifestyles of youths and their use of and trafficking in drugs’, and their place as ‘among the worst law-breakers which made it necessary to clearly spell out their responsibilities to family and community’. One delegate noted, ‘Between 16 and 18 years...their key responsibility was to be good students and obedient children’ (VN News 7/6/2005). They said the law should specify the ‘duties’ of young people in getting vocational training – which related closely to human resources development – to serve industrialization and modernization.

57. For over a decade there has been much public discussion about the roles, rights and responsibilities of youth in Viet Nam. Some of the focus on youth may arise because overall social change (perceived both in positive and negative terms) is most evident in relation to

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<sup>3</sup> It should also be noted that there is a growing interest in a concept called ‘family development’ in Viet Nam, including through VCPFC. ‘Family development’ overlaps to some extent with WHO’s ‘healthy youth development’ in that it recognises the needs and potential of the family unit in the well-being of the individual and the community.

the behaviors and lifestyles of young people, who adapt readily to new technologies, and (through curiosity) seek out new experiences with enthusiasm. Youth are highly visible in some of Viet Nam's fastest growing sectors, such as tourism and industrial zones, and make up much of the country's increasing pool of migrant workers (MoH 2005b). The high proportion of youth among PLWHA undoubtedly adds to generalized concerns about this population.

### **Youth Rights, Duties, Protection and Civil Society**

58. In recent years, there has been increasing discussion of rights in Viet Nam in relation to various issues and populations, including youth. Discussion of rights remains 'sensitive' in Viet Nam, partly because there is an exceptionally high emphasis on civic duty for all population groups (Bondurant et al 2003). Viet Nam's Youth Development Strategy focuses far more on duties than on rights. Child rights receive relatively more attention, as is apparent in the release of reports on children affected by HIV/AIDS (UNICEF 2003; MoLISA and UNICEF 2005a), including a legal review (MoLISA and UNICEF/Viet Nam 2005b). In 2005, the Government signed letters in support of the International Labor Organization's Project to Combat Trafficking in Women and Children. The Grassroots Democracy Decree 79 (2003) is seen as a step towards the building of civil society, as it institutionalizes participation of community-based organizations (CBOs) to make public services more responsive and accountable. The Socio-Economic Development Strategy (2000–2010) and the draft Socio-Economic Development Plan (2006–2010), in line with the policy of decentralization, call for more involvement of CBOs, which should present new opportunities for local partnerships and greater autonomy.

### **HIV/AIDS: Most Vietnamese Youth are NOT at High Risk**

59. While youth make up the greatest number of PLWHA, the vast majority do not engage in risky practices, despite what is suggested by public discourse. A 1999 survey in 6 provinces among 1,500 youth aged 15–22 found that just 10% of males and 5% of females reported having pre-marital sex. The rate among those aged 15–19 was 6% in males and 2% in females (versus 27% in boys and 3% in girls of this age in Thailand) (Mensch et al 2003). The authors argue that assumptions about youth risk (often framed in terms of globalization and contact with Western culture) have not been grounded in population-based studies, but in anecdotal reports and small, unrepresentative surveys in cities where social change is most apparent. Similar findings were released recently from the 2004 Baseline Survey of the Reproductive Health Initiative for Youth in Asia (RHIYA) Vietnam program, which assessed awareness, attitudes, practices and behaviours among 1390 rural and urban respondents aged 15–24 from 11 provinces. The survey found just 7.6% reported having sexual intercourse (EU/UNFPA/ 2005). It also found that 45% reported not knowing how to use condoms.

60. Results from SAVY, the large, population-based national youth survey, conducted in 2004 by the Vietnamese MoH and a number of international organizations, were released in August 2005 (MoH 2005b). SAVY had a sample of 7,584 individuals aged 14–25, and found very low reported rates of risk behaviors<sup>4</sup>. Just 16 boys and four girls aged 14–17 reported having had sex. Among those aged 18–25, 15.4% of males and 2.3% of females reported having sex, with rates somewhat higher for urban males (19.8%) than for rural males (13.6%). Female rates were nearly identical for urban and rural (2.6% vs. 2.2%). It should be said, in addition, that such findings for young women are consistent with those from other Southeast Asian studies. By contrast, for both sexes, rates are extremely low compared to those found in sub-Saharan Africa, Latin America, Great Britain and the United States. SAVY also found that the large majority of both males and females disapproved of the idea of pre-marital sex, even where both partners were willing.

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<sup>4</sup> It must be noted, however, that youth at high risk were unlikely to have been surveyed. The survey had little representation from residents in Rehabilitation Centers, mobile workers, sex workers and Street Children.

61. The Survey found that just 0.5% of respondents reported ever having used any illicit drug, of whom 35 were males and 6 were females. One limitation is that no residents of 05/06 Centers participated in the survey, and the researchers felt the findings almost certainly underreported the real figures, especially since 42.4% of urban youth and 20.8% of rural youth said they knew someone who had used drugs. While 66% overall reported that it was difficult to access heroin, 16.3% of urban males aged 22–25 said it was easy.

### **Knowledge and Attitudes**

62. SAVY explored factors linked to potential HIV risk, including knowledge and attitudes. Results showed knowledge of STIs was incomplete, with about two-thirds of the sample able to identify only three: Hepatitis B, syphilis and gonorrhoea. Nationally, 97% had heard of HIV/AIDS, and about half had heard from multiple sources, with mass media named most frequently, followed by family and professionals (schools and civil society organizations).

63. Just over half the sample (52%) were assessed as having high knowledge levels about HIV, 39% had medium and 8.5% low knowledge. SAVY found 84.5% knew an HIV+ person can look healthy, a 10% improvement on results from the Viet Nam Demographic and Health Survey of 2002. Around two-thirds knew where they could access HIV testing. Nearly 98% recognized that condoms could prevent transmission, while avoiding sharing needles was recognized by 96%. 70% thought condoms reduce pleasure and half felt those who carry them might have ‘improper relations.’

64. Far fewer young men (48%) had spoken to their family about reproductive health than had young women (78%), though similar numbers reported talking about HIV. The SAVY researchers attributed this to the fact that HIV is “a predominantly male issue” linked to drugs and SWs. Overall, 40% claimed they had never heard of homosexuality, and of the 60% who had, 80.4% said they would not accept a homosexual man as a friend (MoH 2005b).

65. The RHIYA Vietnam baseline survey (EU/UNFPA 2005) found over 95% of youth aged 15-24 had heard of HIV/AIDS but 6.3% said that it cannot be prevented, and 31.4% had misconceptions about transmission modes.

### **Risks Among Sub-Groups**

66. It is clear that only a small fraction of Vietnamese youth are in real danger of HIV infection. Until they marry (and if their husbands have multiple partners) the vast majority of young women are not at high risk. Young males are at relatively greater risk of undertaking behaviors that can lead to transmission, which means they merit more attention. IDUs, SWs and MSM remain the sub-groups at highest risk, but it is also clear there are vulnerable communities who may move into the high-risk category. The “clustering” of risks also means those engaged in drugs, for instance, are also likely to engage in sexual activity at an early stage. For these reasons, it is useful to categorize youth in Viet Nam, using the following definitions:

- i) “Mainstream” youth, defined as those who are in school or employed with a reasonable wage, are considered to be at very low risk of transmission, but are likely to hold attitudes that are discriminatory towards PLWHA;
- ii) “Vulnerable” youth include those living with HIV/AIDS, school drop-outs, unemployed youth (especially males), mobile youth, youth living in poverty, homeless youth, and those employed in poorly paid work, e.g. in some industrial zones, tourist spots and construction sites; and
- iii) “High-risk” youth are defined as those already engaging in unprotected sex (heterosexual and homosexual) and injecting drugs.

### Education and Life Chances: Achievements and Gaps

67. Since education is associated with greater life choices and with better health-related decisions, it is relevant to consider the state of education for today's youth in Viet Nam. While literacy rates are very high in Viet Nam (95% for males, 91% for females in 2000 [UNICEF 2005]) and around 95% of youth have attended school, drop-out remains a problem, particularly in rural areas. Mensch et al (2003) found female drop-out was slightly higher than male drop-out among their sample aged 15–22, but that place of residence was far more important than gender. The main reason cited for leaving school was the cost of fees. The relationship with employment was somewhat surprising, with joblessness found most often among those with higher levels of education, especially for urban youth, but this could be explained if rural youth were considered employed even when engaged only on family farms or home gardens, and not separately earning an income. More than half of out-of-school males and unmarried females with some secondary education residing in urban areas were not employed at the time of the survey. Given links between joblessness and both drug use and sex work, these statistics merit attention.

68. The Table 1 shows completion rates for youth aged 14–25 (MoH 2005b). The drop-out points are slightly different for urban and rural youth, with completion rates for higher education much higher in cities.

*Table 1: Educational attainment by urban/rural residence among youth aged 14–25 (%)*

Level attained	Urban %	Rural %
Primary school	9.0	20.2
Lower secondary	38.7	53.7
Upper secondary	30.7	21.1
Less than bachelor	7.5	3.1
Bachelor or higher degree	13.9	1.5
Did not attend school	0.2	0.3
Total	100	100

Source: SAVY draft April 2005

### Youth Needs: Employment in the Context of Renovation and Globalization

69. Youth job creation is a major priority for Viet Nam, where around 1.4 million young people enter the labor market annually. The UN Country Assessment (2004) highlights the inadequacy of opportunities for vocational training and tertiary education, calling youth unemployment a 'missed opportunity for growth and a root cause of social problems such as depression, crime, and alcohol and drug abuse' (p. 26). The report laments the lack of comprehensive plans and systems to promote vocational training and youth employment. Unemployment threatens to undermine the nation's success at poverty reduction.

70. A UN Press Release (2003) raised the issue at the time Viet Nam released its Youth Development Strategy, which emphasizes employment. This emphasis appears appropriate considering the demographic profile of Viet Nam, where about 16 million of the country's estimated 81 million people are aged 15–24. Youth unemployment is estimated at 4–8%, but up to 16% in cities (UN 2004). Young women have slightly higher unemployment rates, but overall, around 26% of youth are underemployed.

71. The Press Release attributed rising youth unemployment to: (i) insufficient jobs to match demand; (ii) youth lack of skills to suit employers' requirements; and (iii) restructuring in state-owned enterprises and fierce competition among enterprises. The latter also results in low wages and long working hours as companies strive for market share in today's global-

ised economy<sup>5</sup>. Youth need specialized assistance to move into today's changing employment environment in Viet Nam. The UN noted the need for employment services that are sensitive to the particular needs of youth, including vocational guidance and counseling.

72. Young people are anxious about jobs and security. Mensch et al (2003), in their survey on adolescents and social change, found that of young people aged 15–22, 69% of males and 66% of females cited employment and/or income as their principal preoccupation for the next five years. SAVY (2005) found that of the total sample, around 12% were neither in work or in school, but this rose to 28.4% among married youth. All age groups reported that it is difficult to find a job (64%). When asked to name their two highest aspirations, employment was named first by the greatest proportion of respondents (49.6%), with 23.3% naming economic security. Less than 10% named overall happiness, a clear indication that economic vulnerability remains a paramount concern.

### **Joblessness, Low Wages, and HIV Risks**

73. At the same time as unemployment is rising, drug availability and promotion are increasing, as are opportunities to enter the commercial sex trade. Job creation and skills development for youth are important elements of an effective HIV prevention program in Viet Nam. It is estimated that thousands of young Vietnamese women are trafficked outside the country each year, particularly into China, Cambodia, Taiwan, Thailand, Singapore and South Korea (United Nations 2004). This exploitation is linked to poverty, family difficulties, low education and unemployment. Trafficking is also occurring domestically, and in 1997 the Government approved a National Plan of Action on Trafficking 2004–2010.

### **e. Lessons Learned—What Works for Youth HIV/AIDS Prevention**

74. The aim of youth prevention programs is to reduce risky behaviors (namely sex without condoms and sharing of needles/syringes). There are no 'magic bullets' to guarantee success; however, information, services, and accurate understanding of the social context in which young people make decisions on health behaviors are all necessary (World Bank 2003). Encouraging behavior change is notoriously difficult, but we are now better able to identify tools and principles that are associated with better outcomes.

75. Lessons learned over the past decade help us to recognize that multiple approaches are needed for youth HIV prevention, including (i) building protection (through skills, knowledge and safer environments); (ii) targeted communication to assist risk groups to change their behaviors; (iii) introducing harm reduction (to enable healthy choices); and (iv) involving youth – including PLWHA – as decision makers and partners in implementation. It is important to note that concrete decisions regarding target groups and the allocation of resources will depend upon the nature of the epidemic in a given setting. The World Bank (2003) suggests that where the epidemic is concentrated, as is the case in Viet Nam, focus should be on youth who are engaged in risk behaviors. Different methods for implementing these approaches will be discussed below.

### **Healthy Youth Development**

76. The concept of Healthy Youth Development is based upon a recognition that building 'protective factors' and removing risk are essential for youth to reach their potential, and also for them to make healthier decisions and thus, it is hoped, avoiding behaviors that pose risk for HIV transmission. This means that influential adults (parents, teachers, leaders) should understand the basics of child/youth development, have empathy for children, and be en-

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<sup>5</sup> In factories visited in several provinces during the Consultation Phase, the TA team met with young employees working 6–7 days per week, and up to 11 hours per day to fulfill quotas and 'to compete with Chinese production'. Wages for a 7-day week in a garment factory were according to output, but averaged only about USD35/month, which clearly perpetuates the practice of long work hours.

couraging and affirming, rather than too critical. Some effective approaches to building protection include Parenting Skills training, participatory teaching methods, and school-based programs.

77. One experimental school-based program that has shown promising results is the Gatehouse Project in Melbourne, Australia, which adopted a randomized controlled design from its starting point in 1997. The study, based on the Healthy Youth Development Framework, is still underway. It aims to help schools promote student emotional health by increasing students' sense of connection with the school and wider community of adults. The intervention operates at the individual level to build students' skills for dealing with difficult situations and emotions, and at the environmental level, using a variety of strategies to reduce risk and increase protective factors in the school environment (Bond et al 2004; RCH 2004). The theory of the Healthy Youth Development continues to be tested. There is still a lack of published findings from rigorously planned and evaluated programs, particularly in developing countries.

### **Strategies for Youth HIV Prevention**

78. There is a growing body of international evidence about the most effective ways to target youth for health promotion in general, and for HIV/AIDS in particular. Successful strategies share a number of common features (UNAIDS 2004; World Bank 2003; Youth and HIV.org 2003). These include:

- i) Creating a supportive environment by implementing policies that ensure youth can access HIV and reproductive health education and services (including voluntary counseling and testing [VCT]), and are not subjects of discrimination;
- ii) Reaching those who influence young people. Parents, families, teachers and leaders are strong influences on young people. Evidence shows that youth act more responsibly and develop self-esteem when these adults offer good role models, affirming relationships and safe environments;
- iii) Placing young people at the center of the response. Young people are assets, not liabilities; their voices need to be heard and their talents cultivated so they can be instruments for change;
- iv) Segmenting programs by age to meet the needs of youth at different developmental stages – and in different environments;
- v) Mobilizing the educational system to become a vehicle for a comprehensive prevention and care program for school-age youth;
- vi) Mainstreaming HIV/AIDS prevention and care into other sectors. Youth can be reached through clubs, religious groups, sports, workplaces and the media;
- vii) Addressing gender by improving girls' opportunities for education, skills and jobs. There is also a need to change the damaging concepts of masculinity that lead young men into risk, and which negatively affect girls and women. Authorities must transmit a clear message that sexual exploitation and violence against youth are unacceptable; and
- viii) Opening dialogue on sensitive issues. Adults and young people need to work together on the issues of adolescent sexuality, sexual health education, sexual violence and abuse, gender roles and traditional practices. Youth sexuality is sensitive, so culturally acceptable ways must be found to overcome opposition to discussing this topic.

### **Life Skills for Youth**

79. Life Skills is a term used loosely around the world, and is no universal agreement about its definition. Life Skills for healthy youth development, and for HIV prevention, are specific, and include: negotiation, conflict resolution, empathy, critical thinking, decision-

making and communication. These skills help youth to get along with each other, and to relate better to parents and adults, but also help to build self-esteem, resolve disagreements peacefully and resist both peer and adult pressure to take unnecessary risks. Life skills can be taught in many creative and innovative ways, both in and out of school ([www.unicef.org/programme/lifeskills](http://www.unicef.org/programme/lifeskills)).

### **Behavior Change Communication (BCC): what works, and why**

80. As noted earlier, HIV prevention depends mainly upon reducing transmission through sex and injecting drugs. Therefore, successful prevention requires changes in these specific risk behaviors. The international community now knows more about what does *not work*, as well as what is required to enable sustained behavior change.

81. *Information on its own is not sufficient* — Analysis of historical trends and prevention strategies shows that provision of information alone is not effective for reducing risk behavior (FHI 2001). For years it was assumed that people would alter their practices if they were made aware of risks, an assumption that led to the proliferation of Information–Education–Communication (IEC) campaigns. However, it gradually became clear that individuals cannot always make changes, despite their willingness, due to the influence of wider socio–cultural, economic and environmental forces. For instance, knowing about condoms is not enough if access, skills, and partners willing to use them are lacking. It became apparent that the obstacles to behavior change must also be addressed, not only through communications, but also through actions to change social norms and situations that make risk-taking more likely. These realizations have contributed to the development of a new term, Behavior Change Communication (BCC), which conveys a new emphasis on enabling the process of change.

82. *Effective BCC needs a research base* — For BCC to be successful, it must be grounded on in–depth assessment of the social and cultural context where behaviors occur (FHI 2001; CDC 2004). Too often, communication materials are developed according to the assumptions of health programmers, which may be out of date, or drawn from unrepresentative samples. If messages do not resonate with target groups, they are a waste of time and money. Careful, formative research, using both qualitative and quantitative methods, is essential to provide understanding of target needs and opportunities. Formative research supplies the baseline needed for systematic planning, and for later program monitoring and evaluation.

83. *Population–based change depends on individual change* — Most health campaigns aim for lasting behavior change in order to see a population–level impact, but behaviors are practiced on an individual level. Hence, campaigns must persuade specific target groups about the actual benefits of behavior change, expressed in terms they understand, rather than appealing to notions of community benefits (though these may also strengthen the argument). This means messages must be ‘customized’ to appeal to and captivate the target group, rather than vague generic messages for everyone; they also must be easy to act upon (CDC 2004). Here, the ‘Stages of Change’ Model (Prochaska and DiClemente 1982) is useful, as it identifies the process of decision–making according to perceived advantages and disadvantages, and the steps towards ultimate adoption and maintenance of healthy behaviors (as well as relapse).

84. *Multiple approaches for achieving maximum impact from communications strategies* — Both UNAIDS (2004) and the US Center for Disease Control (CDC) (2004) agree that best results are produced by a ‘systems approach’ which combines multiple mass media activities with community collaborations, training as needed, and activities by local groups that ‘have credibility’ with target groups. Using several approaches and channels simultaneously, in a coordinated manner, conveys a sense of vigor that adds to the sustainability and impact of the overall program. It also enables the use of different approaches to serve different

needs, which become mutually reinforcing. For example, print materials are good to raise awareness and serve as reminders, while radio and TV reach millions quickly.

85. *Personalized approaches are also highly effective* — Interpersonal communication (IPC) between peers<sup>6</sup>, or between youth and those who influence them, are helpful in persuading individuals to try new services or behaviors. Advocacy through communication channels is also crucial to build support for policies and programs. These can happen at the same time as peer education programs, poster competitions, training videos and leaflet distribution.

86. *Entertainment–Education* — One key approach directed at changing social norms over time is “enter–educate”, that is, to place health or social messages into popular entertainment. CDC (2004) suggests this can be achieved by working with script writers to write messages into television soap operas or dramas, as well as comic books. Magazines and newspapers can also be used for high visibility and to reach mass audiences. In today’s digital age, internet–based activities and CD–ROMs offer further scope to reach target groups, while dramas and contests bring youth together for sharing and learning. While comprehensive data are not available about the impact of using enter–educate for behavior change, but some evidence suggests it has been effective in particular settings. For example, Collins et al (2003) found that 65% of viewers surveyed after an episode of Friends recalled its depiction of condom failure resulting in pregnancy, and 10% had discussed this issue with an adult. The authors conclude: ‘Entertainment television can serve as a healthy sex educator and can work in conjunction with parents to improve adolescent sexual knowledge.’ Enter–educate for HIV prevention has been used in India and Cambodia by the BBC World Service Trust, and in South Africa by local NGO ‘Soul City’. (See Appendix D for a review of the use and impact of the enter–educate approach for behavior change.)

87. *Who should be targeted in a concentrated epidemic?* — For countries with low overall prevalence and concentrated epidemics, such as Viet Nam, the UNAIDS Best Practice series concludes that BCC is the ‘cornerstone’, but should be *targeted to vulnerable and high risk groups* for the most effective impact (FHI 2001). However, it is essential that the BCC activities themselves incorporate the identification of risks, barriers to change, and motivators to change.

88. *After successful targeting of high risk groups, BCC should be extended to groups that are less vulnerable, starting with those who are connected to high risk populations.* — Mass population approaches are also needed to enable a supportive environment for prevention activities – especially harm reduction – and to reach those individuals who were not reached by the earlier approaches, and to strengthen the capacity of whole populations to resist HIV infection.

### **Harm Reduction: Going Beyond Communications for Prevention among IDU Youth**

89. In Viet Nam, a large proportion of transmission occurs by needle sharing among young IDUs. A recent review of HIV prevention for young IDUs (Dolan and Niven 2005) noted that half of new HIV infections worldwide are among youth aged 15–24, but that most research has focused on adult transmission. Young IDUs may be at greater transmission risk due to their involvement in a cluster of risky behaviors, such as unprotected sex, and the most vulnerable of those—who are homeless, marginalized youth—are hardest to reach, and most likely to sell sex for food, shelter or drugs. They also experience more stigma, which may discourage testing and care–seeking.

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<sup>6</sup> To be effective, peer education must be conducted between people who have similar backgrounds and similar status or power. Otherwise it is difficult to establish trust and open communication. It is common in Viet Nam to use ‘peer education’ to describe outreach by people with official or semi–official positions, or to use former sex workers and former drug users. This is not consistent with international definitions.

90. Harm reduction is the most effective approach to concentrated HIV epidemics, such as the one in Viet Nam. In this context, harm reduction consists of needle/syringe exchange, drug substitution and condom distribution and promotion. The evidence for the role of drug substitution programs, such as methadone and buprenorphine, is so compelling that WHO has added these to its Essential Drugs (Complementary) List, a category that requires involvement of specialized diagnostic or monitoring facilities. The governing body of UNAIDS, at its board meeting in June 2005, adopted a new policy that calls for 'comprehensive, integrated and effective system of measures that consists of the full range of treatment options, (notably drug substitution treatment) and the implementation of harm reduction measures (through, among others, peer outreach to injecting drug users, and sterile needle and syringe programs), voluntary confidential HIV counseling and testing, prevention of sexual transmission of HIV among drug users (including condoms and prevention and treatment for sexually transmitted infections), access to primary healthcare, and access to antiretroviral therapy. Such an approach must be based on promoting, protecting and respecting the human rights of drug users (<http://www.ihra.net/> Accessed 31 July 2005).

91. In its Evidence for Action Technical Paper, WHO (2005) recommends that countries with opioid injection (such as in Viet Nam) should consider a range of approaches, including drug substitution. This is based on research which found a 3–7 fold cost–benefit advantage when the burden of the criminal justice process is also factored in. There is no evidence that prolonged incarceration is cost–effective and it is associated with very high relapse rates. Psycho–social therapy on its own is rarely sufficient, but can play an adjunct role together with drug substitution therapy. Lengthy periods of abstinence are effective, but only if individuals do not fall into chaotic drug dependency. Self–help groups, modeled on Alcoholics Anonymous, have been shown to be effective for many people if adherence is high and meetings are frequent. The document urges policy makers to consider shifting funds from incarceration into community rehabilitation programs that include drug substitution, noting that the epidemic is progressing faster where these do not exist, and that 'such negative trends are likely to continue' (p. 19).

92. Another report in the Evidence for Action series (WHO 2004) concluded that community–based outreach programs – that involve risk reduction information, materials for safe/clean injection, referrals for VCT, and treatment for HIV–related illnesses – are effective in reducing HIV transmission among hard–to–reach, hidden populations of IDUs.

#### **f. Current Approaches—Strengths and Limitations**

93. The strengths of the new National HIV/AIDS Strategy and aspects of the new Youth Development Strategy offer some directions for responding to the HIV epidemic among youth in Viet Nam. Concurrently, the growing national interest in 'family development' signals an increasing awareness of the social and health needs of individuals within family units. It is clear that, while the profile of HIV prevention has been high in Viet Nam for over 15 years, there is still an expanding epidemic and a need for new approaches. An analysis of current organizational systems utilized by GoV authorities in HIV prevention was undertaken in 2003 with UNDP funding (CCRD and ILSSA 2003). The study used both qualitative and quantitative methods to survey HIV prevention implementers in five provinces, and to conduct a document review. It found weaknesses in national oversight, and in monitoring and evaluating systems at the provincial level that were attributed to some or all of the following: (1) disruption caused by several phases of restructuring at national level; (2) difficulties in harmonization and coherence of overall national program with increased decentralization (and direct funding) to provincial level; (3) perceived inconsistencies in guidelines and standards disseminated from national to provincial level; (4) limited financial and human resources, particularly in planning, monitoring and evaluation capacity; (5) challenges in correctly attributing impact because of large numbers of concurrent programs; (6) low priority of HIV preven-

tion in some provinces, coupled with 'social evils' emphasis; and (7) relatively small involvement of local NGOs compared with neighboring countries such as Thailand. A very large number of programs are being implemented in Viet Nam, and some show promise. Many of these are small-scale, pilot projects (but do offer hopeful models). Some projects are for the general population, and do not specifically target youth. A number of gaps and limitations remain which offer a niche for the proposed Project.

### **The Youth Union: a Major Player in Viet Nam**

94. Viet Nam's Youth Union is the civil society organization with special responsibility for, and access to, youth aged 14–28. The Youth Union offers a specific channel for youth to become involved, and has a membership of 4.5 million, though its most active members tend to be those who excel academically (UN 2004). The Youth Union almost invariably collaborates on interventions with youth targets, whether GoV, international or NGO.

95. The Youth Union's three main responsibilities are: education; advocacy of youth rights and interests; and supporting Government initiatives aimed at socio-economic development. Though originally a political organization, the Youth Union is increasingly involved in activities related to youth well-being. It has established Steering Committees on HIV/AIDS Prevention in the provinces. In 2003, it launched a national movement to engage youth volunteers in "Preventing AIDS, Drug Use and Prostitution", and much of its focus has been directed at 'social evils'. In addition, the Youth Union sent a group of members on a Harm Reduction Study Tour to Australia in 2002 (Kanaef and Higgs 2003), and during provincial visits the TA team met Youth Union members undertaking outreach to PLWHA and IDUs. However, its current activities largely consist of IEC for HIV/AIDS through dialogues, forums, competitions and dramas.

### **HIV/AIDS and Life Skills Education for Youth in and Out of School**

#### **HIV/AIDS Education**

96. The Ministry of Education and Training (MoET) is currently undertaking a major revision of its curriculum to meet the socio-economic challenges and opportunities of the 21st century. Within this exercise, HIV/AIDS education will be integrated into existing subject curricula starting from Grade 5 (Science), and repeated within Biology (Grades 9 and 10) and Civics (Grades 6–12). Given that most youth drop out after Lower Secondary school (approx age 14), the new curriculum will cover most youth for some period of exposure once it has been implemented. New textbooks for Grade 8 have been implemented nationally, with targets for the introduction of new Grade 9 texts in the coming academic year, and Grade 10 in 2006–07.

97. HIV/AIDS education is also included, but for only a few times a year, in the (compulsory) Extra-Curricular Program for every grade in Lower and Upper Secondary schools. One example in which this appears is a Grade 10 topic, 'Youth and the role of social evil prevention'. This example reflects the current emphasis on youth responsibilities, as well as on 'social evils'. Sexuality is not covered.

#### **Life Skills Training**

98. Schools can play a vital role in reproductive health and HIV education, but to be effective, they should offer Life Skills education, comprehensively covered by trained teachers, with time for consolidation and the practice of new skills. Teachers, students and parents are under increasing academic pressure, making it difficult to introduce new subjects into the curriculum. Understandably, students focus on exam-based subjects, and Life Skills education at present is not examinable. There are other obstacles, as well. During Provincial visits the TA team was told that most teachers don't feel comfortable teaching about sexuality, and most students do not want to receive this information for their class teachers. Teachers also lack skills and teaching aids (these were requested in provincial visits), and class sizes are

very large, posing real challenges for role plays and interactive approaches. At present, comprehensive 'Life Skills' education is not mandated, and where provided, is usually piecemeal and emphasizes avoiding 'social evils'.

99. A Life Skills and HIV/AIDS education program has been progressively implemented in schools in selected provinces since 1997 by UNICEF and MoET. Beginning as a pilot, it involved teacher training and materials development. By early 2000, it had been implemented in all primary schools, and began to be expanded to Lower Secondary schools. With MoET support, the pilots are implemented in a total of 9 provinces (total of 13 districts) and 120 schools. The program covers concepts of gender, as well as skills and risk protection, and also targets parents to raise their awareness of youth needs, and to improve their capacity to communicate with their children. ([www.unicef.org/programme/lifeskills](http://www.unicef.org/programme/lifeskills))

100. The UNICEF Life Skills Program has also been adapted for use in other settings, reaching children and adolescents living on the street, helping them to protect themselves from HIV/AIDS, sexual abuse and drug abuse. Other Governmental organizations, such as the Viet Nam Commission for Population, Family and Children (VCPFC), Viet Nam Family Planning Association (VINAFFPA), Women's Union and Youth Union, have supported street children with housing, health care, education and training, including awareness-raising about HIV/AIDS.

101. A variety of other organizations (mainly UN and international NGOs) have also aimed to increase youth Life Skills for HIV prevention. Some do this systematically in ways similar to the UNICEF, with classroom role plays and awareness-raising exercises. Others do so indirectly, e.g. the KOTO (Know One Teach One) and Hoa Sua projects, which have supported youth in difficult circumstances to gain self-confidence and employment skills through long-term, intensive support. These projects are considered highly successful, but are small-scale.

### **Vocational Training**

102. There are some 130 Employment Promotion Centers throughout the country, either under the direct authority or technical control of the MoLISA, or falling within the authority of other Government sectors (e.g. Ministry of Interior, Ministry of Defense, District People's Committees) or organizations (e.g. the Viet Nam General Confederation of Labor, Youth Union, Women's Union, Technology and Science Association, Veterans Association, Universities and Colleges, etc.).

103. Vocational Training Centers and Job Recruitment Centers are rapidly increasing in number in Viet Nam. Many drop-outs seek vocational training in MoLISA-supported centers. MoLISA has recently sought approval to expand its current network of 1,700 training schools/centers, which train about 1.1 million people annually (Viet Nam News, 28 July 2005). The proposed new system would permit the establishment of another 350 centers, largely through private investment, to extend training to 1.5 million students, while strengthening connections to mechanisms that identify specific labor needs. At present, Life Skills and HIV education are not included in training, but managers in some provinces expressed interest in their inclusion. Vocational training and job recruitment centers also offer easier access to a population that is otherwise dispersed and difficult to reach, thus providing economies of scale. Small vocational training programs also exist in some urban centers for street children.

### **Recent ADB Responses to the HIV/AIDS Epidemic in Viet Nam**

104. The recent ADB project, Community Action for Preventing HIV/AIDS (JFPR: REG-9006), was implemented in Cambodia, Laos and five border provinces of Viet Nam (Lai Chau, Quang Tri, An Giang, Kien Giang and Dong Thap). The project targeted youth (aged 15-24), female SWs, IDUs and male migrant workers, and conducted baseline and end-line

surveys with these groups, as well as health workers, PLWHA and their relatives, and pregnant women. The project combined information and education activities with condom promotion, surveillance and treatment of STIs, piloting of management, care and support at community level, and needle/syringe exchange in Lai Chau province only. The evaluation reported general success in meeting objectives. Correct understanding about HIV/AIDS increased in most groups, and there was a general reported reduction in risk behaviors. Among SWs, rates of gonorrhea and Chlamydia declined in all provinces, but syphilis rates increased in 3 provinces and Herpes simplex type 2 rates increased in 2 provinces. The exit survey found SWs were getting younger and that a small proportion continued to inject drugs. Rates of consistent condom use among street-based SWs with casual partners increased from 18.4% to 57.5%. While rates also increased with husbands/boyfriends (16.2% to 37.8%), it is clear that many sexual encounters happened without barrier protection among this high-risk group. Among IDUs, an increase was found among those who reported never sharing needles (from 80% to 84%), but in two provinces sharing actually became more common, including in Lai Chau, where a needle/syringe exchange was introduced. It is not known why the situation worsened in some provinces; additional data exist which could be subjected to secondary analysis, but it is possible that external factors or deficiencies in the communications component could be responsible.

#### **Summary Gaps in Programs to Date**

105. While most projects include activities that will directly or indirectly benefit youth, none to date has had an explicit focus on BCC for youth. Other limitations are summarized here.

#### **Youth and PLWHA involvement remains low**

106. The new National HIV/AIDS Strategy recognizes the importance of engaging youth in prevention, but more needs to be done in this respect. In SAVY (2005), 22.2% of young people suggested that increasing opportunities for young people to participate could be one role for the Government. However, a recent evaluation of UNFPA programs in Viet Nam found that youth involvement was still largely token, restricted mainly to activity implementation, not as decision-makers (Bondurant et al 2003). During provincial consultations, youth expressed an eagerness to make a real contribution, with many adding that they had very few opportunities to offer their opinions about their needs, dreams, hopes and fears. HIV+ youth are beginning to find a voice, for example, the Friends-Help-Friends group that works in awareness-raising among youth. But young PLWHA met during provincial visits felt they needed more training and assistance to be able to make an impact. They also noted the lack of information for care and treatment of PLWHA, and suggested a website as one means of reaching the many infected people who live apart from families or community support. If target groups are not genuinely engaged in all stages, beginning with research for project design and implementation, the resulting activities may not be relevant or effective (Bondurant et al 2003). The stigma and discrimination from health workers and the negative images of PLWHA illustrated in IEC materials contributed to preventing them from actively participating in social activities (TA consultation with the Bright Future Group of PLWHA in Hanoi in August 2005).

#### **Lack of shift to BCC**

107. IEC campaigns continue to be the norm in health messaging in Viet Nam, and the emphasis continues to be on provision of information for general audiences, rather than targeted information based on comprehensive research to identify obstacles and motivators to behavior change, as recommended (FHI 2001). A recent evaluation (Bondurant et al 2003) of UNFPA reproductive health programs in Viet Nam found an abundance of information materials, but most used conventional IEC approaches. These materials failed to target risk perception or obstacles to behavior change. The materials and strategies used, for example, in new clubs for street children, were virtually identical to those for mainstream youth. The UN Country Assessment (2004) noted that the HIV prevention campaigns, with the focus on 'social evils', had generated fear and awareness, but 'undermined efforts to encourage greater use and acceptance of condoms and voluntary testing and non-discriminatory atti-

tudes.’ (p. 30). It is essential that the obstacles to behavior change are identified, and that interventions are designed to remove or reduce these. The new Strategy emphasizes BCC as a key action area, which should provide an impetus for strengthening of this area.

### **Lack of Impact Data (Monitoring and Evaluation)**

108. Another major shortcoming in many youth and HIV prevention projects is the lack of rigorous monitoring and evaluation (M&E). Many projects are developed without comprehensive baseline data, have weak monitoring and supervision systems (partly due to lack of dedicated funding, as well as staff with requisite skills), and evaluation for impact is rarely undertaken (Bondurat et al 2003; CCRD and ILSSA 2003; Reerink et al 2003). Most of the Project reports assembled by the TA team reveal a continued emphasis on process indicators. It is expected that the new National Strategy, once it has developed an M&E system, will help to address this gap. It is essential, however, that all projects have strong M&E systems for their own components, and that external evaluation is used periodically (Reerink et al 2003).

### **Poor Coordination**

109. Given the large number of donors and activities, coordination is essential. UNAIDS has sponsored donor ‘mapping’ activities, and posted these on its website: [www.unaids.org.vn](http://www.unaids.org.vn). Additionally, several taskforces (e.g. the Technical Working Group) have been established to share information and experiences. However, Viet Nam is a large, diverse country and overall coordination needs to be improved to prevent waste and to facilitate opportunities for synergies. Provinces noted this weakness in particular, stating that some Departments failed to ensure others were aware of activities, leading to overlap and gaps—a finding which had been highlighted in a 2003 review (CCRD and ILSSA 2003). It is hoped that the new National Strategy will focus on this aspect partly through the mechanism of UNAIDS’ ‘Three Ones’.

### **Lack of Voluntary Counseling and Testing**

110. The National HIV/AIDS Strategy indicated that voluntary counseling and testing is not systematically organized at present and the effectiveness is not high. There are still very few VCT services in the country. The Strategy proposes the expansion of VCT services to 100% of provinces and 50% of all districts by 2010, integrating counseling services into health care services, family planning, maternal and child care and protection, and primary health care programs. The Strategy also emphasizes the need to mobilize the private health system to provide counseling and support.

111. It is estimated that less than 100 VCT services exist nationally which have trained counselors and confidentiality guaranteed (for additional detail see Appendix P — **Key Players of VCT in Viet Nam**). Funds from the US President’s Fund for AIDS Reduction (PEPFAR) are likely to add substantially to the national capacity to introduce VCT through projects implemented by CDC/LIFE–GAP and Family Health International (FHI). Other models include the integration of VCT with reproductive health services run by Marie Stopes International (MSI) and inclusion of VCT in the mobile clinics managed by the Medecins du Monde in HCMC (See Appendix P). Since almost all current VCT services are established within or adjacent to health centers and have a focus on high–risk behavior groups, the integration of VCT into community level family planning services can be seen as advantageous.

112. Experience from CDC/LIFE–GAP showed that most referral sources for information about VCT came from mass media. A lesson drawn from FHI’s project was that, to the extent possible, VCT services should be integrated with mass media campaigns and with peer education on HIV/AIDS (FHI 2004). These linkages help ensure that individuals who receive communication messages can also access the necessary services, such as VCT and STI treatment. Additional linkages occur when people and organizations trained in VCT and STI treatment skills learn of other interventions that can assist people seeking services, such as

care and support (e.g. Women's Health Club, Friends Helping Friends activities, etc). At the same time, peer educators can also refer people to outside VCT and STI programs. Establishing and maintaining these linkages effectively reinforces behavior change communication efforts and increases the likelihood that those in need receive appropriate information, and access to treatment, care and support.

113. Although VCT is considered the starting point for a comprehensive HIV prevention and care network, provincial consultations showed that most youth had no idea where to go for VCT. The inclusion of VCT as a major objective for the new National HIV/AIDS Strategy is appropriate but it will take a major effort and commitment to meet the target of having a VCT in every administrative unit of the country.

### **Limited Focus on Gender in Youth Programs**

114. Bondurant et al (2003) found very little focus on gender within country-level youth reproductive health programs supported by UNFPA. The target group overwhelmingly remains girls and young women, which reinforces conventional views that women should take sole responsibility for contraception, while also creating service gaps for STI diagnosis and treatment for young men; the report concludes "this needs to be tackled as a matter of urgency" (2003:9). There is also almost no focus on masculine norms that encourage risk-taking among boys and men, even though PLWHA in Viet Nam are overwhelmingly male, and the epidemic is driven by risky male behaviors (partly because male youth lack skills to resist peer pressure). As well, few projects target gender norms that discourage young women from being assertive about condom use—or to know more about sexuality for the marital relationship—or which address the needs of men—who-have-sex-with-men (MSM) (MAP 2004). MSM remains a taboo subject, but extremely high-risk behavior.

### **Youth Challenges and Needs**

115. The UN Country Assessment (2004) concludes that the key challenges for youth are education, employment and provision of support. Continued economic growth is essential to meet these challenges, but policy support is also important. Youth need a range of Life Skills to make good decisions and for their overall personal development; they need vocational training for the new labor market; and they need youth-friendly information and services. Finally, they need to be involved as decision-makers. The Assessment says that some youth programs 'are planned and developed in a top-down way, and...with a bias toward regulation and compulsion over participation and dialogue. Too much emphasis is given to keeping young people away from problems and "social evils" as opposed to promoting the potential of youth while creating a protective environment' (UN 2004:27).

## **g. Government and Donor Assistance for HIV/AIDS in Viet Nam**

116. The Government currently commits about VND80 billion (approximately USD 6 million) to HIV/AIDS programs each year. The analysis of resource needs in the National Strategy estimates Viet Nam's needs to be about USD 300 million/year for a comprehensive response. Government and external resources are currently meeting about 25–30% of the need.

117. A range of aid and international agencies are active in supporting the response to HIV/AIDS in Viet Nam to date (for additional detail see Appendix O — HIV/AIDS Projects in Viet Nam and Appendix P — Key Players of VCT in Viet Nam). Activities are focused on high-risk groups, harm reduction, care and support, and include the following:

- i) The UK Department for International Development (DFID) and the Norwegian Agency of Development Cooperation (Norad) — USD 25 million over 5 years from January 2005 with a focus on condom promotion, pilot harm-reduction

- programs, and management and care of STIs. Implemented through WHO/MoH;
- ii) The Global Fund for AIDS, Tuberculosis, and Malaria — USD7.5 million over 2 years with a focus on care and support networks for PLWHA, voluntary counseling, and services for testing and preventing mother-to-child transmission;
  - iii) The United States President's Fund for AIDS Reduction — USD 25 million in 2005 and USD 34 million in 2006 – with a focus on care and support, including ARVs, VCT and prevention of mother-to-child transmission; and
  - iv) World Bank—up to USD 35 million from 2005 for strategy implementation in 20 provinces. This project also covers BCC, but does not have a specific youth focus and does not include Life Skills training. It does aim to pilot harm reduction, rehabilitation and care/treatment for 05/06 Center residents, but does not include vocational training.

118. These large sources will offer critically needed funds for treatment of PLWHA, as well as for HIV prevention. However, there will be challenges in distributing ARVs because most PLWHA are from marginalized, hard-to-reach groups. Moreover, the World Bank project documents note that the Government will need to identify and cost alternative delivery models (e.g. tertiary versus community) before decisions are made about program content.

119. One major limitation in current large donor activities is US government policies that proscribe support for harm reduction education and activities, including the distribution of condoms, needles and syringes. On 9 June 2005, the United States Agency for International Development (USAID) promulgated a new policy directive which requires any organization (American or foreign) receiving its funds to adopt a policy “explicitly opposing prostitution and sex trafficking.” DKT International (which is actively involved in HIV/STI prevention, partly through the social marketing of condoms) has filed a lawsuit challenging the policy’s constitutionality. DKT argues that this approach will drive underground and increase the vulnerability of sex workers who need easy access to condoms to protect themselves from a fatal disease. Since DKT refused to endorse the policy, it has lost USAID support for its HIV/AIDS-prevention work in Viet Nam. Similar restrictions on harm reduction for IDUs have led to the termination of some needle/syringe distribution programs in Viet Nam.

120. Other groups active in HIV prevention in Viet Nam include a number of bilaterals, non-government organizations (NGOs) and international programs, including the Swedish International Development Agency (SIDA), US CDC, United Nations Development Programme (UNDP), United Nations Children's Fund (UNICEF), Australian Agency for International Development (AusAID), and the international NGO—FHI. UNAIDS plays a key role in providing technical and coordination support to the Government. Some examples of relevant activities by these donors follow.

121. The United Nations Office on Drugs and Crime (UNODC) currently supports integrated drug treatment, rehabilitation and vocational support programs for several provinces in the northwest. Its holistic, community-based models differ from the large 06 Centers in terms of their size (up to 40 residents), shorter length of stay (3 months), access to drug substitution and rehabilitation counseling by trained staff, multiple support systems for residents post-release and, importantly, far greater success rates (about 30% relapse over one year). They also offer parenting classes and have materials for this purpose.

122. In 2003 the United Nations Country Team established a Youth Task Force to better coordinate the efforts of UN agencies in Viet Nam to promote healthy youth development. The Youth Task Force developed a program called Young Viet Nam, which includes a Youth and HIV Mass Media Project. The Project started in 2004 and has involved research into the

outcomes of previous youth mass media campaigns in Viet Nam and elsewhere, and youth perspectives and preferences on media messages, with a focus on HIV prevention. The main Vietnamese implementing agencies have been MoH, the Health Information and Education Center of Ho Chi Minh City, and the Quality of Life Promotion (LIFE) Center.

123. FHI have a large program in Viet Nam. They have undertaken extensive social research and evaluation studies, pilot rehabilitation activities inside 05/06 Centers, and a variety of BCC programs for a range of targets, particularly vulnerable and high risk groups.

124. Global AIDS Program (GAP) is a CDC initiative that has operated in Viet Nam since 2001; its funding for 2003 was USD 2.85 million. The initiative focuses on: provision of VCT to vulnerable populations in 18 provinces; TB and HIV/AIDS care and treatment; provision of ARVs; surveillance; diagnosis of Opportunistic Infections; and ongoing support to MoH for its HIV prevention activities in 40 provinces and 10 institutes.

125. Marie Stopes International Viet Nam has focused on youth reproductive health since 1998, establishing model 'youth-friendly' services that offer information, education and clinical services. It also offers technical assistance to NGOs and International Non-Governmental Organizations (INGOs) to mainstream 'youth-friendly' approaches into some commune health stations and clinics and, since 2003, has integrated VCT into their clinics, especially for high risk groups.

126. The Reproductive Health Initiative for Youth in Asia (RHIYA) is funded by the European Commission and UNFPA. It operates in seven South and Southeast Asian countries (including Viet Nam) and aims to strengthen and accelerate the implementation of the ICPD Programme of Action. While RHIYA does not explicitly target HIV/AIDS, its focus on sexual and reproductive health knowledge, gender awareness and service provision makes it relevant. In Viet Nam its 2004-06 program has seven interventions and four control provinces and covers young people aged 10-24 years, both in and out of school. It has recently released results from its quantitative baseline survey (EU/UNFPA 2005). It is coordinated by the Umbrella Programme Support Unit/UNFPA with technical assistance from international NGOs. Components include:

- Output Project 1 (executed by the Youth Union): "Advocacy and Behaviour Change Communication" aims at improving knowledge, practices and awareness of young people towards reproductive health.
- Output Project 2 (executed by the Vietnam Family Planning Association, VINAFA): "Promotion of Health Service and Health-Seeking Behaviour" aims at providing youth friendly services, including counseling services, in order to increase the utilization of reproductive health services for youth and adolescents.

127. CARE International has been active in HIV prevention in Viet Nam since 1991. It has produced seminal research into social norms and risk behaviors, and has produced a 30-episode "enter-educate" soap opera, and a pop music album interspersed with HIV education messages. It targets vulnerable groups, including truck drivers and mobile workers, and high risk groups (SWs and IDUs). It is implementing a USAID grants program, 'CORE', for communities to provide care and support for PLWHA and those affected by HIV/AIDS. CARE also operates a micro-credit and vocational training scheme targeting the most economically disadvantaged.

128. International Organization for Migration (IOM) has worked cooperatively with the Women's Union to focus national attention on the trafficking of women and children since 1996. In 2004, it undertook capacity building with the Women's Union to prevent trafficking, and supported a shelter in HCMC for the reintegration of trafficked and vulnerable children.

HIV prevention among mobile and migrant populations is one of its key current project areas, with activities ranging from VCT to advocacy, capacity building, mainstreaming, and research and dissemination.

129. UNAIDS has provided the Ministry of Defense with a Vietnamese-language version of its global document on HIV prevention for the military.

## **h. Economic and Financial Analysis**

### **Economic Analysis**

130. While the economy of Viet Nam is growing steadily, the expanding HIV/AIDS epidemic could jeopardize this progress if it is not brought under control in the short term. The Viet Nam HIV/AIDS Prevention among Youth Project can make a significant contribution to limiting the further transmission of HIV by targeting both youth in general and particular high-risk groups.

131. Ill health is a major cause of impoverishment in Viet Nam. The significant progress made in reducing the poverty rate in Viet Nam since 1990 could be jeopardized by an expanding epidemic. The economic analysis supporting the Project design therefore focuses on an estimation of the productivity gains from a reduction in the rate of HIV transmission, the consequent public and private savings in health care costs, and the improvements in family welfare. Reducing the rate of HIV transmission is a strong public health concern, and HIV prevention activities fall mostly within the category of non-marketed outputs (or public goods provided through the public health system). The case for a strong role for government participation in HIV prevention in Viet Nam is based on the lack of effective private demand for HIV/AIDS preventive activities. Public funding of HIV/AIDS prevention is justified both as a public good and by positive externalities. The externalities associated with HIV prevention activities mean that the social benefits are greater than private benefits: HIV prevention simultaneously protects the individual (from infection) and the community (from increased rates of transmission).

132. The economic effect of HIV/AIDS on households is severe. The justification for strong government participation therefore also reflects equity considerations by addressing issues that are particularly relevant to the poor (who suffer most from HIV/AIDS and who are the most at risk of infection). Equity is therefore a strong rationale for public spending on HIV prevention. It is anticipated that the distributional effects of Project activities will especially benefit the poor and the vulnerable. The major beneficiaries of the Project therefore include youth and the poor.

133. A detailed economic and financial analysis is included in Appendix C. The cost-effectiveness of reducing HIV transmission through preventive and harm-reduction activities has been demonstrated in a number of places internationally. There are both microeconomic (individuals and families) and macroeconomic (productivity and output) costs of HIV/AIDS that may be avoided by successful preventive programs. The Project will consequently focus its activities on those areas where the impact is greatest, particularly on IDUs and SWs through BCC and harm reduction. The most cost-effective approach is to focus on those groups most in danger of HIV infection. The analysis uses a benefit-cost approach to measure the potential impact of Project activities and is consistent with the analysis recently conducted by the World Bank for the preparation of its Viet Nam HIV/AIDS Prevention Project (Report 30319-VN). The World Bank's calculations indicated a benefit-cost ratio of between 4:1 and 8:1 over five years 2006–2010. Working with very limited data, we were able to calculate an approximate cost-benefit ratio over two scenarios, low and high, for the ADB HIV/AIDS Prevention among Youth Project. While these estimates should be treated as indicative, the results suggest a lower benefit-cost estimate of 2:1 and a higher estimate of

11:1, depending on the anticipated reduction in infection rates. Consequently, on the basis of this ratio range, the Project should go ahead.

### **Financial analysis**

134. The Bank is providing US\$20 million in funding to the Executing Agency, the VCPFC, as a grant over five years, managed through a program approach to implementation. The GoV will provide an additional US\$4.3 million as an in-kind contribution to program funding. A summary of costs is presented in section 3(d) Cost Estimates and section 3(e) Financing Plan, and details of the budget and financial analysis are provided in Appendix C.

135. The budget presented here is an indicative budget covering the five years of anticipated program activities, based on the proposed implementation schedule. As a program, however, implementation of the proposed activity will remain flexible and subject to review. Bank funding for Project activities will be provided in three tranches subject to satisfactory performance. The proposed budget is therefore subject to review and amendment based on changing circumstances and needs. The program budget was prepared in consultation with the staff of the VCPFC.

136. The GoV will provide an in-kind contribution to the project equal to 22% of Bank funding. Of the total Project budget, 87% will be expended in local currency and 13% in foreign currency. Investment costs account for 81% of the budget and recurrent costs 19%. The main part of Project funding is allocated to BCC and IPC activities (46% of total funding) and to community-based HIV prevention (31% of total funding). Component 2 activities (mass media and IPC materials) will be offered as a sub-contract to a selected enter-educate mass media agency.

137. Annual budget allocations have been made on the assumption that the program will commence in five provinces in years one and two, expand to 10 provinces in year three subject to satisfactory outcomes, and expand again to 15 provinces in years four and five, also subject to satisfactory performance.

138. The following table summarizes the budget by cost category and by year.

Table 2: Project Budget by Category, Year and Source of Funding (US\$'000)

	2006		2007		2008		2009		2010		Total		Total	
	ADB	GoV	ADB	GoV	ADB	GoV	ADB	GoV	ADB	GoV	ADB	GoV	Budget	
<b>A. Base Costs</b>														
1. Investment Costs														
a. BCC and IPC activities and materials	253,000	114,000	1,882,500	376,600	2,730,500	406,600	3,053,500	452,200	2,352,900	286,700	10,272,400	1,636,100	11,908,500	
b. Surveys and evaluations	131,500		55,000		131,500		40,000		51,500		409,500		409,500	
c. Institutional Strengthening	240		7,140		12,900		12,000				32,280		32,280	
d. Equipment and maintenance	127,456		201,000		216,000		211,000				755,456		755,456	
e. Materials production and distribution	12,500		113,667		95,083		125,250		94,375		440,875		440,875	
f. Consulting services	740,538		890,776		710,476		477,418		378,200		3,197,408		3,197,408	
g. Training, workshops and study tours	125,595		482,100		631,095		727,595		338,100		2,304,485		2,304,485	
Total Investment Costs	1,390,829	114,000	3,632,183	376,600	4,527,554	406,600	4,646,763	452,200	3,215,075	286,700	17,412,404	1,636,100	19,048,504	
2. Recurrent Costs														
a. Salaries	95,865	133,480	64,491	133,480	64,491	244,080	46,065	354,680	66,234	354,680	337,146	1,220,400	1,557,546	
b. Supplies	13,800	7,200	13,800	7,200	13,800	13,200	13,800	19,200	13,800	19,200	69,000	66,000	135,000	
c. Communications	18,030	21,600	26,890	21,600	21,890	33,600	21,890	45,600	20,090	45,600	108,790	168,000	276,790	
d. Vehicles and maintenance		42,288		42,288		71,388		100,488		100,488		356,940	356,940	
e. Office expenses	78,800	205,800	78,800	205,800	81,600	358,800	84,400	511,800	84,400	511,800	408,000	1,794,000	2,202,000	
f. Travel and accommodation	1,615		1,615		4,135		7,160		7,160		21,685		21,685	
Total Recurrent Costs	208,110	410,368	185,596	410,368	185,916	721,068	173,315	1,031,768	191,684	1,031,768	944,621	3,605,340	4,549,961	
3. Total Base Costs	1,598,939	524,368	3,817,779	786,968	4,713,470	1,127,668	4,820,078	1,483,968	3,406,759	1,318,468	18,357,025	5,241,440	23,598,465	
<b>B. Taxes and duties<sup>a</sup></b>														
		212,051		302,421		283,737		222,921		133,711		1,154,840	1,154,840	
<b>C. Contingencies<sup>b</sup></b>														
1. Physical Contingencies	60,759	5,200	152,630	5,200	165,186	8,600	157,572	12,000	104,426	12,000	640,573	43,000	683,573	
2. Price Contingencies	66,476	31,702	199,332	31,702	254,834	52,144	278,993	72,586	202,767	72,586	1,002,402	260,720	1,263,122	
Total Contingencies	127,235	36,902	351,962	36,902	420,021	60,744	436,565	84,586	307,193	84,586	1,642,975	303,720	1,946,695	
<b>Total Costs</b>	<b>1,726,174</b>	<b>773,321</b>	<b>4,169,741</b>	<b>1,126,291</b>	<b>5,133,491</b>	<b>1,472,149</b>	<b>5,256,643</b>	<b>1,791,475</b>	<b>3,713,952</b>	<b>1,536,765</b>	<b>20,000,000</b>	<b>6,700,000</b>	<b>26,700,000</b>	
		2,499,494		5,296,031		6,605,640		7,048,118		5,250,717				

Notes:

a. Estimates based on Government sources; includes VAT (5% and 10%), special MV tax, income tax.

b. Based on latest ADB data; FE = foreign exchange, LC = local currency.

Source: Government staff and estimates.

### **3) Project Proposal**

#### **a. Overview of Project**

##### **Overall Objective (Goal)**

139. The Project goal is to achieve Millennium Development Goal 6 (Target 7) to have halted and begun to reverse the spread of HIV/AIDS by 2010.

##### **Specific Objective (Purpose)**

140. The Project purpose is to reduce HIV–infection risk among youth aged 15–24 through BCC programs.

##### **Scope of Project**

141. The Project will be implemented at the national level and in 15 selected provinces over a five–year period. The project will be administered from the ADB as a Sector Development Program which means implementation will occur in phases funded by tranches released by the ADB to the PMU on successful completion of the milestones for each phase and the submission of an Action Plan for the next phase. In this phased approach the Project activities will commence at the national level and initially in five provinces. Another five provinces selected from the central and southern regions of Viet Nam will be included in the second phase and the final five provinces will be added to the Project during the fourth year. The Project is composed of four components which together form an integrated, interlinked program of activities to reduce HIV–infection risk among youth through BCC programs.

142. At the policy level the project has designed a program of advocacy activities to raise awareness and influence decision making of leaders at national and provincial levels in relation to youth and HIV/AIDS prevention programs. The advocacy activities in Component 1 are aimed at creating a supportive environment for implementation of the National HIV/AIDS strategy in relation to issues affecting youth and HIV/AIDS prevention. Having leaders at all levels that are sensitive to the needs of young people and are willing to support specific policies and programs that focus on youth and their needs in relation to HIV/AIDS prevention will lay the foundation for the other Project activities.

143. The Mass Media and Interpersonal Communications (IPC) Materials component (Component 2) is the centerpiece of the project and will have nationwide reach. Through the contracting of a professional agency capable of developing a high quality, entertaining and influential TV drama series that is broadcast over a three–year period the Project will aim to influence the knowledge, attitudes and behaviors of young people and their families in relation to a number of social issues, including sexuality, HIV/AIDS prevention, stigma and discrimination, gender, etc. The drama series will be linked to provincial radio phone–in programs and web site. A wide range of IPC materials will be developed for distribution through Project IPC activities at the community level and nationwide by other organizations who wish to use the materials.

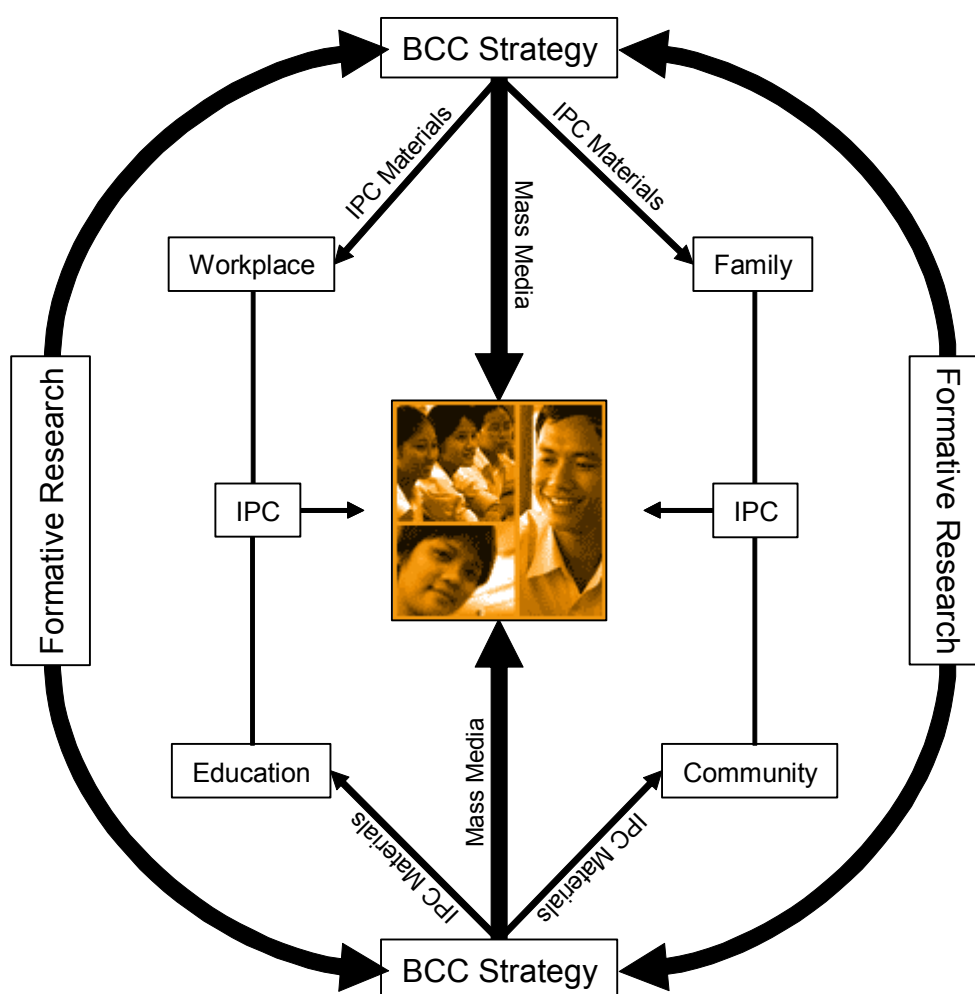
144. The Projects community based activities to reduce the transmission of HIV/AIDS among youth will be implemented under Component 3. Voluntary counseling and testing centers in community settings will increase the opportunity for young people to access youth friendly services for information, counseling and early detection of STI and HIV status. This will increase the opportunity for young people to take preventative measures and especially encourage the use of condoms for safe sex.

145. The strategy of developing peer education programs among the various vulnerable groups (IDUs, street youth, service industry workers and factory workers) provides a large community–based network of youth who, through IPC initiatives, will reach their peers with

HIV/AIDS prevention messages and provide them with condoms. These peer educators will be the network through which the IPC materials developed in Component 2 will be widely distributed. Peer educators will also conduct regular discussion groups using the IPC materials to generate dialogue on the topics raised in the TV drama series. Similar networks will be established through the community collaborators of VCPFC and civil society organizations who will also receive Project IPC materials and conduct adult discussion groups.

146. The figure below illustrates the relationship between the mass media outputs (television and radio programming), IPC materials and the community based IPC interventions. This relationship results in an integrated program linking mass media and interpersonal communications. It is anticipated that ultimately this integrated approach will increase the awareness of HIV/AIDS among youth, empower them to prevent HIV transmission, decrease the stigma and discrimination that exists toward IDUs, SW and PLWHA and increase the use of condoms for safe sex.

**Figure 1 — Relationship between mass media outputs, IPC materials and IPC interventions**



## b. Components

### Component 1 — Advocacy

#### Objective

147. To work with Party and State leaders and Project implementers at all levels to support the implementation of the National Strategy on HIV/AIDS Prevention, and to raise the profile of youth issues.

## Description

148. The focus of this component will be to increase awareness of and support for Project concepts and activities, the National HIV/AIDS Strategy (especially endorsement of harm reduction services BCC, and stigma reduction) and to develop a youth focus in HIV prevention programs.

149. The Project will recruit a Youth Policy and HIV/AIDS Adviser who will advocate for a focus on youth issues related to HIV/AIDS prevention programs among leaders at national and provincial levels. At the national level the Adviser will participate in existing youth and HIV/AIDS technical working groups of International Organizations and Vietnamese Mass Organizations and NGOs to assist them in their advocacy activities. It will also be the role of the Adviser to ensure that all implementers of project components develop strategies to involve youth and PLWHA in their programs.

150. At the national level, the project through the Youth Policy and HIV/AIDS Adviser will work closely with ongoing advocacy projects on HIV/AIDS prevention and adolescent reproductive health, such as the Reproductive Health Program implemented by the MoH and VCPFC, Promotion of Healthy Living Skills implemented by the Youth Union, and Involvement of the Communist Party in the HIV/AIDS Prevention activities implemented by the Committee of Ideology and Culture.

151. Advocacy messages will go beyond HIV/AIDS education to encompass the broader context of Healthy Youth Development and Gender Equality. The communication approach will not only use awareness-raising through mass campaigns but also interpersonal communication channels and should provide a trusting environment for young people to express their needs and concerns. Youth and HIV/AIDS prevention can be more effective if linked to Reproductive and Sexual Health education. Issues to be advocated for include:

- i) Better understanding of concerns and needs of youth;
- ii) Understanding of healthy youth development in the current context of Viet Nam;
- iii) Recognition of the State's role in supporting families and youth in coping with emerging problems;
- iv) Openness towards sexual health education in education settings;
- v) Reduction of stigma against PLWHA;
- vi) Understanding of and support for harm reduction programs; and
- vii) Support for the implementation of the Labor Law to ensure the occupational health of workers, especially young workers in industrial zones.

152. Advocacy materials will be developed based on research findings, data and information on the needs and concerns of youth. The SAVY 2005 report is an example of existing data on which the materials could be developed. Areas for further research studies will be identified during the project baseline/formative research phase. It will be the responsibility of the Youth Policy and HIV/AIDS Adviser to work with PMU to identify research projects to be conducted through the Project. Advocacy materials and information will be widely distributed through Party channels, such as websites and magazines, through Government channels, Parliament and through the network of mass organizations. Funds will be provide through the Project to MoH to support the conducting of the 2<sup>nd</sup> SAVY in 2008.

153. Advocacy efforts at the national level will be linked to advocacy activities carried out at provincial and community levels. This comprehensive approach will support the implementation of Project interventions at the grassroots level. The Project will contribute to creating an enabling environment for the implementation of Project components on HIV/AIDS prevention among youth, including BCC, harm reduction, anti-stigma against PLWHA and

VCT services at community settings, by promoting positive attitudes and gaining support among decision-makers, government authorities, leaders and managers of mass organizations at provincial, district and commune levels.

154. The Project rationale and content, with a focus on youth, as linked to the National HIV/AIDS Strategy, will be clearly presented to the provincial leaders in orientation workshops at the beginning of the Project life. Implementation partners should provide supportive instruction and supervision to their personnel in implementing the guidelines on HIV/AIDS prevention in order to gradually improve the quality of care and services for adolescents and youth. Awareness raising activities will also be given to the service providers, both public and private, in order to increase young people's access to youth-friendly services. Advocacy programs will also use a wide range of opportunities to raise awareness on HIV/AIDS, for instance, by inviting VIPs or well-known artists to talk shows ( on radio and TV), forums and workshops.

155. The fact that youth and PLWHA are often not involved in designing and implementing preventive programs means that these programs are often not responsive to their needs. Too often, youth are considered to be beneficiaries rather than active participants. Therefore, one of the most important aspects of advocacy is to involve youth and PLWHA by providing them with opportunities to convey their concerns and needs and by developing mechanisms for them to participate in decision making related to matters of reproductive health and HIV/AIDS. These opportunities can take the form of dialogue between leaders and youth/PLWHA in forums or meetings, or the indirect feedback from youth/PLWHA through a consultation mechanism. The image of young people will be strengthened through their active participation in national and international conferences with a youth focus.

### **Rationale**

156. In recent years, the GoV has paid increasing attention to issues relating to young people, especially to the rising prevalence of HIV/AIDS among youth. This increased concern was reflected in the establishment of the Strategy for Youth Development for the period 2001–2010 and in the development of the Youth Law which has been submitted to the National Assembly for review and approval. The National Strategy on HIV/AIDS Prevention that was approved in 2004 highlighted the importance of BCC activities targeting high risk groups. Despite increased public concern over sexual health problems such as unwanted pregnancies, abortion, sexually transmitted diseases and HIV infection among young people, awareness of the needs and concerns of adolescents and young people for information, education and services on HIV/AIDS prevention is still limited among government leaders and decision makers.

157. The National HIV/AIDS Strategy endorses some measures that are new to the Vietnamese context, but known to be highly effective in reducing HIV transmission among high risk groups. However, these measures are difficult for some sections of Vietnamese society to understand and support, e.g. "Harm Reduction" (especially needle/syringe exchange, drug substitution and promotion of 100% condom use). Many leaders consulted during the TA's provincial visits were not aware of the content and programming objectives of the National HIV/AIDS Strategy, and were unclear about the meaning of "Harm Reduction".

158. The lessons learned from other HIV/AIDS prevention efforts in Viet Nam show that a widespread acceptance of the specific content of the National HIV/AIDS Strategy by Party officials, policy makers, government authorities, leaders of mass organizations and influential community members is necessary to ensure that targeted and effective youth HIV prevention interventions take place, especially those which have not been widely practiced in the Vietnamese context. As the support and involvement of Party and State leaders in HIV/AIDS prevention for youth is a key requirement for the Project's success, it is essential to focus on

advocacy. The involvement of leaders in the programming process is critical for the following outcomes:

- i) HIV/AIDS is a complex issue, directly and indirectly affecting many sectors, thus requiring the attention and efforts of a large number of groups;
- ii) An enabling environment permits the introduction of new policies and contributes to their sustainability, thus offering new opportunities for more effective HIV/AIDS interventions in the Vietnamese context;
- iii) Harm Reduction and Anti–Stigma campaigns are far likelier to succeed if decision–makers are informed, knowledgeable and confident, making the achievement of the National Strategic Objectives more likely; and
- iv) Promoting placement of VCT centers in community settings.

159. In addition, the Project can capitalize on the gains of other projects working for the political and social support of Party and Government leaders at the national level toward activities related to youth sexual and reproductive health and HIV/AIDS prevention. Examples include the active participation of the UN Youth Taskforce in the revision of the Youth Law through dialogue with the Committee of Social Affairs of the National Assembly; the integration of issues related to Population and Reproductive Health into the curriculum of the Ho Chi Minh National Political Academy with the support of the UNFPA; the involvement of the Committee of Ideology and Culture and the Committee of Science and Education of the Communist Party in the revision of Decree 52 for strengthening the role of the Communist Party in HIV/AIDS prevention program.

## **Component 2 — A National Mass Media production for behaviour change and improved interpersonal communication related to reducing HIV infection risk among youth**

### **Objective**

160. To produce high quality, mass media<sup>7</sup> Behavior Change Communication programs, based around a television drama series that utilizes the ‘enter(tain)-educate’ model of behavior change theory along with supporting Interpersonal Communication (IPC) materials to be disseminated and utilized through various media and youth-focused venues..

### **Description**

161. The Mass Media & IPC Materials Component offers an integrated BCC strategy based on the coordinated and reinforcing use of a professionally developed television drama series, radio phone–in programs, youth–focused documentaries and television and radio spots.

162. Messages delivered via these mass media interventions will be supported and reinforced by a variety of high–quality, professionally developed print materials for use in IPC activities (Component 3) designed to stimulate behavior change among high–risk youth and maintain preferred behaviors among mainstream and vulnerable youth.

163. Audience–based research will be used to inform the development of all outputs under Component 2. This will include: 1) formative research for the development of messages, scripts and visual ideas; 2) rapid feedback assessment to gauge audience responses to outputs in the near–final stages of production; 3) quantitative KAP surveys for baseline analysis; and 4) audience feedback panels, randomly sampled from target groups members, for structured interviews after mass media outputs have been broadcast.

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<sup>7</sup> Television drama, radio phone–in and television and radio discussion programs, documentaries and spots.

164. All outputs under Component 2 will be developed in close consultation with target group members following the model promoted by the United Nations Country Team.<sup>8</sup> Such an approach will ensure that messages and information presented will appeal to youth and PLWHA and will lead to action. The participation of youth and PLHWA in the development of messages, scripts and visual ideas and in the production of outputs is considered essential. The agency contracted to develop outputs under Component 2 will be required to hire youth and PLWHA to work on story development, script and message development and on the design and production of mass media programming and IPC materials.

165. Activities and outputs under Component 2 are considered to be overarching and encompassing, linking mass media, IPC interventions, promotional and education efforts and advocacy at all levels in the variety of settings addressed by Components 1 and 3. In addition to providing materials for use in IPC and advocacy interventions Component 2 will offer orientation and training on the appropriate use of multi-media IPC materials by provincial and community-level users of materials such as teachers and peer educators, and training for media designers and journalists in the development of appropriate mass media and IPC materials targeting youth.

166. Three sub-components have been developed to achieve the objective of this component. Each one will be presented separately below:

- To produce and broadcast a television drama series, radio phone-in programs, youth-focused television documentaries and television and spots.
- To produce a variety of IPC materials for use in advocacy and IPC interventions to be undertaken in Project components 1 and 3.
- To establish an "IPC Clearinghouse" to facilitate the distribution and use of IPC materials produced under Component 2 by non-Project groups.

### **Rationale**

167. There are a variety of reasons for applying an integrated BCC strategy built around high quality mass media programming and supporting IPC materials.

168. Foremost is the recognition that "Entertainment-Education" programs, linked with targeted IPC initiatives, help to maximize attitude and behavior change. Experience shows that reinforcing information presented through a sustained mass media intervention by high quality IPC activities and materials has an impressive impact on influencing attitudes and behavior among target groups.<sup>9</sup> For over six years, the South African BCC program "Soul City" has been at the forefront of the "Entertainment-Education" genre by integrating creative television and radio drama series with quality print media for interpersonal use with youth and adults in South Africa's fight against HIV/AIDS. This integrated approach, combining mass media programs with IPC materials used in a variety of IPC activities, has not only led to an increase in knowledge of the HIV/AIDS epidemic among youth but has also stimulated dialogue among community leaders, fostering an "enabling environment" in which innovative BCC activities and effective HIV/AIDS prevention initiatives can take root. (Coulson 2004).

169. Evidence shows that successful BCC programs have certain features in common. Both UNAIDS (2004) and CDC (2004) agree that best results rely on a "systems approach" which combines multiple mass media approaches, along with community collaborations,

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<sup>8</sup> See Development of Youth Communication Messages on HIV/AIDS, Workshop Report, Quality of Life Promotion (LIFE) Center, February 2005.

<sup>9</sup> As demonstrated by television and radio dramas produced by Soul City Institute for Health & Development Communication in South Africa, the Taste of Life television series produced by the BBC World Service Trust in Cambodia, and the New Dawn Radio Serial Drama produced in Nigeria with support from Johns Hopkins Center for Communication Programs.

training as needed and activities by local groups that “have credibility” with target groups. Using several approaches and channels simultaneously, in a coordinated manner, conveys a sense of vigor that adds to the sustainability and impact of the overall program. It also allows for the use of different approaches to serve different needs, which are mutually reinforcing. For example, print materials are good to raise awareness and as reminders, while television and radio reach millions quickly. Interpersonal communication between peers, or between youth and those who influence them, is helpful in persuading individuals to try new services or adopt different behaviors. Advocacy through communication channels is also crucial to build support for policies and programs. These, along with peer education programs, training videos and leaflet distribution can happen at the same time.

170. Surveys show that youth in Viet Nam access mass media, particularly television and radio, on a regular basis. Television viewership is high, particularly among youth. Television is the major source of information on reproductive health issues for youth with nearly 94% of youth having received information related to reproductive health from the mass media.<sup>10</sup>

171. Television can effectively reach 75% of the entire population. Responses from government staff and community members interviewed during the TA team’s provincial visits indicated that the majority of people regularly view entertainment and information programming, such as films, quiz shows, news and documentaries on television. An impressive 86.5% of youth nationwide watch television at least twice a week and 50% watch television on a daily basis. Moreover, 73% of rural youth have a television in their households, while 85% of them watch television regularly. Youth reported that favorite television programming includes movies and soap operas (29.4%), news (23.9%) and music (23.2%).<sup>11</sup>

172. From the perspective of project sustainability, investing in a high quality television drama and radio phone-in programs can attract advertising revenue which helps to cover production and broadcast costs, acts as an incentive for the broadcaster to place programs on prime-time and enhances the possibility of programming to continue beyond the life of the Project.

173. As an indicator of the popularity and “value” of television in reaching people in Viet Nam, it is notable that the total national advertising expenditure on broadcasting, print media, and outdoor advertising escalated from less than USD 20 million in 1993 to over USD 116 million in 1999 (based on published rates). In 2000, advertising on television made up 53.5% of ad turnover, with print media R 24.5% and outdoor advertising at 21%.<sup>12</sup>

174. Finally, Component 2 builds on ongoing VCPFC interventions—such as the multi-episode serial drama aired on VTV3 that is supported by the Johns Hopkins/Center for Communication Programs. This 26-part drama series explores a number of health and social issues. Program content forms the basis for discussions among youth and adults via forums organized by the Youth Union, Farmer’s Union (FU) and Women’s Union.

## **Component 3 — Community Based HIV/AIDS Prevention**

### **Objective**

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<sup>10</sup> MoH, Ministry of Health 2005b, Survey Assessment of Vietnamese Youth (SAVY) (with GSO, UNICEF Viet Nam, WHO Viet Nam) Hanoi

<sup>11</sup> Ibid.

<sup>12</sup> [http://www.aseanindia.net/asean/countryprofiles/vietnam/mark\\_ent.html](http://www.aseanindia.net/asean/countryprofiles/vietnam/mark_ent.html)

175. To reduce HIV/AIDS infection risk among vulnerable and mainstream youth through BCC programs using materials and messages developed in component 2, through community based advocacy, peer education and life skills training.

### **Description**

176. This component is designed to implement a range of training activities and interventions at the community level that will reduce the risk of HIV/AIDS infection among vulnerable groups. The IPC materials developed in Component 2 will be used in all of the training and outreach activities in this component so that the linkage between the mass media programs and the IPC programs is developed and strengthened and so that consistent messages are presented. The strategy is to implement an integrated package of activities for vulnerable groups, as well as for mainstream youth in schools, and for parents and community collaborators so that an enabling environment is created to support youth in reducing their HIV infection risk.

177. To achieve the component objective, the Project will work with a number of different vulnerable groups including IDUs, youth working in exposed service industries and in factories, unemployed youth, mainstream youth and parents. By having an integrated approach that combines harm reduction and peer education for specific groups with community education and support programs, it is anticipated that more effective models of HIV prevention can be introduced in the community.

178. Interlinked activities of this component include: harm reduction services; peer education and life skills programs for high risk and vulnerable youth groups, and training of community collaborators/networkers and teachers to provide primary prevention for mainstream youth and their parents. The activities will provide young people with information and knowledge, as well as with condoms and needle exchange, and will offer them the opportunity to have counseling and testing in a convenient and safe setting. Through awareness raising by community networkers, parents and community leaders will gain a greater understanding of how to sympathize with and relate to young people. Through the links with the TV drama, radio programs and IPC materials developed in Component 2, it is anticipated that more open discussion on HIV/AIDS issues and harm reduction will occur in families and in the community, and that there will be more tolerance and understanding of IDUs and PLWHA living in the community as a result of the Project activities.

The following three sub-components have been developed to achieve the objective of this component:

- i) To implement comprehensive HIV and health harm-reduction outreach services incorporating voluntary counseling and testing (VCT), condom and needle provision and peer education outreach services for high risk groups.
- ii) HIV/AIDS prevention programs for vulnerable youth implemented in workplaces, vocational training centres and other youth focused venue and
- i) HIV/AIDS primary prevention programs implemented for mainstream youth, parents and community collaborators.

### **Rationale**

- i) There is a growing acceptance by provincial authorities that VCT can help in the early detection of STIs and/or HIV; therefore, making VCT services available through community-based centers will improve surveillance estimates of the number of youth that are HIV+;
- ii) VCT is endorsed by the National HIV/AIDS Strategy;
- iii) Youth communicate best with and trust other youth in the same social, economic and cultural group;

- iv) Youth are often shy and embarrassed about discussing sexuality with their parents or other elders; therefore, there is a need to train youth to be able to speak to their peers on such issues and to share information on prevention methods, such as condom use, which will help to reduce transmission of HIV/AIDS;
- v) Rapid social change, urbanization and lifestyle changes in Viet Nam present some risks for healthy youth development and family harmony;
- vi) Young male drop-outs are at particular risk of drug use, and many lack skills to resist peer pressure;
- vii) Young female drop-outs who lack self-esteem and other Life Skills may be at risk of early and unprotected sex, as well as involvement in sex work;
- viii) Life Skills training is not included in current programs in vocational training/job recruitment centers; and
- ix) Current public awareness of youth employment and vocational training needs offers an opportunity to strengthen current models to contribute to healthy youth development and also HIV prevention.

## **Component 4 — Project Management**

### **Objective**

179. To establish and implement efficient and effective project management systems incorporating capacity building support for EA and implementing agencies. To provide technical support for integrating the project M&E system with the national HIV/AIDS M&E framework as well as for a comprehensive capacity building program in the executing and implementing agencies.

### **Description**

180. This component is designed to support the implementation of the Project ensuring that efficient management, financial, and monitoring and evaluation systems are in place at national and provincial levels. The VCPFC, under the guidance of a Steering Committee, will establish a central Project Management Unit (PMU) to direct and coordinate the implementation of the Project, which will be managed as a SDP. (See section on Implementation Arrangements below for details.) This SDP approach means that the PMU will receive Project funding through an agreed schedule of large tranches from the ADB and they will be responsible for the management and administration of the funds according to agreed work plans. The PMU will develop sound monitoring and evaluation systems to ensure that Project activities are conducted according to plan and to agreed standards because the payment of subsequent tranches will be based on performance, submission of agreed milestones and the development of an Action Plan for the next phase. The benefit of this SDP approach is that it allows for flexibility and for the opportunity to respond to the changing nature of the HIV/AIDS epidemic over the life of the Project. Unlike a project where the activities are set for the Project's lifetime, a program approach permits adjustments to be made in each phase to respond to lessons learned, emerging needs and changing circumstances.

181. In order to implement the Project under the SDP approach, the PMU must establish strong planning, financial, monitoring and reporting systems to ensure that they are able to manage all the Project activities. The PMU will assign sufficient staff to work in the areas of project management and accounting, both at the national and at the provincial levels. To support the PMU to establish Project systems and set up central level activities, implementation of activities will occur in five provinces in the northern region in the first phase. Through the appointment of an Institutional Capacity Building (ICB) Adviser and a Monitoring and Evaluation Adviser in the first year of the Project, the PMU staff and PPMU staff will be supported in the development of management and monitoring systems through a capacity building program and mentoring by the advisers.

182. A Capacity building program for the EA, PPMUs and the implementing agencies will be designed by the ICB Adviser using the findings of a training needs analysis to be conducted in the first six months. The management capacity improvement program will be implemented first at the national level with the EA in the first year of the Project. In the second years the ICB adviser will work in the selected provinces and provide training and mentoring for the PPMUs and the contracted implementing agencies.

183. The M&E Adviser will develop the M&E framework and systems. This activity will draw on the work currently being done by the MoH to develop a national M&E framework for the national HIV/AIDS strategy, to ensure consistency across the national indicators.

184. The Management Structure underpinning national project implementation is as follows. A Project Steering Committee (PSC) will be established by the EA at the commencement of the Project. The PSC will be headed by the Minister of VCPFC and will include senior officials from the participating ministries and organizations, including Ministry of Planning and Investment, Ministry of Finance, the State Bank of Viet Nam, the VAAC, Youth Union, Women's Union and Farmer's Union. The PSC will provide the EA with overall direction and guidance for the Project.

185. A Project Management Unit at the national level will be established which will be headed by a designated project director from the EA. There will also be a Vice Director and a group of regular EA staff and contracted personnel who will constitute the National PMU. It will be responsible to pay for contracted staff as part of the GoV contribution. These positions may include Project support staff such as: Project Manager; Component Coordinators; Accountants; and Administrative staff. These individual staff will have experience in planning, accounting, disbursement, procurement and contract administration. The Component Coordinators will be responsible for co-ordination and monitoring of the component at the national level. An Organogram of the project management arrangements is shown in Appendix G.

186. The PMU will be responsible for the financial and organizational management of the Project. It will provide overall coordination and support to the Component Coordinators and to the Provincial Project Management Units (PPMUs). The Component Coordinators will be responsible for coordinating with the agencies that are sub-contracted to implement the Project activities.

#### **Rationale**

187. By presenting Project management as a separate Component, activities required for effective Project management are budgeted for and monitored. This will include the conducting of baseline surveys and evaluations, consulting services and procurement. It also allows for a capacity building element to be included for the institutions involved in managing the Project. The Project M&E systems can be developed and adequate resources for implementation can be assured through allocation of personnel and equipment. It also allows for the development of a formative research phase in the first year to develop the baselines for the Project. This is important for measuring impact at the Project's conclusion.

### **c. Special Features**

188. The Project does not have any adverse social impacts. Social issues that the Project addresses include:

#### **Healthy Youth Development in the Context of HIV/AIDS**

189. Youth aged 15–24 are increasingly represented in the Viet Nam's HIV/AIDS statistics, comprising about 40% of those infected. The Project will utilize WHO's "healthy youth development" model of reducing risks and building protection in order to prevent health prob-

lems and maximize individual potential (WHO 1999). The Project will reduce risks directly through harm reduction, stigma reduction, VCT services, safer environments, and targeted IPC activities for behavior change in specific sub-groups. It will build protective factors for youth (directly, and via those who influence them) through parenting skills, counseling and teaching skills, Life Skills, vocational skills, peer education skills and community supports. Results will be visible in family relationships, participatory classrooms, counseling opportunities, self-esteem, capacity to resist peer pressure, and skills for employment (Dolan KA and Niven H. 2005; World Bank 2003). Employment opportunities are crucial for reducing the likelihood of drug use and sex work (United Nations Country Team. 2004). Improved sexuality education and more open dialogue will help prevent unwanted pregnancy, as well as unprotected sex. Additionally, the Project will promote youth health indirectly through the Advocacy Component, which will raise the profile of youth in national HIV prevention (via a Youth Advisor), and support implementation of the National HIV/AIDS Strategy (as well as Project components). Opportunities for youth to be employed by the Project, to act as peer educators, and to contribute intellect and energy at all stages (including Formative Research and M & E), will also confer social (and economic) benefits to youth as well as to their communities. Supporting a repeat of the SAVY study will enable the maintenance of a sex- and age-disaggregated database that incorporates concepts of risk and protective factors.

### **Community Participation**

190. The Project calls for broad and deep engagement from a wide variety of organizations and groups, both public and community-based. The IPC activities will offer opportunities to build collaborative relationships between generations, and between civil society organizations (e.g., Youth Union, Women's Union and Farmers' Union), government departments (especially the Commission for Population, Family and Children [CPFC] and DoLISA), specialist NGOs and other community-based groups that have networks at commune levels. These activities will build civil society<sup>13</sup>, and offer new partnership models, with a focus on flexible approaches appropriate to local needs. Skills in counseling and communication, planning, and M & E will not only assist Project sustainability, but also strengthen the work currently done by government and non-government organizations, thus conferring additional social benefits.

### **Migration and Mobility**

191. Youth aged 20–24 comprise the largest group of a growing population of mobile workers traveling within Viet Nam and across borders to seek work. Large infrastructure projects, including those through ADB, attract large numbers of young men (and, typically, young women selling sex to these transient communities). While migration offers good economic opportunities for many, it presents HIV risks for some through commercial sex, exploitation and sexual abuse, and through pressure to use drugs (Dang Nguyen Anh. 2005; UNICEF. 2003). Migrants need education, skills, job opportunities and enforcement of legal protections to reap the benefits of migration, and to resist risk behaviors and situations. Because many are unregistered, they are likely to be overlooked by mainstream services, and may be reluctant to seek help, including, for example, VCT and harm reduction services. The Project will offer harm reduction and education for some migrants who are reached in work-sites and vocational training or job recruitment centers. It will also provide opportunities to build skills and self-confidence through Life Skills training, and through becoming peer educators. Through Advocacy, the Project will raise awareness of vulnerability and legal obligations to protect workers. Indirectly, the Project may reduce migration to the extent that it assists in developing skills and opportunities for employment in some local settings.

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<sup>13</sup> Development and strengthening of Community-Based Organizations (CBOs) has been endorsed in Viet Nam's Strategy for Socio-Economic Development in the Period 2001–10 and in Grassroots Democracy Decree 79 (2003).

## Gender

192. As in most countries, HIV/AIDS transmission and prevention in Viet Nam has important gender dimensions. This issue has been a central focal area during the Design phase, and featured prominently in consultations and review of secondary literature. Currently, 86% of all PLWHA are male (MoH 2005a), largely because the vast majority of injecting drug users are male. However, most sex workers are young women, and there is an increasing tendency for them to inject drugs (ADB JFPR 2005)<sup>14</sup>. Young women are also infected by boy-friends and husbands. Normative gender roles are instrumental in creating different risks for young men and young women, and there is evidence these norms are strongly enduring (MoH 2005b; Morrow M, et. al. 2002). Achievement of Project Purpose and Objectives will have benefits for both women and men. Because of the importance of gender and the opportunity to address it within this Project, a Gender Strategy has been developed which includes mainstreaming, where relevant (see Appendix E). The Project will provide benefits not only through its components, but also via opportunities for employment and personal development through involvement in the Project as researchers, research participants, actors, developers of IPC materials, trainers, peer educators and counselors, and through the M & E process.

### d. Cost Estimates

193. The total cost of the Project is US\$24.3 million including taxes, duties and contingencies. The table below summarizes the cost of the project by component and by currency. Contingencies are relatively high at 9.8% of budget mainly due to the nature of the Project as a supplier of mass media and IPC materials, which accounts for 45.7% of budget. Another 31.2% is expended on community-based HIV/AIDS prevention, with 6.7% on advocacy. Project management costs are 16.4%, which is appropriate for a project of this nature, where management of sub-contractors and of community based activities is a key part of implementation. Foreign exchange costs are low at US\$3 million, or 13% of budget and 87% of funds are expended in Vietnam. Foreign technical assistance has been kept to a minimum.

Table 3: Cost estimates by Component (US\$'000)

				Total
		FE	LC	Budget
<b>A. Base Costs</b>				
1	National Leadership and Strategy	250,000	1,728,499	1,978,499
2	Mass-media and IPC materials	2,005,488	8,756,131	10,761,619
3	Community-based HIV prevention		6,831,520	6,831,520
4	Project management	710,650	3,316,176	4,026,826
Total base costs		2,966,138	20,632,326	23,598,464
<b>B. Taxes and duties</b>				
			1,154,840	1,154,840
<b>C. Contingencies<sup>b</sup></b>				
1.	Physical Contingencies	134,594	548,979	683,573
2.	Price Contingencies	56,817	1,206,305	1,263,122
Total Contingencies		191,412	1,755,284	1,946,695
<b>Total Costs</b>		<b>3,157,550</b>	<b>23,542,450</b>	<b>26,699,999</b>

Notes:

a. Estimates based on Government sources; includes VAT (5% and 10%), special MV tax, income tax.

b. Based on latest ADB data. FE = foreign exchange. LC = local currency.

Source: Government staff and estimates.

<sup>14</sup> Ministry of Health, NIHE, FHI, USAID. No date. What can we do to control the HIV epidemic in Viet Nam? What high-risk groups have to tell us.

194. Contingencies have been provided for variations in the extent of activities and the quantity of mass media and IPC materials required and for variations in price of inputs due to inflation and other price-effective events using the most recent ADB data on Domestic and International Cost Escalation Factors (2005–2009) for Vietnam. Taxation rates were calculated, where applicable for VAT on the purchase of materials at 10% and for equipment at 5%. Income tax of 17% was deducted for salaries above the tax threshold of approximately US\$300 per month. Special sales tax on motor vehicles was calculated at 100%.

### e. Financing Plan

195. The Bank will provide US\$20 million to the GoV as a grant. The GoV will provide an in-kind contribution of US\$4.3 million comprising a commitment from the VCPFC as the EA and partner institutions including MOH, MOET and MOLISA. The VCPFC will meet provide office accommodation, management staff and meet most of the management costs of the Project at central and provincial level. The budget includes funds for capacity building activities designed to strengthen the EA's ability to carry out this role. The GoV contribution constitutes 22% of Bank funding and 18% of the Project budget overall. The GoV will pay the cost of all local taxes and duties. Foreign currency expenditures have been kept to a minimum, at 12%, with the bulk of expenditures occurring in-country. The Project requires only a limited amount of equipment and little foreign technical assistance (aside from sub-contracting mass-media activities). Most of the Project expenditure will occur in-country, where all materials, supplies and equipment will be sources. The local currency cost is justified by the urgent need to halt the expansion of the HIV/AIDS epidemic before it becomes an unmanageable national and economic burden. Given the nature of the Project as strong in the provision of public goods, no co-financing arrangements have been proposed at this time. However, cooperation with other government departments, non-government organizations, and mass media agencies will contribute to meeting the demands of the wider HIV-prevention effort and provide the scope for the consideration of co-financing once the Project commences.

*Table 4: Financing Plan by source of funds (US\$)*

			<b>Total</b>	<b>% of</b>
<b>Funds</b>	<b>FE</b>	<b>LC</b>	<b>Budget</b>	<b>total</b>
ADB	3,157,550	16,842,450	20,000,000	75%
GoV		6,700,000	6,700,000	25%
	<b>3,157,550</b>	<b>23,542,451</b>	<b>26,700,000</b>	100%

Notes:

FE = foreign exchange. LC = local currency.

Source: Government staff and estimates.

### f. Implementation Arrangements

#### Project Management

196. The Viet Nam Commission for Population, Family and Children will be the Executing Agency for the proposed Project. It has been agreed during the PPTA by GoV and the ADB that the grant for this Project will be provided to the GoV and VCPFC as a Sector Development Program. As this type of program is new to VCPFC, it will be described here in detail. It is a combination of an investment component (project or sector) and a policy-based (program) component along with technical assistance, with a view to meeting sector needs in a comprehensive and integrated fashion. The SDP is designed to foster an integrated and generally long-term approach to sector needs. Since there is already a National HIV/AIDS Strategy and a National Monitoring and Evaluation System to support the Strategy is cur-

rently being developed, the strategy and systems are in place to support the implementation of a SDP.

197. For the investment component of this proposal, the Draft Final Report details the key project activities for national and provincial levels for the five years of the program. This will guide the implementation of the SDP in its first phase but refinements can be made in the action plans developed for the second phase based on the implementation experience and success and timing of achieving the milestones.

198. The program–financing component will be divided into tranches. It is expected that this program will have three tranches. The first tranche will be provided on the signing of the Project agreement between GoV and VCPFC with ADB. This will fund the first phase, which will be for the first two years of the Project. This will include Project implementation at the central level and in the first group of five provinces in the northern region. It is considered appropriate to start with a group of selected provinces that the VCPFC can access easily for the purposes of intensive management and monitoring in the first phase of the Project. The financing commitments for the second and third phases will be contingent on the timely and effective implementation of the agreed program of activities as measured and indicated by the milestones (Appendix A, i and ii). Table 2 below indicates the expected program phases and the tranche payments from the ADB to VCPFC.

*Table 5: SDP schedule of implementation phases and payments*

Schedule	Phase	Provinces Selected	Total number of provinces	Tranches from ADB
Months 1–24 (Y1, 2)	Phase One	5 northern provinces	5 northern provinces	1 <sup>st</sup> released at commencement of Project
Months 25–36 (Y3)	Phase Two	5 provinces (2 central, 3 southern)	Plus 5 new provinces = total of 10 provinces	2 <sup>nd</sup> released at month 25
Months 37–60 (Y 4, 5)	Phase Three	5 provinces from central and southern regions	Plus 5 new provinces = total of 15 provinces	3 <sup>rd</sup> released at month 37

199. This SDP approach represents a combination of program and project support for the GoV at a stage when it is initiating implementation of its National HIV/AIDS Strategy. By committing funds on a tranche basis the EA has greater flexibility to determine key details, such as provincial selection, in a more timely manner. The program is also more flexible to respond to the rapidly changing field of HIV/AIDS related activities, as other donors and government–supported programs come on line.

### **Implementation Structure**

200. A Project Steering Committee (PSC) will be established by the EA at the commencement of the Project. The PSC will be headed by the Minister of VCPFC and will include senior officials from the participating ministries and organizations, including Ministry of Planning and Investment, Ministry of Finance, the State Bank of Viet Nam, the VAAC, Youth Union, Women’s Union and Farmer’s Union. The PSC will provide the EA with overall direction and guidance for the Project.

201. A Project Management Unit at the national level will be established which will be headed by a designated project director from the EA. There will also be a Vice Director and a group of regular EA staff and contracted personnel who will constitute the National PMU. It will be responsible to pay for contracted staff as part of the GoV contribution. These positions may include Project support staff such as: Project Manager; Component Coordinators; Accountants; and Administrative staff. These individual staff will have experience in planning, accounting, disbursement, procurement and contract administration. The Component Coordinators will be responsible for co–ordination and monitoring of the component at the

national level. An Organogram of the project management arrangements is shown in Appendix G.

202. The PMU will be responsible for the financial and organizational management of the Project. It will provide overall coordination and support to the Component Coordinators and to the Provincial Project Management Units (PPMUs). The Component Coordinators will be responsible for coordinating with the agencies that are sub-contracted to implement the Project activities.

203. At the provincial level, the Provincial Chairperson of the Commission of Population Family and Children will be the Director of the PPMU. There will be no provincial level Steering Committees. In the first phase of the Project there will be five provinces from the northern region selected to implement the project. They are Hanoi, Quang Ninh, Bac Ninh, Phu Tho and Ha Tay. The PPMU will be responsible to pay for contracted staff as part of the GoV contribution. These positions may include Project support staff such as: Project Manager, Chief Accountant, Book Keeper and Provincial Activity Coordinator for planning, monitoring, accounting, disbursement and procurement. Each position will have a written job descriptions prepared by the EA and Provincial CPFC offices to ensure their role and responsibilities are fully understood. The PPMU staff will be responsible for monitoring the implementation of the Project activities that have been sub-contracted to specific agencies. They will ensure that the sub-contracted agencies provide financial reports to the PPMU for processing and financial monitoring on a quarterly basis.

### **Implementation Period**

204. The Project will be implemented over a five year period, which is expected to commence by mid 2006. As a Sector Development Program the Project will be implemented at the national level and initially in five selected provinces in the northern region in the first two year phase. Following successful completion of Phase One the Project will be expanded to another five selected provinces in the 3<sup>rd</sup> year and a further five provinces in the 4<sup>th</sup> year. This will result in a total of 15 provinces by the 4<sup>th</sup> year. The expansion to provinces will be determined according to analysis of provincial progress and capacity and the recommendation of the SC and NPMU after review.

205. The project implementation schedule is presented in Appendix F.

### **Procurement**

206. All ADB procurement and consulting services will follow ADB guidelines. The PMU will be responsible for: (i) procurement that requires international competitive bidding (ICB) and international shopping (IS) procedures; and (ii) engagement of international consultants. The PPMUs will be given responsibility for: (i) procurement that follows local competitive bidding (LCB) or direct purchase (DP); (ii) engagement of local domestic consultants for each province; (iii) sub-contracting/engagement of agencies to implement peer education programs, VCT services, community collaborators training program; and (iv) other local procurement following the division of work and implementation regulations as established at the commencement of the project. Procedures for LCB procurement and the selection of organizations to implement activities will follow government procedures and other arrangements satisfactory to the ADB. (See Appendix K — Summary List of Procurement Items)

### **Consulting Services**

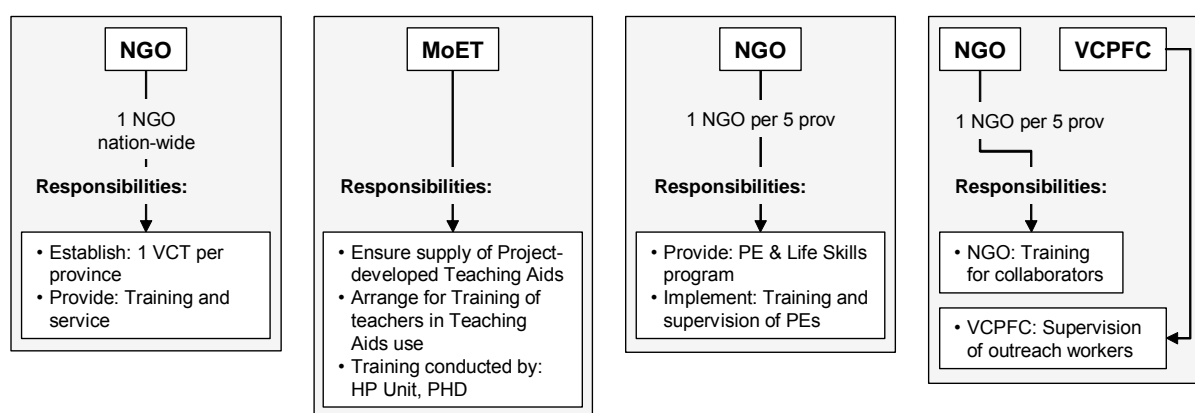
207. The Project will recruit the following three international consultants for the positions of Youth Policy and HIV/AIDS Adviser (24 months), Monitoring and Evaluation Adviser (20 months) and Institutional Capacity Building Adviser (15 months). The Youth Policy and HIV/AIDS Adviser will work within the Component One which focuses on Advocacy. The M&E Adviser and the Institutional Capacity Building Adviser will be assigned under Component Four which focuses on project management. The M&E Adviser will work across all

components assisting with baseline surveys and formative research and the development of indicators for monitoring and evaluation. The Institutional Capacity Building Adviser will work with the PMU and PPMUs to build their capacity in project management.

208. The strategy for recruiting consulting services for the Mass Media and IPC component is to sub-contract the component by appointing an agency with the professional expertise in the specific area of mass media production and with experience in HIV/AIDS programs in developing countries. The appointed agency will develop a proposal to implement the component activities and this will be appraised and approved by the PMU. A contract will then be signed between the PMU and the agency for the life of the Project.

209. Within Component Three it will be necessary to sub-contract a number of different consulting agencies to implement the different sub-components at the provincial level as illustrated in the diagram below.

**Figure 2 — Recommended Sub-Contracting Arrangements**



210. The Voluntary Counseling and Testing (VCT) services will be sub-contracted by PMU through a bidding process to one consulting agency to pilot the implementation of VCT services in all five provinces in Phase One.

211. For the Peer Education and Life Skills training programs which is for the number of different target groups (IDUs, service industry workers, factory workers, vocational training center trainees etc) it is proposed that each PPMU will use a bidding process to sub-contract one consulting agency or one consortium of agencies to provide the PE/Life Skills program in each province.

212. The same process will be applied in each province to sub-contract consulting services to provide training programs for community based collaborators from CPFC and other civil society organizations (e.g. Women’s Union). As there are a number of topics to be cover in the training, including HIV/AIDS, care and support for PLWHA, it is recommended that the EA engage external trainers. After training the outreach activities of the sub-component will be managed by CPFC managers at the provincial, district and commune levels. (See Appendix I, Consulting Services.)

### Disbursement Arrangements

213. The grant will be disbursed in three tranches: the first at the signing of the agreement between the EA/GoV and the ADB to commence the Project. The second and third tranches will be contingent upon satisfactory completion of the milestones agreed for each phase and upon submission of an Action Plan for the next phase based on criteria for expansion to more provinces. PMU will open and maintain an imprest account in USD at a commercial bank in order to receive the grant funds from the ADB. The first tranche will be lodged in the

account after the agreement is signed between the ADB and the EA. Funds to the provinces will be transferred annually when Annual Plans are approved by PMU. PPMU will also have their own sub-imprest accounts in VND at the Provincial Treasury for receiving funds from PMU. The account ceiling will depend on PPMU's annual budget. The liquidation between PPMU and PMU will be done six monthly and will conform to ADB guidelines on disbursement.

### **Accounting and Auditing and Reporting**

214. The GoV acting through the EA, will maintain separate records and accounts adequate to identify goods and services financed from the proceeds of the ADB grant. The total Project accounts will be maintained by the PMU of the EA. Separate accounts for appropriate project components and activities will also be maintained by the designated agency as in the case of the mass media and IPC component and by the each PPMU for provincial activities. All accounts will be kept in accordance with sound accounting practices.

215. The PMU will: (i) keep project accounts separate from regular accounts; (ii) ensure accounts and financial statements are audited annually, according to sound accounting principles, by external auditors acceptable to the ADB; and (iii) submit to ADB, not later than 9 months after the close of each fiscal year certified copies of audited project accounts and financial statements, the auditor's reports and opinions and management letter together with a report of actions taken by the EA to improve the financial management system based on the auditor's findings and recommendations. The EA will select and appoint an auditor acceptable to the ADB within sufficient time to carry out its responsibilities. The costs of auditing are included in the grant.

216. The EA will prepare six monthly Progress Reports for submission to the ADB. The Report will be prepared according to agreed format and guidelines. In the first month of the last quarter of each phase (i.e. month 21, month 33 and month 57) a Phased Completion Report will be submitted by the EA to the ADB. This Report will include the proposed Action Plan and budget for the next phase of the Project. This Report will be prepared in the format provided in the Project Administration Memorandum. It will summarize: (i) progress made against established targets, including aspects of quality; (ii) delays, problems encountered and actions taken to resolve issues; (iii) compliance with grant guidelines; (iv) a proposed program of activities to be undertaken during the next phase; and (v) expected progress during the succeeding period. Within 3 months of physical completion of the Project, the GoV will prepare and submit to the ADB a Project Completion Report on the execution of the Project, including costs and compliance with grant guidelines.

### **Project Performance Monitoring and Evaluation**

217. The Project proposal has identified a set of key verifiable indicators to assess the impact of the Project. (Appendix A iii). A provisional target level is provided for each indicator. In the first year of the Project these indicators and targets will be reviewed using the results of the baseline surveys and ensuring alignment with the indicators for National Strategy on HIV/AIDS Prevention and Control.

218. The MoH with assistance from the World Bank are currently in the process of developing a Monitoring and Evaluation system for all the program areas of this Strategy. It is expected that this work will be completed in the first half of 2006. As the ADB and this Project supports the UNAIDS principles of the "3 ones" it will be necessary to review the proposed indicators once the MoH have decided on their list of key performance indicators and ensure that the Project uses the same indicators so that it is supporting and working with the one national monitoring and evaluation system.

219. The Monitoring and Evaluation Adviser to the Project will be responsible in the first six months of the project to do this review and revision of the Project key indicators. The Pro-

ject through this M&E adviser will also provide mentoring and coaching to the provincial level staff of MoH (in the Project provinces) who will be doing the surveillance and data collection for the new indicators.

220. A baseline survey in the first years of the project and a final survey in the last quarter of the project will be used to assess changes in the indicators. The PMU will be overall responsible for ensuring that data is collected, analyzed and reported to all interested parties.

221. Since the Project is being implemented under the SDP approach the PMU will be required to monitor and report on progress to the ADB at the end of each phase. Each phase will have a set of milestones to be achieved by the PMU before the funds will be released by the ADB for the next phase (Appendix A i). This will require the PMU to have good monitoring and reporting systems in place so that they can ensure that the Project activities are being implemented on schedule and to the appropriate technical standards. For this reason the M&E adviser will work closely with the PMU and PPMUs and the sub-contracted agencies to ensure their capacity is built in the area of project reporting and monitoring systems. The concept of supervision through regular site visits will be emphasized and had been budgeted so that both national level and provincial level staff can physically monitor progress and work closely with implementers to ensure activities are conducted on time and to the standards required.

222. The PMU will submit Phased Completion Reports including evidence that the agreed milestones for each Phase have been completed. An Action plan for the next phase will also be submitted at the same time. If adjustments to the original project implementation schedule or to the scope of the project in terms of the number of new provinces to be included in this phase need to be made they will be presented and justified in this report. The GoV and ADB will then review and decide on the Plan of Action for the next phase.

### **Project Review**

223. The Project will be implemented in three phases under a Sector Development Program, with Phase One being the first two years of the Project, Phase Two being the 3<sup>rd</sup> year and Phase Three being the 4<sup>th</sup> and 5<sup>th</sup> year. The GoV and ADB will jointly undertake a mid-term review of the Project. To align with these phases it is recommended that the mid-term review be conducted in the 9<sup>th</sup> month of the third year so that the findings and recommendations can be reviewed by the GoV and ADB and decide on any necessary changes to be made in the final implementation phase of the Project.

224. The mid term review will:

- i) review the original Project scope, design, implementation arrangements and other relevant issues in the light of the Government's development strategies and policy framework, and strategic concerns of the ADB, including and modifications, if needed;
- ii) examine progress towards achieving measurable objectives of the Project and agree on adjustment to the project implementation plan; and
- iii) identify problems and constraints and formulate appropriate recommendations for corrective actions to be taken by PMU.

### **g. Provincial Selection**

225. This section provides a description of the process followed in the selection of candidate provinces for inclusion in the HIV/AIDS Prevention Among Youth project.

### **Overview of the selection process**

226. It was envisioned in the Project Proposal document that the Project would be implemented in 15–17 provinces. The TA team indicated to the EA that the number of provinces might need to be reconsidered once the Project components were identified and agreed and once the costs of the project activities are calculated. If a large number of provinces is maintained the budget allocation for each may be too small to allow for wide coverage within each province.

227. Implementation in a large number of provinces increases the management and monitoring responsibility of the project implementation agency and may reduce its efficiency. By concentrating on a smaller number of provinces that are clustered around major regional centers, the Project can be more efficiently managed. This matter was discussed with the EA at the beginning of the TA in May 2005 and it was agreed that the idea of selecting fewer provinces was worth considering. In a joint meeting of the TA and EA in July selection criteria were agreed and a tentative list of 22 provinces was developed, from which the final selection could be made.

228. At a meeting of the ADB, PMU and GoV in August 2005, it was decided that the ADB Grant would be administered as a Sector Development Program. This SDP approach means that the Project will receive funding in three tranches, with each payment dependent on achieving the milestones for each phase. With this approach the Project will be implemented in three phases, starting with five provinces in Year 1, adding five more provinces in Year 3 and the final five provinces in Year 4, giving a total of 15 provinces. Depending on the progress made in implementing the activities this timetable for expanding to more provinces may be accelerated or delayed depending on a review of Project progress at the end of each phase.

229. The selection of provinces was made based on the following rationale:

- i) A clustering approach is appropriate and applicable to the BCC approach. The selection of regional capital cities in the North, Central and South allows the Project to have regional centers for mass media interventions and for the management and implementation of the BCC approach. Provinces surrounding the regional capital cities are closely linked with young people moving in and out of the cities for entertainment, services, education and employment.
- ii) As urbanization takes place, industrial zones are developing in provinces close to major cities and large semi-urban centers are developing. These areas attract young people for employment. It is expected that the impact of the BCC approach will be maximized from the active interaction between provinces, especially with mass media approach in the key provinces and the specific interventions using IPC approach in each region.
- iii) Provinces selected can represent different geographical regions/areas in Viet Nam. This includes core urban, semi-urban, and rural areas. The experience gained from implementation in these different settings will provide lessons of the targeting of youth-focused programs in different settings.

### **Criteria for province selection**

230. A set of criteria for selection was discussed with the PMU. Agreement was reached that the following criteria will be applied for in provincial selection:

- i) Provinces with large urban centers and regional capitals which reflect the geographical differentials;
- ii) Provinces with a large population of youth, including a concentration of vulnerable and high risk groups;

- iii) Provinces that are education centers with universities, colleges, and technical training schools. Each region has its designated high–education institutions (universities, colleges, etc) with a large population of young students;
- iv) Provinces with developing industrial zones as these provide employment for large numbers of young people from surrounding provinces;
- v) Provinces with tourist attractions as these both attract a large number of young people who come for entertainment as well as being a source of employment for young people in the entertainment and service industries;
- vi) Provinces with a growing population of vulnerable youth (IDUs, sex workers);
- vii) Provinces involved in the previous ADB project and ADB highways corridor projects were given priority to support sustainability of activities and to build on the already established management and technical capacity in the province;
- viii) Prevalence rates for HIV+ and other epidemiological data have been used to rank provinces; and
- ix) The twenty provinces where the World Bank HIV/AIDS prevention project is being implemented were excluded as the Government guideline is to only have one major donor in each province. They will still participate in some components of the Project that are carried out nationwide (for example TV programs).

231. The above principles and criteria divided Viet Nam’s 64 provinces into two groups of candidate provinces (21 provinces) and Less Likely or Not Selected (45 provinces).

*Table 6: Provinces and selection group for project interventions, Viet Nam*

Candidate Provinces	Less Likely/Not selected
<b>Northern Region</b> Ha Noi Hai Duong Bac Ninh Ha Tay Ha Nam Quang Ninh Phu Tho Dien Bien  <b>Central Region</b> Da Nang Thua Thien Hue Quang Tri Quang Nam Quang Ngai Lam Dong  <b>Southern Region</b> HCM City * Binh Duong Binh Phuoc Long An Ba Ria—Vung Tau Dong Thap Can Tho	Ha Giang, Cao Bang, Lao Cai, Lai Chau, Bac Can, Lang Son, Bac Giang, Tuyen Quang, Vinh Phuc, Thai Nguyen, Bac Giang, Hoa Binh, Yen Bai, Ninh Binh, Son La, Thai Binh, Thai Nguyen, Hai Phong Thanh Hoa, Nam Dinh, Binh Dinh, Binh Thuan, Phu Yen, Nghe An, Quang Binh, Ninh Thuan, Tay Ninh, Kon Tum, Gia Lai, Dak Lak, Dak Nong, Lam Dong, An Giang, Ben Tre, Dong Nai, Khanh Hoa, Kien Giang, Tien Giang, Vinh Long, Hau Giang, Tra Vinh, Soc Trang, Bac Lieu, Ca Mau.

Note: \* Media center only

### Scoring method

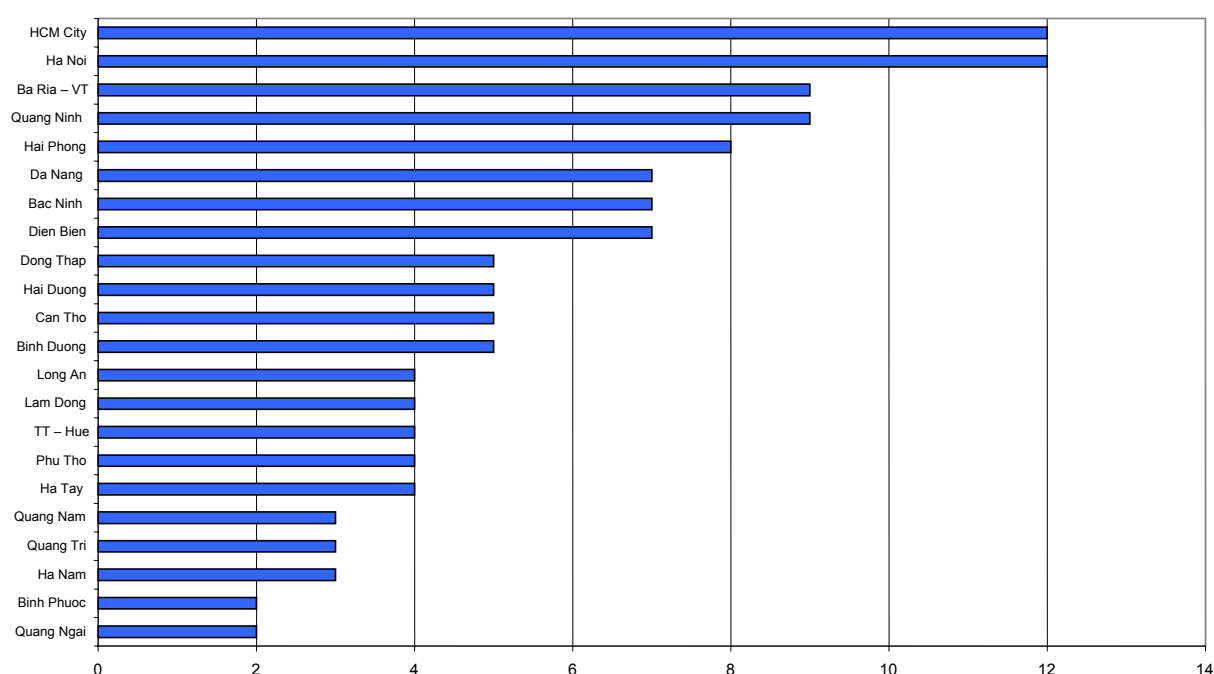
232. Having agreed upon the criteria for provincial selection and taking into account the availability of relevant data, a set of indicators was first developed to form a criteria matrix for

the 21 candidate provinces. A point score was then calculated for each of the provinces. The score takes the major indicators into account and is used to classify the provinces in a ranking order of priority (Appendix H).

233. Mean/median values of the indicators were computed. A province with the value of a given indicator higher than the mean/median was given one point. Additional points were awarded depending upon the value of selected indicators. A statistical correction was made to deflate the influence of outliers in the values of indicators. The resulting scores tended to be vary between 2–12 depending on the nature of HIV–related indicators allocated in response to the level of HIV prevalence among youth in the province.

234. When the scores were applied to rank the provinces, provinces which had the same score were ranked again. Among these provinces, those with a higher HIV preference per 100,000 people were given a higher priority. The graph below depicts the provincial ranking based upon scores.

**Figure 3 — Ranking order of Provinces by Scores**



235. All subsequent descriptions can be based upon the results of scoring and provincial ranking. The final decision regarding the number of provinces to be selected, taking consideration of the costs of implementing the proposed activities and scheduled installment of project funds can be made on the basis of the ranking order obtained from the above exercises. Table 4 provides a list of provinces in order of priority for Project interventions by three regions.

*Table 7: Provinces selected for project interventions by region, Viet Nam*

North	Central	South
1. Ha Noi (2)	1. Da Nang (8)	1. HCM City ** (1)
2. Quang Ninh (5)	2. Thua Thien – Hue (18)	2. Ba Ria – Vung Tau (4)
3. Hai Phong * (3)	3. Lam Dong (16)	3. Dong Thap (13)
4. Bac Ninh (9)	4. Quang Nam (20)	4. Can Tho (6)
5. Dien Bien (10)	5. Quang Tri (21)	5. Binh Duong (7)
6. Hai Duong (14)	6. Quang Ngai (23)	6. Long An (15)
7. Phu Tho (11)		7. Binh Phuoc (22)
8. Ha Tay (12)		
9. Ha Nam (19)		

Note: \* World Bank province; \*\* Media center only

236. Following the decision to implement the project as a SDP it was decided that in Phase One, five provinces would be selected for project implementation. The PMU decided to select five provinces from the northern region that are in close proximity to Hanoi. This is to facilitate their ability to manage and monitor the selected provinces closely in the first two years of the project. The provinces selected for the first phase are: Hanoi, Quang Ninh, Bac Ninh, Phu Tho and Ha Tay.

237. Before inclusion of other provinces after the first phase, the PMU will have to review the provincial matrix and the status of the HIV/AIDS epidemic in these provinces as the situation may have changed, which would influence the decision about Project in the second and third phase.

#### 4) Technical Assistance

238. The technical assistance required to support the implementation of the proposed project will be provided through three main sources: (i) local contracted staff hired by the EA; (ii) international or local agencies subcontracted by the EA; and (iii) international consultants hired by the EA.

239. On the assumption that the professional skills required to manage and coordinate the project components is available in country, the PMU and PPMUs will directly contract the required Project Manager, Component Coordinators (national level) and Project Activity Coordinators (one per province) for the duration of the project.

240. It is also assumed that there are professional and technical skills available within the local community of international and local NGOs and civil society organizations to implement the provincial based programs of voluntary counseling and testing, peer education and life skills programs and training for community workers in HIV/AIDS prevention, parenting, gender awareness and other related topics. The PMU and PPMUs will, through a bidding process, sub-contract suitable, qualified professional agencies to be responsible to implement these activities in the provinces.

241. For mass media and IPC materials activities it is recognized that the production of a high quality TV entertainment-education drama series and supporting IPC materials will require an agency with the appropriate professional skills and experience. The EA, through their contracting regulations and guidelines, will identify and sub-contract a suitable agency to manage and implement the program of work involved in Component Two

242. Two international consultants will be contracted by the EA to provide capacity building and technical input in the areas of youth policy and monitoring and evaluation.

243. In Appendix I — Consulting Services, the Terms of Reference for the Technical Assistance proposed for the project are presented for the following positions and agencies:

- i) Youth Policy and HIV/AIDS Adviser;
- ii) Monitoring and Evaluation Adviser;
- iii) Institutional Capacity Building Adviser (DRAFT – for consideration by the EA and ADB before Final Report submitted); and
- iv) Agency to implement the Mass Media and IPC Materials development program.

244. Agencies (Local or International) to implement each of the following:

- i) VCT services for a set of five provinces;
- ii) Peer Education /Life skills programs for a set of five provinces; and
- iii) Training program for community based workers (each PPMU to contract an agency at the provincial level).

## 5) Project Benefits, Impacts and Risks

### Benefits

245. The Project will have significant impact on vulnerable and high risk groups of youth through the application of BCC strategies and interventions to reduce HIV transmission including harm reduction programs, care and treatment, and skills training.

246. Through an integrated use of mass media and IPC, youth, parents and community leaders will be influenced to reduce stigma and discrimination towards IDUs, SWs and PLWHA.

247. The drama series will seek to alter attitudes towards gender, youth, marginalized populations and PLWHA, over time, for a mass audience. Women and girls will benefit from a reduction in male risk behavior, and from more open, and equal, personal relationships (including across generations). Boys and men will benefit from safer practices and more positive attitudes towards women.

248. IPC activities will focus on vulnerable youth, and include a strong focus on gender training and gender awareness through workshops, peer education, outreach, classroom settings, workplace programs. Both sexes will be beneficiaries.

249. IPC activities targeting young men (including MSM) and women will lead to decreased risk of transmission from improved HIV knowledge, Life Skills, facilitation skills, harm reduction and vocational opportunities.

250. It is recognized that the integrated use of sustained mass media programming and IPC activities and material can have an impressive impact on influencing attitudes and behavior change among vulnerable and high risk target groups.

251. Youth and PLWHA will gain skills, training and employment opportunities through their involvement in the design, production and delivery of Project supported mass media programming and IPC materials.

252. High skill levels of local media production specialists will help to facilitate the production of a complex set of TV and radio programming and ensure the production of high quality products.

253. Investing in a high quality television drama and radio phone-in programs can attract advertising revenue which helps to cover production and broadcast costs, acts as an incentive for the broadcaster to place programs on prime-time and enhances the possibility of programming continuing beyond the life of the Project.

### Risks

254. GoV policies relating to HIV/AIDS and youth will not be implemented at the local level thereby undermining support for the introduction of activities such as harm reduction, community based rehabilitation and home care for IDUs and PLWHA.

255. Leaders will not endorse the involvement of vulnerable and high risk youth in the design and implementation of Project activities.

256. Leaders will not allow for full editorial and creative control by the agency engaged to develop mass media programming and IPC materials under Component 2. Given that HIV prevalence among youth continues to increase it is considered urgent that new, innovative and potentially controversial messages and ways of delivering them be introduced to Viet

Nam. The agency responsible for the development of mass media programming and IPC materials under Component 2 will need to be provided the creative and editorial leeway necessary for the development of effective and persuasive messages and scripts while maintaining sensitivity to cultural and social norms. This will require close collaboration between the EA, the contracted agency's creative directors/producers and the Ministry of Culture and Information (MoCI).

257. Leaders unwilling to allow for the publication of "sensitive" content in mass media periodicals, i.e. materials dealing with sexual and reproductive health issues. As with the concern regarding the mass media programming and IPC materials mentioned above, the close collaboration between the EA, the contracted agency's creative directors/producers and the MoCI will be necessary to ensure the smooth implementation of this output of the Project.

258. Lack of assurance by decision makers to commit sufficient resources to the development of a high quality BCC program, involving the production of a TV drama series, radio series and accompanying IPC materials for youth in schools and in community settings. The proposed Project calls for a substantial investment in mass media and IPC materials production, far beyond the scope of previous, similar projects. To ensure the agreement of the decision makers to such an investment advocacy efforts by the EA may be required.

259. Government journalists may be reluctant to apply alternative and new approaches in reporting on HIV/AIDS and reproductive health issues targeting youth.

260. Authorities may be reluctant to establish of community-based VCT.

261. Authorities may not be willing to allow Peer Educators to carry and distribute condoms and syringes.

## 6) Assurances

- i) Implementation of the Prime Minister's National Strategy on HIV/AIDS Prevention and Control in Viet Nam till 2010 with a Vision to 2020.<sup>15</sup> It is expected that the National Assembly will formally adopt a legal framework to operationalize this Strategy in 2005. This law would enable smoother Project implementation at central and provincial levels, particularly in the more contentious spheres of harm reduction and VCT. It would enable the commencement of Project Advocacy activities aimed at fostering support for the Strategy at all levels. The implementation of the National HIV/AIDS Strategy would also provide a more coherent foundation for donor harmonization, particularly for ARV and VCT and, importantly, to develop a single national M&E framework for HIV/AIDS prevention and control.
- ii) Gender strategy. The EA will ensure the implementation of the Gender strategy (see Appendix E). This will entail accepting the notion that some normative gender roles for both men and women are harmful and should be challenged in order to prevent HIV transmission. The EA will further assure that at least half of those selected for positions of responsibility for Project implementation and those selected as master trainers and peer educators will be women.
- iii) Involvement of youth and PLWHA. The EA will ensure that youth (aged 15–24) and PLWHA are involved in all stages of Project planning, formative research, implementation and evaluation, wherever possible and appropriate. There should be representation from youth and PLWHA on PPMUs in order to ensure more than token engagement. Specific targets for their involvement will be identified during the Project inception phase, and incorporated into the Logframe.

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<sup>15</sup> Government of Viet Nam. 2004. National Strategy on HIV/AIDS Prevention and Control in Viet Nam till 2010 with a Vision to 2020. 17 March 2004, Decision of the Prime Minister, Hanoi.

# Appendixes

## a. Project Framework, Milestones, Key Indicators and Logframe

### i. Design and Monitoring Framework with Milestones

Design Summary	Performance Targets/ Indicators	Data Sources/Reporting Mechanisms	Assumptions and Risks
<b>Impact</b> 1. To contribute to achieve Millennium Development Goal 6/Target 7: have halted and begun to reverse the spread of HIV/AIDS by 2010	<ul style="list-style-type: none"> <li>HIV prevalence in target populations</li> </ul>	<ul style="list-style-type: none"> <li>Baseline, mid-term, and final surveys</li> </ul>	<ul style="list-style-type: none"> <li>Project design implemented effectively.</li> <li>Government policy commitment to HIV/AIDS control.</li> </ul>
<b>Outcome</b> 1. HIV infection risk reduced among youth ages 15–24 through behavioral change programs	<ul style="list-style-type: none"> <li>Percentage of 15–24 year olds with comprehensive correct knowledge of HIV/AIDS</li> <li>Condom use rate at most recent high risk sex among youth and clean needles/ syringes use rate among IDUs</li> </ul>	<ul style="list-style-type: none"> <li>Baseline, mid-term, and final surveys</li> </ul>	<ul style="list-style-type: none"> <li>Government and donor priorities do not change</li> </ul>
<b>Outputs</b> 1. Leadership support gained for implementation of the National Strategy on HIV/AIDS Prevention targeting youth 2. High quality mass media, BCC programming, and supporting IPC materials produced and widely circulated 3. HIV prevention achieved through VCT services, peer education and community support programs. 4. Effective Program management and M&E systems established and functioning	<ul style="list-style-type: none"> <li>Resolutions on HIV/AIDS prevention and control issued and concretised in the local socio-economic development programs.</li> <li>Mass media products and messages on HIV prevention diversified and reached all segments of the society and target groups</li> <li>Increase vulnerable and mainstream youth correctly identify ways of preventing HIV transmission.</li> <li>Increased reporting of Safe sexual behaviour among young people</li> <li>Capacity of staff in charge of project monitoring and evaluation raised at all levels</li> </ul>	<ul style="list-style-type: none"> <li>Government document</li> <li>Regular report</li> <li>Special assessment among vulnerable youth</li> <li>Baseline, mid-term, and final surveys</li> </ul>	<ul style="list-style-type: none"> <li>Stability of Leaders in key positions of influence.</li> <li>Support generated for Harm Reduction programs in all provinces</li> <li>Permission to develop VCT sites in community locations</li> <li>Government authorities support mass media messages for broadcasting</li> <li>Leaders endorse the involvement of youth and PLWHA in community action programs.</li> </ul>

### Key Activities with Milestones for ADB

Activities with Milestones	Phase 1		P2	Phase 3	
	Y1	Y2	Y3	Y4	Y5
<b>OVERALL CRITERIA (for each phase)</b> Overall report submitted by PMU to ABD will include:					
<ul style="list-style-type: none"> <li>PMU has selected and contracted suitable agencies to implement program activities</li> </ul>	✓		✓	✓	
<ul style="list-style-type: none"> <li>No major delays have occurred in implementing project at the national level and in selected provinces</li> </ul>	✓		✓	✓	

## Key Activities with Milestones for ADB

Activities with Milestones	Phase 1		P2	Phase 3	
	Y1	Y2	Y3	Y4	Y5
• TV dramas have been produced and broadcasted		✓	✓	✓	✓
• IPC materials have been produced and distributed		✓	✓	✓	✓
• Provincial PMUs established in all provinces	✓		✓	✓	
• Timely disbursement of project budget		✓	✓	✓	✓
<b>SPECIFIC CRITERIA – Component 1: Advocacy (all 3 phases)</b> <i>Phase completion report submitted by PMU to ADB will include:</i>					
• Annual progress report on advocacy issues showing on–time implementation according to schedule	✓	✓	✓	✓	✓
• Copies of information packs		✓	✓	✓	
• Forum report/workshop proceeding reports	✓	✓	✓	✓	✓
• Articles , website address /access information report		✓	✓	✓	
<b>Component 2 – Mass Media and IPC materials (all 3 phases)</b> <i>Phase completion report of Implementing Agency submitted by PMU to ADB will include:</i>					
• Annual progress report showing on–time implementation according to schedule on activities and programs under Component 2	✓	✓	✓	✓	✓
• Annual progress report	✓	✓	✓	✓	✓
• Copies of TV dramas, TV and radio spots, IPC materials, sample of radio phone–in programs and newspaper/magazine articles/columns (provided on CD)		✓	✓	✓	✓
• Summary report of TV drama audience feedback		✓	✓	✓	
• Summary report of web site user feedback		✓	✓	✓	
<b>Component 3 – Community based HIV/AIDS Prevention (all 3 phases)</b> <i>Phase completion report of Implementing Agency submitted by PMU to ADB will include</i>					
• Annual progress report showing on–time implementation according to schedule of Component 3 programs:	✓	✓	✓	✓	✓
• Community based VCT program activity report		✓	✓	✓	
• PE/LS program report and copies of training materials		✓	✓	✓	
• Community collaborators/worker program report		✓	✓		✓
• IPC materials, condoms and needles/syringes distribution report		✓	✓	✓	
• Training CDs, teaching aid provision report	✓		✓	✓	
• TV & VCD/DVD equipment distribution report	✓		✓	✓	
<b>Component 4: Project management and M&amp;E (all 3 phases)</b> <i>Phase completion report submitted by PMU to ADB will include:</i>					
• Annual progress report showing on–time implementation according to schedule of Component 4 programs	✓	✓	✓	✓	✓
• Baseline Survey Report	✓				
• M&E Framework	✓				
• Mid–term Review report ( in Y3)			✓		
• Financial Audit reports( annually)	✓	✓	✓	✓	✓
• PPMU annual Plans (annually)	✓	✓	✓	✓	✓
• Consulting services report (annually report of contract arrangements with consultants and agencies contracted)	✓	✓	✓	✓	✓
<b>Inputs</b>	ADB: USD 20 million GoV: USD 4 million				

**ii. Milestones for Project Management Unit — Phase One (first five provinces)**

Activities with Milestones	Y1		Y2	
	Mo 1–6	Mo 7–12	Mo 1–6	Mo 7–12
<b>Component 1 – Advocacy</b>				
• Youth policy advisor recruited and functioning	✓			
• Research conducted and topic identified		✓		✓
• Information packs designed, produced and distributed		✓	✓	✓
• Youth articles published and website updated		✓	✓	✓
• Policy maker forum held in each province	✓		✓	
• Advocacy meeting between youth and community leaders		✓	✓	✓
• Awareness raising workshop		✓		
• Annual progress report for the component		✓		✓
• Phase completion report submitted by PMU to ADB				✓
<b>Component 2 – Mass media and IPC materials</b>				
• Implementing agency identified and contracted	✓			
• Formative research conducted, analyzed and storylines/ scripts developed		✓	✓	✓
• National TV dramas broadcasted		✓	✓	✓
• Provincial radio phone–in program broadcasted		✓	✓	✓
• IPC materials produced and distributed to provinces	✓	✓	✓	✓
• Articles/features placed in newspaper and magazines		✓	✓	✓
• Annual progress report for the component		✓		✓
• Phase completion report submitted by PMU to ADB				✓
<b>Component 3 – Community based HIV/AIDS prevention</b>				
• NGO(s) identified, selected and contracted	✓			
• VCT established in project provinces		✓	✓	✓
• PE/LS programs established		✓		
• IPC materials and equipment distributed		✓	✓	
• Training programs established and community workers trained			✓	✓
• Annual progress report for the component		✓		✓
• Phase completion report submitted by PMU to ADB				✓
<b>Component 4 – Project management and M&amp;E</b>				
• PMU/PPMU in placed	✓			
• PPMU plans prepared and approved	✓		✓	
• Provincial M&E unit set up and trained annually	✓			
• Baseline study conducted and reported		✓		
• Financial audit reported		✓		✓
• Annual progress report for the component		✓		✓
• Phase completion report submitted by PMU to ADB				✓

**ii. Milestones for Project Management Unit (cont) — Phase Two (5 old provinces + 5 new provinces)**

Activities with Milestones	Y3	
	Months 1-6	Months 7-12
<b>Component 1 – Advocacy</b>		
• Information packs produced and distributed	√	√
• Youth articles published and website updated	√	√
• Policy maker forum held in each province	√	
• Advocacy meeting between youth and community leaders		√
• Awareness raising workshop held (for new provinces only)		√
• Annual progress report for the component completed		√
• Phase completion report submitted by PMU to ADB		√
<b>Component 2 – Mass media and IPC materials</b>		
• Research conducted, analyzed and storylines/scripts developed		√
• National TV dramas broadcasted	√	√
• Provincial radio phone-in program broadcasted	√	√
• IPC materials produced and distributed to provinces	√	√
• Articles/features placed in newspaper and magazines	√	√
• Annual progress report for the component		√
• Phase completion report submitted by PMU to ADB		√
<b>Component 3 – Community based HIV/AIDS prevention</b>		
• VCT established and operated (for new provinces only)		√
• PE/LS programs established (for new provinces only)	√	
• IPC materials and equipment distributed (new provinces)	√	
• Training programs established and community workers trained		√
• Annual progress report for the component		√
• Phase completion report submitted by PMU to ADB		√
<b>Component 4 – Project management and M&amp;E</b>		
• PMU/PPMU in placed (for new 5 provinces only)	√	
• PPMU plans prepared and approved	√	
• Provincial M&E unit set up and trained annually	√	
• Mid-term review held and reported		√
• Financial audit reported		√
• Annual progress report for the component		√
• Phase completion report submitted by PMU to ADB		√

**ii. Milestones for Project Management Unit (cont) — Phase Three (10 old provinces + 5 new provinces)**

Activities with Milestones	Y4		Y5	
	Mon 1-6	Mon 7-12	Mon 1-6	Mon 7-12
<b>Component 1 – Advocacy</b>				
• Information packs produced and distributed		√	√	√

**ii. Milestones for Project Management Unit (cont) — Phase Three (10 old provinces + 5 new provinces)**

Activities with Milestones	Y4		Y5	
	Mon 1–6	Mon 7–12	Mon 1–6	Mon 7–12
• Youth articles published and website updated		✓	✓	✓
• Policy maker forum held in each province	✓		✓	
• Advocacy meeting between youth and community leaders		✓	✓	✓
• Awareness raising workshop held (new provinces only)		✓		
• Annual progress report for the component completed		✓		✓
• Phase completion report submitted by PMU to ADB				✓
<b>Component 2 – Mass media and IPC materials</b>				
• Formative research conducted, analyzed and storylines/scripts developed		✓	✓	✓
• National TV dramas broadcasted		✓	✓	✓
• Provincial radio phone-in program broadcasted		✓	✓	✓
• IPC materials produced and distributed to provinces	✓	✓	✓	✓
• Articles/features placed in newspaper and magazines		✓	✓	✓
• Annual progress report for the component		✓		✓
• Phase completion report submitted by PMU to ADB				✓
<b>Component 3 – Community based HIV/AIDS prevention</b>				
• VCT established (new provinces only)		✓	✓	✓
• PE/LS programs established (new provinces only)		✓		
• IPC materials and equipment distributed		✓	✓	
• Training programs established and community workers trained (for new provinces only)			✓	✓
• Annual progress report for the component		✓		✓
• Phase completion report submitted by PMU to ADB				✓
<b>Component 4 – Project management and M&amp;E</b>				
• PMU/PPMU in placed (new provinces only)	✓			
• PPMU plans prepared and approved (new provinces only)	✓		✓	
• Provincial M&E unit set up and trained annually	✓			
• Baseline study conducted and reported		✓		
• Financial audit reported		✓		✓
• Annual progress report for the component		✓		✓
• Phase completion report submitted by PMU to ADB				✓

### iii. Summary of Key Indicators

Eight key indicators have been selected to measure the potential success and achievements of the Project. Construction of the indicators is guided by the Project's goal and objectives as well as the Government's own objectives and strategies. Currently the Vietnamese Administration on HIV/AIDS Control with assistance from the World Bank is developing a set of key performance indicators for the National Strategy on HIV/AIDS Prevention and Control. This task is expected to be completed in 2006. The Project M&E Adviser in the first quarter of the project will therefore need to review and revise this list of key indicators for the Project in order to align them with the national indicators, and thereby support the use of one set of national monitoring and evaluation indicators.

#### A Summary of Key Indicators

Indicator	Definition	Source	Notes
1. HIV prevalence among young people aged 15–24	<ul style="list-style-type: none"> <li>The proportion of young people aged 15–24 who test positive for HIV in a general population survey</li> </ul>	<ul style="list-style-type: none"> <li>Nationally representative general population survey</li> </ul>	<ul style="list-style-type: none"> <li>Examples are such surveys as SAVY, BSS, NHS, etc conducted by GSO/MoH</li> </ul>
2. HIV prevalence in sub-populations of young people with high-risk behavior	<ul style="list-style-type: none"> <li>The proportion of young people aged 15–24 defined as sub-populations at high risk who test HIV-positive</li> </ul>	<ul style="list-style-type: none"> <li>HIV sentinel surveillance survey among groups with high-risk behavior</li> <li>Baseline and final evaluation years</li> </ul>	<ul style="list-style-type: none"> <li>It requires a sufficient large sample to provide reliable estimates for young people, although it would be difficult to estimate the extent to which it describe prevalence among all members of the groups</li> </ul>
3. HIV testing behavior among young people	<ul style="list-style-type: none"> <li>The proportion of young people aged 15–24 who had an HIV test by VCT services in the last 12 months and know the results</li> </ul>	<ul style="list-style-type: none"> <li>Baseline, mid-term and final evaluation surveys</li> <li>VCT service-based survey</li> </ul>	<ul style="list-style-type: none"> <li>This indicator is very important as it gauges the effects of VCT services on youth behavior</li> </ul>
4. Condom use at most recent high risk sex among youth	<ul style="list-style-type: none"> <li>The percent of young people aged 15–24 who say they used a condom the last time they had sex with a non-marital, non-cohabiting partners, of those who had sex with such a partner in the last 12 months</li> </ul>	<ul style="list-style-type: none"> <li>Baseline, mid-term and final evaluation surveys</li> <li>SAVY II</li> </ul>	<ul style="list-style-type: none"> <li>The accuracy of this indicator depends on the reported incidence of safe sex among respondents</li> </ul>
5. Safe practices among young injecting drug users	<ul style="list-style-type: none"> <li>The percent of IDUs who report not having shared needles and at any time in the last month and who also report that a condom was used the last time they had sex.</li> </ul>	<ul style="list-style-type: none"> <li>HIV sentinel surveillance survey or</li> <li>special survey among drug injectors</li> </ul>	<ul style="list-style-type: none"> <li>This requires a sufficient large sample to provide reliable estimates for young people</li> </ul>
6. Mass media products and messages on HIV prevention diversified and reached youth and all segments of the society	<ul style="list-style-type: none"> <li>The percent of young people aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV/AIDS and reject major misconceptions about HIV transmission.</li> </ul>	<ul style="list-style-type: none"> <li>Baseline, mid-term and final evaluation surveys</li> <li>SAVY II</li> </ul>	<ul style="list-style-type: none"> <li>A measure of the overall impact on HIV prevention knowledge of mass media and IPC materials to reach target groups</li> </ul>
7. Community support for de-stigmatization and care efforts for PLWHA	<ul style="list-style-type: none"> <li>The percent of respondents expressing accepting attitudes towards PLWHA</li> </ul>	<ul style="list-style-type: none"> <li>Baseline, mid-term and final evaluation surveys</li> <li>SAVY II</li> </ul>	<ul style="list-style-type: none"> <li>This indicator is important as it measures the de-stigma and harm reduction which is a crucial condition for HIV/AIDS prevention</li> </ul>

## A Summary of Key Indicators

Indicator	Definition	Source	Notes
			among youth
8. Leadership commitment for HIV/AIDS prevention among youth	<ul style="list-style-type: none"> <li>The percent of districts that have the National Strategy on HIV endorsed in the resolutions of the People's Council and youth friendly services/activities included in local socio-economic development plans</li> </ul>	<ul style="list-style-type: none"> <li>Government documents</li> <li>Project reports</li> </ul>	<ul style="list-style-type: none"> <li>A reflection of political and policy commitment to HIV/AIDS prevention among youth.</li> </ul>

Computation of key indicators should be carried out at the beginning of the Project, at mid-term and following completion of the project. The Project will determine current levels of the indicators and objectives after the baseline survey and formative research in the first year of the Project. The age range 15-24 years will be used as this is the international standard to define youth. The first SAVY survey used 14-25 years in the survey sample and if this age range continues to be used in SAVY II the calculation for the indicators will be confined to 15-24 years. These key indicators, especially behavior-related indicators, should be sex-disaggregated in calculations. It is also necessary to ensure that young people, especially those who are most vulnerable are reached and covered by data collection.

### 1. HIV prevalence among young people aged 15–24

**Definition:** The proportion of young people who test positive for HIV in a general population survey.

**Target population:** Young people aged 15–24 years.

**Numerator:** The number of young people who test positive for HIV infection.

**Denominator:** The number of young people tested.

**Requirement:** This indicator should be reported as percentages for males and females and the age groups 15–19, 20–24 and 15–24 years because this information allows the targeting of interventions and policies. The un-weighted sample sizes and non-response rates should be given for each category. The best measure of the long-term impact of all HIV prevention activities is the HIV incidence. However, general population-based surveys are likely to underestimate prevalence levels, in countries with relatively low levels of adult HIV prevalence (between 1 and 3%). Indeed, people at higher risk of HIV are more likely to be missed by general population-based surveys, either because they are typically excluded from the sample, or because they live outside of households for reasons related to their risk behaviors (sex workers, IDU), or because of their mobility (e.g. truckers, fishermen, other mobile groups). In addition, where prevalence is low unless, an unusually large sample size is used.

### 2. HIV prevalence in sub-populations of young people with high-risk behavior

**Definition:** The proportion of young members of defined subpopulations at high risk of contracting or transmitting HIV infection who test HIV-positive.

**Target population:** Young people with high-risk behaviors aged 15–24 years.

**Numerator:** The number of young people participating in high-risk behaviors who test positive for HIV infection.

**Denominator:** The number of young people tested for HIV infection.

**Requirement:** This indicator should be reported as percentages for males and females and the age groups 15–19, 20–24 and 15–24 years. Any data available on younger people aged 10–14 years can also be given. If available, the median duration of the high–risk behavior should be reported for each age group. Trends in prevalence can indicate whether interventions are having an impact or whether some other factors are driving prevalence up or down. The sampling and estimation of total population sizes are key issues and should be given for each category. It may be appropriate to give estimates disaggregated by the duration of the high–risk behaviors. The groups of interest generally include one or more of the following: IDUs, MSM, sex workers and frequent clients of sex workers. In surveys conducted among these groups, sampling should not be restricted to young people. Instead, this indicator should be based on data from a subset of respondents. It is important that surveys among these groups cover a sufficiently large sample to provide reliable estimates for young people. This indicator should be therefore considered in conjunction with the behavioral indicators that refer to the membership and activity of groups with high–risk behaviors, because changes in recruitment to or exit from the groups may be responsible for changes in observed prevalence.

### **3. HIV testing behavior among young people aged 15–24**

**Definition:** The proportion of sexually active young people who had an HIV test by VCT services in the last 12 months and know the results.

**Target population:** Young people aged 15–24 years.

**Numerator:** The number of young people 15–24 who have had an HIV test by VCT services in the last 12 months and know the results.

**Denominator:** The number of young people tested for HIV infection.

**Requirement:** This indicator should be reported as percentages for males and females and the age groups 15–19, 20–24 and 15–24 years. It can provide a measure of the effectiveness of interventions that promote voluntary counseling and testing (VCT). This indicator aims to give an idea of the reach of HIV testing services in the general population and of the percentage of sexually active young people who are aware of their HIV status. This topic has special significance for young people because they may feel that there are barriers to accessing and using many services and facilities, particularly for sensitive concerns relating to sexual health.

This indicator has several components: (i) young people who have a test and return for the results; (ii) must consider themselves or their partners to be at risk of having contracted HIV; (iii) must know where to get a test and feel able to have it; and, (iv) after the test, must want to know the results and be able to return to the testing centre to get them.

### **4. Condom use at most recent high risk sex among youth**

**Definition:** The percent of young people aged 15–24 who say used a condom the last time they had sex with a non–marital, non–cohabiting partners, of those who had sex with such a partner in the last 12 months

**Target population:** Persons aged 15–24 years.

**Numerator:** The number of respondents aged 15–24 years who had sex with a non–cohabiting, non–marital partner in the preceding 12 months and used a condom the last time they had sex with such a partner.

**Denominator:** The number of respondents aged 15–24 years who had sex with a non-cohabiting partner in the preceding 12 months.

**Requirement:** This indicator should be presented as separate percentages for males and females in the age groups 15–19, 20–24 and 15–24 years. It shows the extent to which condoms are used by young people who engage in non-regular sexual relationships. The respondents are first asked if they have ever had sex. Among those who have, questions are asked about their last three partners. Information on the type of partner (e.g. spouse, live-in partner, boyfriend/girlfriend, acquaintance or commercial sex worker) is used to determine whether they had higher-risk sex last time (sex with anyone other than a spouse or live-in partner) and thus are counted in the denominator. Respondents are also asked about condom use with their last three partners in the preceding 12 months. If they had higher-risk sex, and used a condom with the last higher-risk partner they are included in the numerator.

## 5. Safe practices among young injecting drug users

**Definition:** The percent of IDUs who report not having shared needles, syringes or other injecting equipment at any time in the last month and who also report that a condom was used the last time they had sex.

**Target population:** Sexually active IDUs aged 15–24 years.

**Numerator:** The number of respondents who report not having shared injecting equipment during the preceding month and who also report that a condom was used the last time they had sex during this month.

**Denominator:** The number of respondents who report injecting drugs and having sexual intercourse during the preceding month.

**Requirement:** This indicator should be reported as separate percentages for men and women and for the age groups 15–19, 20–24 and 15–24 years. The results should be compared with those for other high risk age groups. In a behavioral survey among IDUs the respondents are asked whether they shared a needle at any time in the preceding month. They are then asked whether they had sex in the preceding month, and, if so, whether a condom was used. It is essential to make sure that locally appropriate terminology is used in order to collect the correct information. The time limit of one month is used because it minimizes recall bias, which may be a particular problem for IDUs. This time limit also means that the indicator gives some perspective on the consistency of the behaviors.

## 6. Knowledge on HIV/AIDS prevention

**Definition:** Percent of young people aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.

**Target population:** Persons aged 15–24 years.

**Numerator:** Number of respondents (aged 15–24 years) who gave the correct answers to all five questions.

**Denominator:** Number of respondents (15–24) who gave answers (including “don’t know”) to all five below questions.

**Requirement:** This indicator is constructed from responses to the following set of prompted questions. Scores for each of the individual questions (based on the same denominator) are required in addition to the score for the composite indicator.

- i) Can the risk of HIV transmission be reduced by having sex with only one faithful, uninfected partner?
- ii) Can the risk of HIV transmission be reduced by using condoms?
- iii) Can a healthy-looking person have HIV? (example, local misconceptions should be questioned here)
- iv) Can a person get HIV from mosquito bites? (example, local misconceptions should be questioned here)
- v) Can a person get HIV by sharing a meal with someone who is infected? (example, local misconceptions should be questioned here)

The indicator should be reported separately for men and women. Those who have never heard of HIV/AIDS should be excluded from the numerator but included in the denominator. Indicator scores are required for all respondents aged 15–24 years and for males and females, separately, each according to urban/rural residence. Even in such as setting where knowledge about HIV/AIDS is high, the indicator can be used to ensure that pre-existing high levels of knowledge are maintained.

## **7. Community support on de-stigmatization and care efforts for HIV/AIDS prevention**

**Definition:** The percent of respondents expressing accepting attitudes towards people with HIV

**Target population:** General population

**Nominator:** The number of respondents who report an accepting or supportive attitude on all four component questions: 1) would be willing to care for a family member who became sick with the AIDS virus; 2) would buy fresh vegetables from a vendor whom they knew was HIV+; 3) female teacher who is HIV+ but not sick should be allowed to continue teaching in school; 4) would not want to keep the HIV+ status of a family member a secret

**Denominator:** Total number of respondents who have heard of HIV/AIDS

**Requirement:** Respondents in a general population survey are asked a series of questions about people with HIV, as follows:

- i) If a member of your family became sick with the AIDS virus, would you be willing to care for him or her in your household?
- ii) If you knew that a shopkeeper or food seller had the AIDS virus, would you buy fresh vegetables from them?
- iii) If a female teacher has the AIDS virus but is not sick, should she be allowed to continue teaching in school?
- iv) If a member of your family became infected with the AIDS virus, would you want it to remain a secret?

Only a respondent who reports an accepting or supportive attitude on all four of these questions enters the numerator. The denominator is all people surveyed who have heard of HIV/AIDS. This is a relatively easy way to construct an indicator of attitudes to people with HIV. A low score on the indicator is a fairly sound indication of high levels of stigma, and for that reason alone it may constitute the first step in project success. This indicator can be used to measure differences in discrimination or stigma by gender. Women are more likely than men to be treated and viewed harshly if they have HIV/AIDS

## 8. Leadership support for HIV/AIDS prevention among youth

**Definition:** The percent of districts that have the National Strategy on HIV endorsed in the resolutions of the People's Council and youth friendly services/activities included in local socio-economic development plans

**Target population:** Government office and policy

**Nominator:** The number of districts that have the National Strategy on HIV/AIDS prevention and control endorsed in the resolutions of the People's Council and youth friendly services/activities included in local socio-economic development plans.

**Denominator:** Total number of districts covered under the project

**Requirement:** This indicator reflects political and policy commitment to HIV/AIDS prevention and control among youth. It is also indicative of the local government's willingness to back up and implement the national policy on HIV/AIDS that respond to the epidemic (*vis-à-vis* other priorities such as economic growth, education, health care, defense or infrastructure development. More political commitment in the People's Council resolutions to dealing with HIV leads inevitably to a stronger response and funds allocated to addressing the epidemic in several ways. A stronger commitment also means there will be more activity to monitor and evaluate. Recording changes in political commitment may act as a reality check for other M&E efforts—if commitment is low and showing no signs of rising, it may be too optimistic to expect a massive impact.

### References:

Macro International/Measure DHS. 2005. HIV/AIDS Survey Indicator Database. ([http://www.measuredhs.com/hivdata/about\\_db.cfm](http://www.measuredhs.com/hivdata/about_db.cfm))

PEPFAR (The President's Emergency Plan for AIDS Relief). 2004. PEPFAR Indicators. Reporting Requirements, and Guidelines: Revised based on FY2005 Country Operation Plans. Washington

WHO/UNAIDS. 2004. Guide to Monitoring and Evaluating National HIV/AIDS Programmes for Young People. Geneva: WHO.

#### iv. Project Logframe

##### Overall Objective (Goal)

The Project goal is to achieve Millennium Development Goal 6 (Target 7) to have halted and begun to reverse the spread of HIV/AIDS by 2010.

##### Specific Objective (Purpose)

The Project purpose is to reduce HIV–infection risk among youth aged 15–24 through BCC programs.

##### Component 1 — Advocacy

Objectives/Outputs	Indicators	Means of Verification	Assumptions
1.1 Researches on youth issues conducted and disseminated	<ul style="list-style-type: none"> <li>• 2nd SAVY study received funding</li> <li>• 2 research studies completed</li> <li>• One national dissemination workshop organized in the end of Year 1</li> </ul>	<ul style="list-style-type: none"> <li>• Study reports</li> <li>• Workshop report</li> </ul>	Government officials support the conducting of a 2nd SAVY study
1.2 Advocacy materials developed and distributed through appropriate channels	<ul style="list-style-type: none"> <li>• 500 Youth Information Packages distributed</li> <li>• 120 articles on youth related issues published in the Party magazines, newspapers and on their websites</li> </ul>	<ul style="list-style-type: none"> <li>• Project reports</li> </ul>	<ul style="list-style-type: none"> <li>• Government agreeable to content of the information packs</li> <li>• Publishers of Party Newspaper agreeable to publish articles on youth related issues.</li> </ul>
1.3 Youth participation mechanism established and implemented through existing networks	<ul style="list-style-type: none"> <li>• 1 policy maker forum per year held in each province</li> <li>• 2 radio/TV talk shows held in each province in each year</li> <li>• Two community leaders/youth meetings held each year in each province</li> <li>• 10 young people annually attend regional or national level conferences.</li> <li>• In five year a total of 10 young people attend international conferences on youth</li> </ul>	<ul style="list-style-type: none"> <li>• Minutes of meetings,</li> <li>• Project reports</li> <li>• Conference reports</li> </ul>	<ul style="list-style-type: none"> <li>• Government officials allow youth to participate in and contribute in meeting and in conferences</li> </ul>
1.4 Youth and HIV issues mainstreamed into existing and planned policies and programs by GoV and large donors.	<ul style="list-style-type: none"> <li>• 2 awareness–raising workshops conducted per province in the Year 1 and 3.</li> <li>• 1 workshop per year per province held with project implementing partners</li> <li>• 1 workshop per province per year held with service provid-</li> </ul>	<ul style="list-style-type: none"> <li>• Workshop reports</li> </ul>	<ul style="list-style-type: none"> <li>• Government and IO support the inclusion of a Youth Adviser to support an increased emphasis on youth</li> </ul>

## Component 1 — Advocacy

Objectives/Outputs	Indicators	Means of Verification	Assumptions
	ers at the provincial/district/communes levels		

## Component 2 — Mass Media and IPC Materials

Sub-Component 1 — Mass Media			
Objectives/Outputs	Indicators	Means of Verification	Assumptions
<b>Formative Research</b> 2.1.1 To collect data necessary for the design of mass media and IPC materials	<ul style="list-style-type: none"> <li>Dissemination workshop</li> <li>Formative research report</li> </ul>	<ul style="list-style-type: none"> <li>Dissemination workshop report</li> <li>Research report</li> </ul>	<ul style="list-style-type: none"> <li>Can access high risk groups for research, interventions and evaluations</li> </ul>
<b>Electronic Mass Media</b> 2.1.2 To develop a variety of electronic mass media initiatives in support of the national response to HIV/AIDS	<ul style="list-style-type: none"> <li>Thirty episodes per year of original 30 min television drama produced — national level</li> <li>Weekly, 60 min radio phone-in shows — provincial level</li> <li>Two 30 min television documentaries produced each year — national level</li> <li>Twenty-five television spots and 50 radio spots produced each year — national level</li> <li>Provincial level broadcasters training conducted in each Project province</li> </ul>	<ul style="list-style-type: none"> <li>Video and audio tapes of programming</li> <li>Audience panel feedback</li> <li>Monitoring reports of television and radio broadcasts</li> </ul>	<ul style="list-style-type: none"> <li>Government agreeable to sole-source contracting to implement Component 2</li> <li>Government agreeable to editorial content and creative approach</li> <li>National and provincial level television/radio producers and broadcasters able to meet quality standards</li> </ul>
<b>Print Mass Media</b> 2.1.3 To develop a variety of print mass media initiatives in support of the national response to HIV/AIDS	<ul style="list-style-type: none"> <li>Bi-weekly column published in youth focused newspaper and magazine</li> <li>Monthly feature article published in youth focused newspapers and magazines</li> </ul>	<ul style="list-style-type: none"> <li>Copies of published materials</li> <li>Monitoring reports of published materials</li> <li>Audience panel feedback</li> </ul>	<ul style="list-style-type: none"> <li>Government agreeable to editorial content and creative approach</li> <li>National and provincial level journalists and publications able to meet quality standards</li> </ul>
<b>Internet and Phone Hot-Line</b> 2.1.4 To design, post and maintain an interactive web site — linked to television drama and radio phone-	<ul style="list-style-type: none"> <li>Interactive web site posted by end of first year of Project</li> <li>Web site updated on a monthly basis</li> </ul>	<ul style="list-style-type: none"> <li>Monthly monitoring reports</li> <li>Monthly site statistics</li> <li>Audience panel feed-</li> </ul>	<ul style="list-style-type: none"> <li>Government agreeable to editorial content and creative approach</li> <li>Web site designers able to meet quality standards</li> </ul>

## Component 2 — Mass Media and IPC Materials

in content — national level		back/on-line surveys	
2.1.5 To link Project messages and information to existing phone hot-lines 2.1.6 To promote use of phone hot-lines	<ul style="list-style-type: none"> <li>Existing phone hot-lines includes information presented through TV drama and reinforced in IPC activities</li> </ul>	<ul style="list-style-type: none"> <li>Phone hot-line monthly monitoring reports</li> <li>Audience panel feedback</li> </ul>	<ul style="list-style-type: none"> <li>Government agreeable to editorial content</li> <li>Management of existing phone hot-lines agree to cooperate with Project</li> </ul>
<p><b>Capacity building</b></p> <p>2.1.7 To train broadcast and print journalists in creative and ethical reporting on HIV/AIDS and Reproductive Health (RH) issues affecting youth</p> <p>2.1.8 To orient staff of existing phone hot-lines to issues and information presented in TV drama/radio phone-in programs</p>	<ul style="list-style-type: none"> <li>One training held per year in each participating province</li> <li>One orientation held per year with management and staff of existing phone hot-lines</li> </ul>	<ul style="list-style-type: none"> <li>Training reports</li> <li>Training outputs</li> </ul>	<ul style="list-style-type: none"> <li>Government journalists agreeable to alternative and new approaches in reporting on HIV/AIDS and RH issues targeting youth</li> </ul>
<b>Sub-Component 2 — IPC Materials</b>			
<b>Objectives/Outputs</b>	<b>Indicators</b>	<b>Means of Verification</b>	<b>Assumptions</b>
<p><b>Formative Research</b></p> <p>2.2.1 Formative research</p>	<ul style="list-style-type: none"> <li>Dissemination workshop</li> <li>Formative research report</li> </ul>	<ul style="list-style-type: none"> <li>Dissemination workshop report</li> <li>Research report</li> </ul>	<ul style="list-style-type: none"> <li>Can access high risk groups for research, interventions and evaluations</li> </ul>
<p><b>Production of IPC Materials</b></p> <p>2.2.2 To produce a broad range of high-quality IPC materials for use in IPC activities under Component 3 and Component 1 advocacy activities</p>	<ul style="list-style-type: none"> <li>Production of required materials on a quarterly basis — national level design and provincial level production/printing (if feasible)</li> </ul>	<ul style="list-style-type: none"> <li>Final materials</li> <li>Authenticated distribution lists</li> <li>Observation of material use</li> </ul>	<ul style="list-style-type: none"> <li>Government agreeable to editorial content and creative approach</li> <li>Graphic designers and content developers able to meet quality standards</li> </ul>
<p><b>Capacity Building</b></p> <p>2.2.3 To train users of IPC materials (i.e., peer educa-</p>	<ul style="list-style-type: none"> <li>One training held per year in each participating province</li> </ul>	<ul style="list-style-type: none"> <li>Training report</li> <li>Training outputs</li> </ul>	<ul style="list-style-type: none"> <li>Peer educators and collaborators available for</li> </ul>

## Component 2 — Mass Media and IPC Materials

tors, collaborators) on the proper use of materials			training
<b>Sub-Component 3 — IPC Clearinghouse</b>			
<b>Objectives/Outputs</b>	<b>Indicators</b>	<b>Means of Verification</b>	<b>Assumptions</b>
<b>Site Identification</b> 2.3.1 To identify and renovate site for use as clearinghouse	<ul style="list-style-type: none"> <li>• Site made available for use as clearinghouse</li> <li>• Formative research report</li> </ul>	<ul style="list-style-type: none"> <li>• Renovated room</li> </ul>	<ul style="list-style-type: none"> <li>• EA has space available</li> </ul>
<b>Capacity Building</b> 2.3.2 To train EA staff in the management of IPC Clearinghouse	<ul style="list-style-type: none"> <li>• Training held for selected staff upon completion of site renovation.</li> </ul>	<ul style="list-style-type: none"> <li>• Training report</li> <li>• Training outputs</li> </ul>	<ul style="list-style-type: none"> <li>• EA agreeable to assigning staff responsibility for management of clearinghouse</li> </ul>

## Component 3 — Community Based HIV Prevention

<b>Sub-Component 1 — To implement HIV/AIDS prevention programs for vulnerable youth (street youth, service industry employees, industrial zone workers and trainees in Vocational Training &amp; Job Recruitment Centers</b>			
<b>Objectives/Outputs</b>	<b>Verifiable Indicators</b>	<b>Means of Verification</b>	<b>Assumptions</b>
3.1.1 Formative research conducted to assess current KAP and appropriate life skills training needs on HIV prevention	<ul style="list-style-type: none"> <li>• Three studies completed as planned</li> <li>• Study tools and reports</li> <li>• Results used for IPC material development and project planning</li> </ul>	<ul style="list-style-type: none"> <li>• Qualitative and quantitative studies</li> </ul>	<ul style="list-style-type: none"> <li>• Target groups willing to participate in research</li> <li>• Independent researchers with relevant skills and expertise available</li> </ul>
3.1.2 Community based VCT services established	<ul style="list-style-type: none"> <li>• Number of HIV-infected individuals receiving specialized VCT services from project-funded centers in the past twelve months (to be stratified by age groups)</li> <li>• Condoms, needles/syringes, VCT and STI treatment available and distributed as needed, and are actually used</li> <li>• Increase 10% in the percentage of people accepting attitudes towards PLHWA</li> <li>• Increase in the condom use among PLWHA living in the community</li> <li>• Reduction in using injection drugs / sharing needles among frequent clients/visitors</li> </ul>	<ul style="list-style-type: none"> <li>• Project report</li> <li>• Special assessment among PLWHA and center clients/visitors</li> </ul>	<ul style="list-style-type: none"> <li>• Authorities permit to set up VCTCs run by capable and relevant NGOs</li> <li>• Vulnerable groups can access to the VCTCs. Anonymity must be warranted</li> <li>• Condoms, quick-test and STI treatment available and distributed as needed, and are actually used</li> </ul>

### Component 3 — Community Based HIV Prevention

<p>3.1.3 HIV prevention education, harm reduction trained for IDUs in project provinces</p>	<ul style="list-style-type: none"> <li>• Number of HIV/AIDS training courses with associated IPC materials developed, tested and available for IDUs in the community</li> <li>• Increase in the percentage IDUs who can correctly identify ways of preventing HIV transmission</li> <li>• Increase in the proportion of IDUs who report confidence in responding assertively to potentially harmful situations</li> </ul>	<ul style="list-style-type: none"> <li>• Project report</li> <li>• Special assessment among IDUs</li> </ul>	<ul style="list-style-type: none"> <li>• Authorities permit IDU and harm reduction interventions</li> <li>• Equipment reach target groups as planned and being used as intended</li> </ul>
<p>3.1.4 HIV prevention education, Life Skills training, trained for Street Youth through peer education &amp; “sympathy houses and classes” in project provinces</p>	<ul style="list-style-type: none"> <li>• Number of HIV/AIDS training courses with associated IPC materials developed, tested and available for Street Youth living in “sympathy houses and classes”</li> <li>• Increase in the percentage of the above street youth who can correctly identify ways of preventing HIV transmission and reject major misconceptions</li> <li>• Increase in the proportion of street youth who report confidence in responding assertively to potentially harmful situations</li> </ul>	<ul style="list-style-type: none"> <li>• Project report</li> <li>• Special assessment among street youth in “sympathy houses and classes” in selected provinces</li> </ul>	<ul style="list-style-type: none"> <li>• Authorities, employers, managers permit all interventions</li> <li>• Children/youth willing to become peer educators</li> <li>• Supplies and equipment reach target groups as planned and being used as intended</li> </ul>
<p>3.1.5 HIV prevention education, harm reduction training for service industry employees in project provinces</p>	<ul style="list-style-type: none"> <li>• At least 80% of the workplaces visited by peer educators</li> <li>• Increase in the proportion of service employees who can correctly identify ways of preventing HIV transmission and reject major misconceptions</li> <li>• Increase in the percentage of service employees who report able to refuse undesired sex and/or drug use</li> <li>• Reduction in the proportion of young males and females with non-regular partners</li> <li>• Increase in the proportion of young males who report having sex with sex workers and/or casual partners and using condoms</li> <li>• Increase in the proportion of employees who report confidence in responding assertively to potentially harmful situations</li> </ul>	<ul style="list-style-type: none"> <li>• Project report</li> <li>• Special assessment among service employees in selected provinces</li> </ul>	<ul style="list-style-type: none"> <li>• Authorities, employers, managers permit all interventions</li> <li>• Time available for activities in workplace</li> <li>• Supplies and equipment reach target groups as planned and being used as intended</li> </ul>
<p>3.1.6 HIV prevention education and harm reduction trained for industrial zone employees in project provinces</p>	<ul style="list-style-type: none"> <li>• At least 60% of the workplaces visited by peer educators</li> <li>• Increase in the proportion of industrial zone workers who can correctly identify ways of preventing HIV transmission and reject major misconceptions</li> <li>• Increase in the percentage of industrial zone workers who</li> </ul>	<ul style="list-style-type: none"> <li>• Project report</li> <li>• Special assessment among industrial zone workers in selected provinces</li> </ul>	<ul style="list-style-type: none"> <li>• Authorities, and managers permit all interventions</li> <li>• Time available to consolidate skills</li> </ul>

### Component 3 — Community Based HIV Prevention

	<ul style="list-style-type: none"> <li>report able to refuse undesired sex and/or drug use</li> <li>Reduction in the proportion of young male and female workers with non-regular partners</li> <li>Increase in the proportion of young males who report using condoms when having sex with sex workers and/or casual partners and using condoms</li> <li>Increase in the proportion of workers who report confidence in responding assertively to potentially harmful situations</li> </ul>		<ul style="list-style-type: none"> <li>Supplies and equipment reach target groups as planned and being used as intended</li> </ul>
3.1.7 HIV prevention education, Life Skills training, and harm reduction trained for trainees in vocational and job recruitment centers in project provinces	<ul style="list-style-type: none"> <li>At least 80% of trainees can correctly identify ways of preventing HIV transmission and reject major misconceptions</li> <li>Increase in the proportion of trainees who can correctly identify ways of preventing HIV transmission and reject major misconceptions</li> <li>Reduction in the proportion of male and female trainees with non-regular partners</li> <li>Increase in the proportion of male trainees who report using condoms when having sex with sex workers and/or casual partners</li> <li>Increase in the proportion of trainees who report confidence in responding assertively to potentially harmful situations</li> <li>Reduction in the percent of trainees who would refuse casual contact with a PLWHA.</li> </ul>	<ul style="list-style-type: none"> <li>Project report</li> <li>Special assessment among trainees in selected vocational and job-recruitment centers</li> </ul>	
<b>Sub-component 2 — To implement HIV/AIDS prevention programs for youth in schools</b>			
<b>Objectives / Outputs</b>	<b>Verifiable Indicators</b>	<b>Means of Verification</b>	<b>Assumptions</b>
3.2.1 Support HIV education and stigma reduction trained for teachers in Lower and Upper secondary schools and Teacher education colleges	<ul style="list-style-type: none"> <li>At least 80% of the above trained teachers use IPC materials and HIV teaching aid in their regular teaching session in class.</li> <li>90% pre-service and in-service teachers answering correct answers in knowledge test</li> <li>Increase in the percentage of pre-service and in-service teachers who are in favor of young people being educated about the use of condoms and clean needles in order to prevent HIV/AIDS</li> <li>Increase in the percentage of pre-service and in-service</li> </ul>	<ul style="list-style-type: none"> <li>Project report</li> <li>Special assessment among teachers in secondary schools and education colleges in selected provinces</li> </ul>	<ul style="list-style-type: none"> <li>Time available to train teachers</li> <li>Interest from teachers</li> <li>Teachers use IPC materials supplied</li> <li>Education about stigma leads to change in attitudes and behavior</li> <li>Teachers share project views on definitions and</li> </ul>

### Component 3 — Community Based HIV Prevention

	<p>teachers who report confidence and willingness to teach about HIV/AIDS</p> <ul style="list-style-type: none"> <li>• Increase in the condom use among pre-service and in-service teachers</li> <li>• Reduction in the percent of pre-service and in-service teachers expressing willing to discriminate against person living with HIV/AIDS.</li> </ul>		harmfulness of stigma and discrimination
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#### Sub-component 3 — To implement HIV/AIDS prevention programs for parents and community collaborators

Objectives / Outputs	Verifiable Indicators	Means of Verification	Assumptions
3.3.1 NGOs specializing in parental skills, social welfare, family and advocacy selected	<ul style="list-style-type: none"> <li>• At least 80% of the trained collaborators organizing parenting skills education and regular individual families with vulnerable children visited</li> <li>• At least 30% parents report conversations across generations about gender norms and sexuality</li> </ul>	<ul style="list-style-type: none"> <li>• Project report</li> <li>• KAP specially designed surveys among parents and youth</li> <li>• Baseline, mid-term, and final surveys</li> </ul>	<ul style="list-style-type: none"> <li>• Reported behavior is valid and reliable indicator of actual behavior</li> <li>• Parenting skills and collaborators skills training classes are taught well and able to consolidate skills in given timeframe</li> </ul>
3.3.2 Parenting skills, social welfare skills and advocacy provided for parents/ collaborators at district and commune levels in project provinces	<ul style="list-style-type: none"> <li>• At least 20% of youth reporting they have sought advice from a trusted adult</li> <li>• At least 80% parents and 50% youth report increased openness of communication across generations</li> <li>• Reduction in the percent of parents who report difficulties in disciplining children (aged 15–24)</li> <li>• Increase in the percent of parents who report increased success in disciplining their children without violence</li> <li>• Reduction in the percentage of youth stating it is morally more important for a woman to be a virgin at marriage than for a man</li> <li>• Reduction in the percentage of youth stating that a man should be sexually experienced prior to marriage</li> <li>• Increase in the percentage of adults who support education on condom use/needle-cleaning</li> </ul>		<ul style="list-style-type: none"> <li>• Trainers share Project understanding about harmfulness of some gender social norms</li> </ul>

### Component 4 — Project Management

Objectives/Outputs	Indicators	Means of Verification	Assumptions
4.1. Project management and financial systems func-	<ul style="list-style-type: none"> <li>• Annual Action Plan are produced</li> <li>• Milestones of annual work plans are met in a timely man-</li> </ul>	<ul style="list-style-type: none"> <li>• Annual action Plan from each province.</li> </ul>	

<b>Component 4 — Project Management</b>			
<b>Objectives/Outputs</b>	<b>Indicators</b>	<b>Means of Verification</b>	<b>Assumptions</b>
tioning at national and provincial levels	<ul style="list-style-type: none"> <li>• Satisfactory external Audit reports</li> </ul>	<ul style="list-style-type: none"> <li>• Milestone reports</li> <li>• Phased Completion report from PMU to ADB</li> <li>• Auditor reports</li> </ul>	
4.2. Consulting services contracted and managed	<ul style="list-style-type: none"> <li>• Qualified professionals hired to the two adviser position in the first three months of the project</li> <li>• Contract signed with a professional Mass Media agency in the first month of the Project</li> <li>• Contracts signed with agencies to implement sub-groups of activities by the end of the 3rd quarter of 1st year for Phase One activities</li> <li>• Financial and reporting systems between PMU and agencies functioning.</li> </ul>	<ul style="list-style-type: none"> <li>• Staff contracts</li> <li>• Contracts with agencies</li> <li>• Six month progress reports from agencies to PMU/PPMUs</li> <li>• Audit reports</li> </ul>	
4.3. Baseline and formative research surveys and mid-term and final evaluations conducted	<ul style="list-style-type: none"> <li>• Baseline survey conducted in 1st year</li> <li>• Conduct formative research surveys for each component</li> <li>• Set of targets for project performance agreed using results of baseline survey and formative research by end of 1st year</li> <li>• Mid term review conducted by 4th quarter of 3rd year and results used to prepare Action Plan for Phase 3</li> <li>• Final evaluation conducted in the last quarter of 5th year</li> </ul>	<ul style="list-style-type: none"> <li>• Baseline survey report</li> <li>• Formative research reports</li> <li>• Mid term report</li> <li>• Final evaluation report</li> </ul>	
4.4. Effective M&E systems developed and implemented	<ul style="list-style-type: none"> <li>• M&amp;E adviser develop monitoring tools and indicators for project monitoring</li> <li>• PPM and PPMU staff providing quarterly project progress reports using monitoring tools /indicators developed by the M&amp;E adviser</li> </ul>	<ul style="list-style-type: none"> <li>• M&amp;E framework</li> <li>• Quarterly Progress reports from PPMU</li> <li>• Reports from site visits</li> </ul>	
4.5. Procurement of equipment and supplies	<ul style="list-style-type: none"> <li>• All equipment and supplies purchased and delivered in a timely manner</li> </ul>	<ul style="list-style-type: none"> <li>• Purchase orders</li> <li>• Delivery notices</li> </ul>	

## b. Project Budget Tables

**Table 1A. Project Budget: Component by Year**

National/Provincial	Base cost (US\$)					
	Y1	Y2	Y3	Y4	Y5	Total
National Budget	1,673,947	3,120,970	3,399,085	3,049,216	2,163,897	13,407,115
Provincial Budget	449,360	1,483,777	2,442,053	3,254,830	2,561,330	10,191,350
<b>Total</b>	<b>2,123,307</b>	<b>4,604,747</b>	<b>5,841,138</b>	<b>6,304,046</b>	<b>4,725,227</b>	<b>23,598,465</b>
Per cent national						56.81%
Per cent provincial						43.19%

**Table 1B: National and Provincial by Year**

National/Provincial	Budget incl. taxes and contingencies (US\$)					
	Y1	Y2	Y3	Y4	Y5	Total
National Budget	2,015,985	3,692,238	3,975,574	3,544,408	2,499,107	15,727,312
Provincial Budget	483,509	1,603,793	2,630,067	3,503,710	2,751,610	10,972,689
<b>Total</b>	<b>2,499,494</b>	<b>5,296,031</b>	<b>6,605,640</b>	<b>7,048,118</b>	<b>5,250,717</b>	<b>26,700,000</b>
Per cent national						58.90%
Per cent provincial						41.10%

**Table 2A: Component by Year**

Component	Base cost (US\$)					
	Y1	Y2	Y3	Y4	Y5	Total
Component 1 Advocacy	228,500	256,000	479,000	569,500	445,500	1,978,500
Component 2 Mass Media and IPC Materials	852,451	2,681,571	2,882,981	2,600,023	1,744,593	10,761,619
Component 3 Community-based HIV Prevention	133,100	1,167,167	1,758,933	2,227,700	1,544,620	6,831,520
Component 4 Project Management	909,256	500,009	720,224	906,823	990,514	4,026,826
<b>Total</b>	<b>2,123,307</b>	<b>4,604,747</b>	<b>5,841,138</b>	<b>6,304,046</b>	<b>4,725,227</b>	<b>23,598,465</b>

**Table 2B: Component by Year**

Component	Budget incl. taxes and contingencies (US\$)					Total
	Y1	Y2	Y3	Y4	Y5	
Component 1 Advocacy	256,210	285,360	519,915	626,020	483,855	2,171,360
Component 2 Mass Media and IPC Materials	1,022,571	3,190,906	3,403,361	3,041,395	2,028,150	12,686,383
Component 3 Community-based HIV Prevention	145,386	1,267,657	1,903,029	2,410,122	1,668,963	7,395,157
Component 4 Project Management	1,075,327	552,109	779,335	970,580	1,069,749	4,447,100
<b>Total</b>	<b>2,499,494</b>	<b>5,296,031</b>	<b>6,605,640</b>	<b>7,048,118</b>	<b>5,250,717</b>	<b>26,700,000</b>
Per cent of total budget	9.36%	19.84%	24.74%	26.40%	19.67%	100.00%

**Table 3A: Component by National and Provincial**

Component	Base cost (US\$)			
	National	Provincial	Total	% Budget
Component 1 Advocacy	906,000	1,072,500	1,978,500	8.38%
Component 2 Mass Media and IPC Materials	10,761,619		10,761,619	45.60%
Component 3 Community-based HIV Prevention	157,520	6,674,000	6,831,520	28.95%
Component 4 Project Management	1,581,976	2,444,850	4,026,826	17.06%
<b>Total</b>	<b>13,407,115</b>	<b>10,191,350</b>	<b>23,598,465</b>	<b>100.00%</b>

**Table 3B: Component by National and Provincial**

Component	Budget incl. taxes and contingencies (US\$)			
	National	Provincial	Total	% Budget
Component 1 Advocacy	1,015,510	1,155,850	2,171,360	8.13%
Component 2 Mass Media and IPC Materials	12,686,383		12,686,383	47.51%
Component 3 Community-based HIV Prevention	171,847	7,223,310	7,395,157	27.70%
Component 4 Project Management	1,853,572	2,593,529	4,447,100	16.66%
<b>Total</b>	<b>15,727,312</b>	<b>10,972,689</b>	<b>26,700,000</b>	<b>100.00%</b>
Per cent of total budget	58.90%	41.10%	100.00%	

**Table 4A: Cost Category by Year**

Cost category	Base cost (US\$)					
	Y1	Y2	Y3	Y4	Y5	Total
BCC and IPC activities and materials	367,000	2,259,100	3,137,100	3,505,700	2,639,600	11,908,500
Surveys and evaluations	131,500	55,000	131,500	40,000	51,500	409,500
Institutional Strengthening	240	7,140	12,900	12,000	0	32,280
Equipment and maintenance	127,456	201,000	216,000	211,000	0	755,456
Materials production and distribution	12,500	113,667	95,083	125,250	94,375	440,875
Consulting services	740,538	890,776	710,476	477,418	378,200	3,197,408
Training, workshops and study tours	125,595	482,100	631,095	727,595	338,100	2,304,485
Salaries	229,345	197,971	308,571	400,745	420,914	1,557,546
Supplies	21,000	21,000	27,000	33,000	33,000	135,000
Communications	39,630	48,490	55,490	67,490	65,690	276,790
Vehicles and maintenance	42,288	42,288	71,388	100,488	100,488	356,940
Office expenses	284,600	284,600	440,400	596,200	596,200	2,202,000
Travel and accommodation	1,615	1,615	4,135	7,160	7,160	21,685
<b>Total</b>	<b>2,123,307</b>	<b>4,604,747</b>	<b>5,841,138</b>	<b>6,304,046</b>	<b>4,725,227</b>	<b>23,598,465</b>

**Table 4B: Cost Category by Year**

Cost category	Budget incl. taxes and contingencies (US\$)					
	Y1	Y2	Y3	Y4	Y5	Total
BCC and IPC activities and materials	428,445	2,581,231	3,558,611	3,955,587	2,960,586	13,484,460
Surveys and evaluations	139,390	58,300	133,390	42,400	54,590	428,070
Institutional Strengthening	254	7,568	13,674	12,720	0	34,217
Equipment and maintenance	177,946	233,450	250,350	244,550	2,400	908,696
Materials production and distribution	15,125	134,537	112,051	148,553	114,194	524,459
Consulting services	926,970	1,122,008	889,976	581,754	445,370	3,966,077
Training, workshops and study tours	131,872	509,357	666,677	767,532	355,077	2,430,516
Salaries	265,211	225,658	344,794	440,624	466,009	1,742,295
Supplies	22,260	22,260	28,620	34,980	34,980	143,100
Communications	42,008	51,649	58,819	71,539	69,631	293,647
Vehicles and maintenance	44,825	44,825	75,671	106,517	106,517	378,356
Office expenses	303,476	303,476	468,624	633,772	633,772	2,343,120
Travel and accommodation	1,712	1,712	4,383	7,590	7,590	22,986
<b>Total</b>	<b>2,499,494</b>	<b>5,296,031</b>	<b>6,605,640</b>	<b>7,048,118</b>	<b>5,250,717</b>	<b>26,700,000</b>

**Table 5A: Cost Category by National and Provincial**

Cost category	Base cost (US\$)			% Budget
	National	Provincial	Total	
BCC and IPC activities and materials	4,849,900	7,058,600	11,908,500	50.46%
Surveys and evaluations	409,500		409,500	1.74%
Institutional Strengthening	32,280		32,280	0.14%
Equipment and maintenance	112,706	642,750	755,456	3.20%
Materials production and distribution		440,875	440,875	1.87%
Consulting services	2,691,888	505,520	3,197,408	13.55%
Training, workshops and study tours	366,985	1,937,500	2,304,485	9.77%
Salaries	451,546	1,106,000	1,557,546	6.60%
Supplies	75,000	60,000	135,000	0.57%
Communications	156,790	120,000	276,790	1.17%
Vehicles and maintenance	65,940	291,000	356,940	1.51%
Office expenses	654,000	1,548,000	2,202,000	9.33%
Travel and accommodation	10,585	11,100	21,685	0.09%
<b>Total</b>	<b>9,877,120</b>	<b>13,721,345</b>	<b>23,598,465</b>	<b>100.00%</b>

**Table 5B: Cost Category by National and Provincial**

Cost category	Budget incl. taxes and contingencies (US\$)			% Budget
	National	Provincial	Total	
BCC and IPC activities and materials	5,646,684	7,837,776	13,484,460	50.50%
Surveys and evaluations	428,070		428,070	1.60%
Institutional Strengthening	34,217		34,217	0.13%
Equipment and maintenance	159,424	749,273	908,696	3.40%
Materials production and distribution		524,459	524,459	1.96%
Consulting services	3,404,950	561,127	3,966,077	14.85%
Training, workshops and study tours	376,766	2,053,750	2,430,516	9.10%
Salaries	550,935	1,191,360	1,742,295	6.53%
Supplies	79,500	63,600	143,100	0.54%
Communications	166,447	127,200	293,647	1.10%
Vehicles and maintenance	69,896	308,460	378,356	1.42%
Office expenses	702,240	1,640,880	2,343,120	8.78%
Travel and accommodation	11,220	11,766	22,986	0.09%
<b>Total</b>	<b>11,630,350</b>	<b>15,069,651</b>	<b>26,700,000</b>	<b>100.00%</b>

**Table 6A: Component by Local and Foreign Currency**

Component	Base cost (US\$)		
	Local currency	Foreign currency	Total Base Cost
Component 1 Advocacy	1,728,499	250,000	1,978,499
Component 2 Mass Media and IPC Materials	8,756,131	2,005,488	10,761,619
Component 3 Community-based HIV Prevention	6,831,520	0	6,831,520
Component 4 Project Management	3,316,176	710,650	4,026,826
<b>Total donor funding</b>	<b>20,632,326</b>	<b>2,966,138</b>	<b>23,598,464</b>
Per cent of total budget	87.43%	12.57%	100.00%

**Table 6B: Component by Local and Foreign Currency**

Component	Quantity contingencies		Price contingencies		Total	
	Taxes	Local currency	Foreign exchange	Local currency	Foreign exchange	Taxes and Conting.
Component 1 Advocacy	47,600	42,800	0	97,710	4,750	192,860
Component 2 Mass Media and IPC Materials	851,314	409,703	100,274	525,368	38,104	1,924,764
Component 3 Community-based HIV Prevention	84,000	93,926	0	385,711	0	563,637
Component 4 Project Management	171,926	2,550	34,320	197,516	13,963	420,274
	<b>1,154,840</b>	<b>548,979</b>	<b>134,594</b>	<b>1,206,305</b>	<b>56,817</b>	<b>3,101,535</b>

**Table 7A: Component by Investment and Recurrent costs**

Component	Base cost (US\$)		
	Investment costs	Recurrent costs	Total
Component 1 Advocacy	1,678,500	300,000	1,978,500
Component 2 Mass Media and IPC Materials	9,965,199	796,420	10,761,619
Component 3 Community-based HIV Prevention	6,100,520	731,000	6,831,520
Component 4 Project Management	999,785	3,027,041	4,026,826
<b>Total</b>	<b>18,744,004</b>	<b>4,854,461</b>	<b>23,598,465</b>
Per cent of total budget	79.43%	20.57%	100.00%

**Table 7B: Component by Investment and Recurrent costs**

Component	Budget incl. taxes and contingencies (US\$)		
	Investment costs	Recurrent costs	Total
Component 1 Advocacy	1,838,360	333,000	2,171,360
Component 2 Mass Media and IPC Materials	11,785,269	901,114	12,686,383
Component 3 Community-based HIV Prevention	6,601,297	793,860	7,395,157
Component 4 Project Management	1,213,799	3,233,301	4,447,100
<b>Total</b>	<b>21,438,725</b>	<b>5,261,275</b>	<b>26,700,000</b>
Per cent of total budget	80.29%	19.71%	100.00%

**Table 8A. Project Budget: By component and year**

<b>Component 1 Advocacy Outputs and Activities</b>	<b>Budget incl. taxation and contingencies (US\$)</b>					<b>Total</b>
	<b>Y1</b>	<b>Y2</b>	<b>Y3</b>	<b>Y4</b>	<b>Y5</b>	
<b>Research on youth issues conducted and disseminated</b>	-	<b>42,400</b>	<b>100,000</b>	<b>42,400</b>	-	<b>184,800</b>
Contribution to the 2nd SAVY study	-	-	100,000	-	-	100,000
Research studies during implementation phase	-	31,800	-	31,800	-	63,600
Dissemination workshops	-	10,600	-	10,600	-	21,200
<b>Advocacy materials developed and distributed</b>	<b>105,875</b>	<b>105,875</b>	<b>132,495</b>	<b>159,115</b>	<b>72,600</b>	<b>575,960</b>
Information Packages on Youth and HIV/AIDS	33,275	33,275	59,895	86,515	-	212,960
Production of mass media materials	72,600	72,600	72,600	72,600	72,600	363,000
<b>Youth participation mechanism established</b>	<b>77,285</b>	<b>77,285</b>	<b>154,570</b>	<b>231,855</b>	<b>231,855</b>	<b>772,850</b>
Annual forum with policy makers	13,250	13,250	26,500	39,750	39,750	132,500
Radio/TV talk shows at the local TV	8,880	8,880	17,760	26,640	26,640	88,800
Advocacy meetings at community level	8,480	8,480	16,960	25,440	25,440	84,800
Attendance at national youth conferences and workshops	21,200	21,200	42,400	63,600	63,600	212,000
Attendance at international youth conferences and workshops	25,475	25,475	50,950	76,425	76,425	254,750
<b>Youth and HIV issues mainstreamed</b>	<b>73,050</b>	<b>59,800</b>	<b>132,850</b>	<b>192,650</b>	<b>179,400</b>	<b>637,750</b>
Mainstream youth issues with partners	13,250	-	13,250	13,250	-	39,750
Planning workshop with local authorities/partners	13,250	13,250	26,500	39,750	39,750	132,500
Workshops with service providers	13,250	13,250	26,500	39,750	39,750	132,500
VCPFC annual commune outreach activity	22,200	22,200	44,400	66,600	66,600	222,000
MoH HIV/AIDS communication activities	11,100	11,100	22,200	33,300	33,300	111,000
<b>TOTAL</b>	<b>256,210</b>	<b>285,360</b>	<b>519,915</b>	<b>626,020</b>	<b>483,855</b>	<b>2,171,360</b>

**Table 8B. Project Budget: By component and Year**

Component 2 BCC and IPC Outputs and Activities	Budget including contingencies (US\$)					Total
	Y1	Y2	Y3	Y4	Y5	
<b>Mass media formative research</b>	<b>31,800</b>	<b>5,300</b>	<b>10,600</b>	<b>10,600</b>	<b>10,600</b>	<b>68,900</b>
Mass media formative research	31,800	-	-	-	-	31,800
Audience feedback panel	-	5,300	10,600	10,600	10,600	37,100
<b>Mass Media Production</b>	<b>53,360</b>	<b>1,234,240</b>	<b>1,686,640</b>	<b>1,686,640</b>	<b>1,307,784</b>	<b>5,968,664</b>
TV drama series	-	591,600	591,600	591,600	295,800	2,070,600
TV documentaries	-	27,840	27,840	27,840	27,840	111,360
TV spots - 30 sec & 1 min	18,560	92,800	92,800	92,800	44,544	341,504
Provincial radio phone-in show	-	452,400	904,800	904,800	904,800	3,166,800
Radio spots - 30 sec & 1 min	34,800	69,600	69,600	69,600	34,800	278,400
<b>Mass Media Broadcast</b>	<b>194,880</b>	<b>726,856</b>	<b>726,856</b>	<b>744,952</b>	<b>390,572</b>	<b>2,784,116</b>
TV drama series	-	52,200	52,200	52,200	26,100	182,700
TV spots - 30 sec & 1 min	174,000	580,000	580,000	580,000	290,000	2,204,000
TV documentaries	-	6,960	6,960	6,960	3,480	24,360
Provincial radio phone-in show	-	18,096	18,096	36,192	36,192	108,576
Radio spots - 30 sec & 1 min	20,880	69,600	69,600	69,600	34,800	264,480
<b>Newspaper/Magazine Publication</b>	<b>7,950</b>	<b>15,900</b>	<b>15,900</b>	<b>15,900</b>		<b>63,600</b>

					<b>7,950</b>	
Weekly column - newspaper	2,067	4,134	4,134	4,134	2,067	16,536
Weekly column - magazine (national)	2,067	4,134	4,134	4,134	2,067	16,536
Mthly feature article - newspapers	1,908	3,816	3,816	3,816	1,908	15,264
Mthly feature article - magazine	1,908	3,816	3,816	3,816	1,908	15,264
<b>IPC Materials Production</b>	<b>39,325</b>	<b>93,170</b>	<b>50,518</b>	<b>42,653</b>	<b>17,394</b>	<b>243,059</b>
Design fee	24,200	12,100	24,200	12,100	-	72,600
Posters (printing)	15,125	7,563	3,630	3,630	-	29,948
Leaflets (printing)	-	3,025	6,050	6,050	3,025	18,150
Flipcharts (printing)	-	19,360	-	-	-	19,360
Comic (printing)	-	12,100	12,100	12,100	12,100	48,400
Booklet (printing)	-	4,538	4,538	4,538	2,269	15,881
Teaching cards (printing)	-	30,250	-	-	-	30,250
CD sets (production)	-	4,235	-	4,235	-	8,470
<b>Web site</b>	<b>32</b>	<b>9,673</b>	<b>4,123</b>	<b>4,123</b>	<b>2,215</b>	<b>20,167</b>
Domain registration	32	-	-	-	-	32
Design	-	5,550	-	-	-	5,550
Yearly domain maintenance	-	42	42	42	42	170
Yearly host service	-	265	265	265	265	1,060
Site maintenance	-	3,816	3,816	3,816	1,908	13,356
<b>Capacity Building</b>	<b>254</b>	<b>7,568</b>	<b>13,674</b>	<b>12,720</b>	<b>-</b>	<b>34,217</b>
Print journalist training	-	1,590	3,180	3,180	-	7,950
Broadcast journalist training	-	1,590	3,180	3,180	-	7,950
Phone hot-line staff/counselor training	-	954	954	-	-	1,908
Collaborator training in IPC material use	254	254	-	-	-	509

Orientation training of EA staff for Resource Center	-	3,180	6,360	6,360	-	15,900
<b>Research Centre and operation costs</b>	<b>80,037</b>	<b>58,512</b>	<b>58,512</b>	<b>58,512</b>	<b>58,512</b>	<b>314,085</b>
Computer/printer	2,849	-	-	-	-	2,849
Photocopier	11,600	-	-	-	-	11,600
LCD projector	3,828	-	-	-	-	3,828
TV monitor	2,900	-	-	-	-	2,900
VCR	348	-	-	-	-	348
Office space	38,160	38,160	38,160	38,160	38,160	190,800
Electricity and water	2,544	2,544	2,544	2,544	2,544	12,720
Telecom	6,360	6,360	6,360	6,360	6,360	31,800
Supplies/consumables/printing	11,448	11,448	11,448	11,448	11,448	57,240
<b>Media agency technical assistance</b>	<b>399,280</b>	<b>792,788</b>	<b>615,910</b>	<b>301,780</b>	<b>107,705</b>	<b>2,217,464</b>
Mass media manager TA	101,932	203,865	203,865	203,865	101,932	815,459
Executive Producer, TV Drama and Documentaries	92,143	184,285	184,285	92,143	-	552,856
Executive Producer, Radio	73,996	147,992	73,996	-	-	295,984
Executive Producer, TV spots	73,996	147,992	147,992	-	-	369,980
Story Consultant	25,721	51,441	-	-	-	77,162
Script Consultant	25,721	51,441	-	-	-	77,162
Media agency management	5,773	5,773	5,773	5,773	5,773	28,863
<b>TA Subsistence (housing)</b>	<b>51,312</b>	<b>102,624</b>	<b>76,327</b>	<b>32,711</b>	<b>10,904</b>	<b>273,878</b>
Mass media manager housing	10,904	21,808	21,808	21,808	10,904	87,230
Executive Producer, TV Drama and Documentaries	10,904	21,808	21,808	10,904	-	65,423
Executive Producer, Radio	10,904	21,808	10,904	-	-	43,615
Executive Producer, TV spots	10,904	21,808	21,808	-	-	54,519
Story Consultant	3,848	7,697	-	-	-	11,545
Script Consultant	3,848	7,697	-	-	-	11,545

<b>TA Travel (International)</b>	<b>13,469</b>	<b>23,090</b>	<b>17,318</b>	<b>9,621</b>	<b>3,848</b>	<b>67,347</b>
Mass media manager travel	1,924	3,848	3,848	3,848	1,924	15,394
Executive Producer, TV Drama and Documentaries	1,924	3,848	3,848	1,924	-	11,545
Executive Producer, Radio	1,924	3,848	1,924	-	-	7,697
Executive Producer, TV spots	1,924	3,848	3,848	-	-	9,621
Story Consultant	1,924	1,924	-	-	-	3,848
Script Consultant	1,924	1,924	-	-	-	3,848
BBC London management	1,924	3,848	3,848	3,848	1,924	15,394
<b>Media agency management</b>	<b>150,871</b>	<b>121,183</b>	<b>126,983</b>	<b>121,183</b>	<b>110,665</b>	<b>630,886</b>
Chief accountant	21,673	21,673	21,673	21,673	21,673	108,365
Accountant x 2	20,398	20,398	20,398	20,398	20,398	101,990
Receptionist	6,374	6,374	6,374	6,374	6,374	31,872
Local Consultants	3,506	10,518	10,518	10,518	-	35,059
Office rent	39,960	39,960	39,960	39,960	39,960	199,800
Office Furniture	10,600	-	-	-	-	10,600
Telecom	19,080	19,080	19,080	19,080	19,080	95,400
Computer/printer	14,500	-	5,800	-	-	20,300
Photocopier	11,600	-	-	-	-	11,600
Stationary	3,180	3,180	3,180	3,180	3,180	15,900
<b>TOTAL</b>	<b>1,022,571</b>	<b>3,190,906</b>	<b>3,403,361</b>	<b>3,041,395</b>	<b>2,028,150</b>	<b>12,686,383</b>

**Table 8C. Project Budget: By component and Year**

<b>Component 3 HIV/AIDS Prevention Outputs and Activities</b>	<b>Budget incl. tax and contingencies (US\$)</b>				
	<b>Y2</b>	<b>Y3</b>	<b>Y4</b>	<b>Y5</b>	<b>Total</b>
<b><u>Sub-component 1: Harm Reduction outreach services</u></b>					
<b>Community-based harm reduction services</b>	<b>54,710</b>	<b>93,450</b>	<b>178,810</b>	<b>242,760</b>	<b>569,730</b>
Contract NGOs for one VCTC per province per year	39,960	66,600	139,860	206,460	452,880
Distribute IPC materials to VCTCs	2,650	2,650	2,650	-	7,950
Provision of 1,000,000 condoms to VCTC	2,689	5,378	8,067	8,067	24,200
Provision of 1,000,000 clean needles	9,411	18,822	28,233	28,233	84,700
<b>IDU peer education</b>	<b>62,450</b>	<b>95,750</b>	<b>129,050</b>	<b>99,900</b>	<b>387,150</b>
Distribution of IPC materials to IDU peer educators	2,650	2,650	2,650	-	7,950
Training for peer educators	26,500	26,500	26,500	-	79,500
Outreach peer education	21,200	42,400	63,600	63,600	190,800
Provision of 1,000,000 condoms to NGO contractor	2,689	5,378	8,067	8,067	24,200
Provision of 1,000,000 clean needles	9,411	18,822	28,233	28,233	84,700
<b>Service industry</b>	<b>50,350</b>	<b>71,550</b>	<b>92,750</b>	<b>63,600</b>	<b>278,250</b>
Distribution IPC materials to service industry peer educators	2,650	2,650	2,650	-	7,950
Training course for peer educators	26,500	26,500	26,500	-	79,500
Outreach peer education	21,200	42,400	63,600	63,600	190,800
<b><u>Sub-component 2: HIV prevention among vulnerable youth</u></b>					

<b>Formative research</b>	-	-	-	-	<b>63,600</b>
HIV prevention among vulnerable youth	-	-	-	-	21,200
HIV prevention for mainstream youth	-	-	-	-	21,200
HIV prevention through parental, care and support skills	-	-	-	-	21,200
<b>NGO selection</b>	<b>9,546</b>	<b>9,546</b>	<b>9,546</b>	<b>1,909</b>	<b>30,547</b>
Contract 1 x NGO for training and supervision of community collaborators:	9,546	9,546	9,546	1,909	30,547
<b>Street youth</b>	<b>102,230</b>	<b>154,110</b>	<b>205,990</b>	<b>122,340</b>	<b>584,670</b>
Distribution of IPC materials to Sympathy Houses and Peer Educators	2,650	2,650	2,650	-	7,950
Training for teachers in ‘Sympathy Classes’	26,500	26,500	26,500	-	79,500
HIV prevention and life skill education at Sympathy Classes	29,680	59,360	89,040	89,040	267,120
Training for peer educators	21,200	21,200	21,200	-	63,600
Outreach peer education at ‘Sympathy Houses’	22,200	44,400	66,600	33,300	166,500
<b>Industrial workers</b>	<b>217,339</b>	<b>405,528</b>	<b>593,717</b>	<b>564,567</b>	<b>1,781,150</b>
Distribution of IPC materials industrial worker peer educators	2,650	2,650	2,650	-	7,950
Training course for peer educators	26,500	26,500	26,500	-	79,500
Outreach peer education	53,000	106,000	159,000	159,000	477,000
Outreach subsidy to industrial workers	132,500	265,000	397,500	397,500	1,192,500
Provision of 1,000,000 condoms to NGO contractor	2,689	5,378	8,067	8,067	24,200
<b>Vocational centres</b>	<b>84,729</b>	<b>113,808</b>	<b>137,587</b>	<b>76,637</b>	<b>433,850</b>
Distribution of IPC materials to VCTC trainers					

	2,650	2,650	2,650	-	7,950
Training of teachers in HIV prevention and life skills	53,000	53,000	53,000	-	159,000
HIV prevention and life skills	5,300	10,600	10,600	5,300	31,800
Provision of 1,000,000 condoms to each centre (2 centres per province)	2,689	5,378	8,067	8,067	24,200
MOLISA facilities for program implementation	21,090	42,180	63,270	63,270	210,900
<b><u>Sub-component 3: HIV prevention among mainstream youth</u></b>					
<b>NGO selection</b>	<b>20,868</b>	<b>20,868</b>	<b>20,868</b>	<b>15,096</b>	<b>77,700</b>
Contract 1 x NGO for all peer education and life skills TOT and supervision	20,868	20,868	20,868	15,096	77,700
<b>Skills training for parents and collaborators</b>	<b>254,545</b>	<b>506,440</b>	<b>588,735</b>	<b>416,485</b>	<b>1,803,410</b>
Distribution of IPC materials to community collaborators and parents	2,650	2,650	2,650	-	7,950
Training for commune collaborators	53,000	106,000	106,000	53,000	318,000
Parenting classes at communes	116,600	233,200	233,200	116,600	699,600
Outreach peer education	42,400	84,800	127,200	127,200	381,600
VCPFC collaborators outreach activities at commune level	16,536	33,072	49,608	49,608	165,360
MOH collaborators outreach activities at commune level	20,670	41,340	62,010	62,010	206,700
Provision of 1,000,000 condoms to collaborators in community	2,689	5,378	8,067	8,067	24,200
<b>HIV prevention: youth at schools</b>	<b>177,440</b>	<b>198,530</b>	<b>219,620</b>	<b>63,270</b>	<b>679,950</b>
Distribution of teaching aids and IPC materials to schools	2,650	2,650	2,650	-	7,950
Training of teachers in IPC by provincial Health Promotion officers	74,200	74,200	74,200	-	222,600
Pre-service teacher training in teacher education colleges	26,500	26,500	26,500	-	79,500
In-service teacher training at two secondary schools					

	53,000	53,000	53,000	-	159,000
MOET facilities for program implementation	21,090	42,180	63,270	63,270	210,900
<b>Other management and equipment costs</b>	<b>233,450</b>	<b>233,450</b>	<b>233,450</b>	<b>2,400</b>	<b>705,150</b>
TV & VCD sets	231,200	231,200	231,200	1,200	696,000
Cassette players	2,250	2,250	2,250	1,200	9,150
<b>TOTAL</b>	<b>1,267,657</b>	<b>1,903,029</b>	<b>2,410,122</b>	<b>1,668,963</b>	<b>7,395,157</b>

**Table 8D. Project Budget: By component and Year**

Component 4 Project Management Outputs and Activities	Budget including contingencies (US\$)					
	Y1	Y2	Y3	Y4	Y5	Total
<b>National PMU</b>	<b>176,027</b>	<b>137,537</b>	<b>130,957</b>	<b>119,871</b>	<b>143,469</b>	<b>707,861</b>
VCPFC project directors and staff	3,816	3,816	3,816	3,816	3,816	19,080
Steering Committee members	3,053	3,053	3,053	3,053	3,053	15,264
Project officers	1,526	1,526	1,526	1,526	1,526	7,632
CPMU staff x 9	13,738	13,738	13,738	13,738	13,738	68,688
Finance, accounting and administration consultants	22,630	7,559	7,559	-	7,559	45,305
Project management consultant	9,448	3,149	3,149	-	3,149	18,896
Project technical consultants	37,793	12,598	12,598	-	25,195	88,183
Travel (air fares)	212	212	1,060	2,120	2,120	5,724
Travel per diem	95	95	286	572	572	1,622
Travel accommodation	228	228	684	1,367	1,367	3,874
Study tours	-	10,190	-	10,190	-	20,380
Conference attendance	5,808	5,808	5,808	5,808	5,808	29,042
Staff training (1 course = 12 people x 3 days)	2,115	-	2,115	2,115	-	6,344

Office space at VCPFC	50,880	50,880	50,880	50,880	50,880	254,400
Telecom	3,816	3,816	3,816	3,816	3,816	19,080
Translation costs	2,120	2,120	2,120	2,120	2,120	10,600
Stationary	1,272	1,272	1,272	1,272	1,272	6,360
Maintenance	5,088	5,088	5,088	5,088	5,088	25,440
Depreciation of equipment and vehicles	6,347	6,347	6,347	6,347	6,347	31,736
Transport (petrol, taxi)	2,544	2,544	2,544	2,544	2,544	12,720
Electricity and water	2,544	2,544	2,544	2,544	2,544	12,720
Steering committee meetings	954	954	954	954	954	4,770
<b>Provincial PMU</b>	<b>276,863</b>	<b>254,941</b>	<b>520,981</b>	<b>775,922</b>	<b>764,822</b>	<b>2,593,529</b>
PPMU directors (PCPFC)	6,360	6,360	12,720	19,080	19,080	63,600
PPMU consultants x 4 per province	25,440	25,440	50,880	76,320	76,320	254,400
Provincial technical consultants	7,950	7,950	15,900	23,850	23,850	79,500
Travel fares	530	530	1,060	1,590	1,590	5,300
Travel per diem	191	191	382	572	572	1,908
Travel accommodation	456	456	912	1,367	1,367	4,558
PPMU meetings (10 people)	1,908	1,908	3,816	5,724	5,724	19,080
Office space at PCPFC	159,000	159,000	318,000	477,000	477,000	1,590,000

Telecom	12,720	12,720	25,440	38,160	38,160	127,200
Stationary	3,180	3,180	6,360	9,540	9,540	31,800
Printing	3,180	3,180	6,360	9,540	9,540	31,800
Maintenance	3,180	3,180	6,360	9,540	9,540	31,800
Depreciation of equipment and vehicles	24,486	24,486	48,972	73,458	73,458	244,860
Transport (petrol, taxi)	3,180	3,180	6,360	9,540	9,540	31,800
Electricity and water	3,180	3,180	6,360	9,540	9,540	31,800
Accounting software	10,823	-	-	-	-	10,823
Computer and printer	5,550	-	5,550	5,550	-	16,650
Office furniture	5,550	-	5,550	5,550	-	16,650
<b>Equipment and supplies</b>	<b>95,399</b>	-	-	-	-	<b>95,399</b>
Project car	76,400	-	-	-	-	76,400
Photocopier upgrade	6,960	-	-	-	-	6,960
Computers and printers	5,800	-	-	-	-	5,800
Accounting software	689	-	-	-	-	689
Office furniture and fittings	5,550	-	-	-	-	5,550
<b>Monitoring and Evaluation</b>	<b>64,130</b>	<b>26,500</b>	<b>43,990</b>	<b>7,420</b>	<b>62,010</b>	<b>204,050</b>
Baseline survey not including TA	42,400	-	-	-	-	42,400

Mid-term review not including TA	-	21,200	21,200	-	-	42,400
Project final evaluation not including TA	-	-	-	-	42,400	42,400
M&E workshop (indicators)	10,600	-	10,600	-	-	21,200
Evaluation workshops	4,240	-	4,240	-	-	8,480
Final evaluation workshop	-	-	-	-	10,600	10,600
Printing evaluation reports	1,590	-	1,590	-	1,590	4,770
Annual audit cost	5,300	5,300	6,360	7,420	7,420	31,800
<b>Consulting services</b>	<b>462,908</b>	<b>133,131</b>	<b>83,408</b>	<b>67,367</b>	<b>99,448</b>	<b>846,262</b>
Capacity Building Advisor	106,839	35,613	-	-	-	142,452
Travel	1,604	1,604	-	-	-	3,207
Accommodation	30,787	7,697	-	-	-	38,484
Per diem	19,242	4,811	-	-	-	24,053
M&E Advisor	106,839	23,742	23,742	11,871	35,613	201,807
Travel	1,604	1,604	1,604	1,604	1,604	8,018
Accommodation	23,090	5,131	5,131	2,566	7,697	43,615
Per diem	14,432	3,207	3,207	1,604	4,811	27,260
Youth Advisor	106,839	35,613	35,613	35,613	35,613	249,291
Travel	1,604	1,604	1,604	1,604	1,604	8,018
Accommodation	30,787	7,697	7,697	7,697		

					7,697	61,574
Per diem	19,242	4,811	4,811	4,811	4,811	38,484
[All TA for TV production sub-contracted to media agency contractor]						
<b>TOTAL</b>	<b>1,075,327</b>	<b>552,109</b>	<b>779,335</b>	<b>970,580</b>	<b>1,069,749</b>	<b>4,447,100</b>

## **c. Economic and Financial Analysis**

### **A. Development context**

#### **(1) Economic growth**

The economy of Viet Nam is growing consistently at an annual rate of more than 7%, and prospects for the future economic development of the country are good. The expanding HIV/AIDS epidemic, though still limited, could jeopardize this progress if it is not brought under control in the short term. The Viet Nam HIV/AIDS Prevention Among Youth Project can make a significant contribution to limiting the further transmission of HIV by targeting both youth in general and particular high-risk groups, namely Intravenous Drug Users (IDUs) and Sex Workers (SWs), with preventive programs. The economic and social savings to Viet Nam will be significant.

The Project, which will be implemented through the EA in selected provinces over the five years 2006–2010, supports Viet Nam's development objectives as expressed in the Comprehensive Poverty Reduction and Growth Strategy<sup>1</sup>, which aims in part to halve the rate of increase in HIV transmission by 2010. The ADB Viet Nam Country Strategy and Program<sup>2</sup> indicates that the ability to reverse the increasing trend in HIV transmission will depend on whether effective preventive steps are taken in the next few years. It is widely recognized that HIV/AIDS has a severe impact on macroeconomic growth and consequential reductions in per capita income, savings and productivity, mainly because HIV/AIDS strikes mainly among working age individuals.<sup>3</sup>

#### **(2) Poverty and health**

Ill health is a major cause of impoverishment in Viet Nam, as indicated by the Viet Nam Household Living Standards Survey 2002 (VHLSS).<sup>4</sup> The National Assembly has set a target for reducing the proportion of households living below the national poverty line to less than 10%. However, the significant progress made in reducing the poverty rate since 1990 could be jeopardized by an expanding HIV/AIDS epidemic. According to a UNDP analysis, all households that include a person with AIDS will fall below the poverty line due to the income and expenditure effects of HIV/AIDS, except for those in the highest income quintile. Households in the third and fourth income quintiles who are affected by HIV/AIDS will become newly poor. Poverty also increases the risk of HIV transmission: poor families are generally less well educated, more prone to the effects of drug addiction, less likely to use condoms during sex, and more likely to report sex with SW.

#### **(3) Population health**

In 2004, the population of Viet Nam was an estimated 82 million. The number of officially reported HIV-positive cases by March 2005 was 93,402<sup>5</sup>, but the Ministry of Health estimates that actual numbers may be three times this level. According to estimates made by the Viet Nam Technical Working Group on HIV Estimates and Projections<sup>6</sup>, the number of

<sup>1</sup> Government of Viet Nam, 2002 (May), Comprehensive Poverty and Growth Reduction Strategy, Hanoi.

<sup>2</sup> ADB, (2004, July), Socialist Republic of Viet Nam Country Strategy and Program Update 2005–2006 ([www.adb.org](http://www.adb.org)).

<sup>3</sup> See, for example, WHO, (2001), 'Aids and Economics', Macroeconomic Commission on Health, Working Paper WG1:15, Geneva.

<sup>4</sup> General Statistics Office, (2002), Preliminary Data from the Viet Nam Households Living Standards Survey, Hanoi.

<sup>5</sup> Government of Viet Nam, General Department of Preventive Medicine and HIV/AIDS Control, Ministry of Health, Hanoi.

<sup>6</sup> Ministry of Health, General Department of Preventive Medicine and HIV/AIDS Control, HIV/AIDS Estimates and Projections 2005–2010, Hanoi, 2005.

PLWHA has been estimated in 2005 at 263,470 (in the medium scenario) for a national prevalence rate of 0.51% in the 15–49 years age group. It is estimated that by 2010 these rates will rise to 311,500 PLWHA or 0.544% in the 15–49 years age group. The TWG estimates are used below to calculate the Project benefit–cost ratio. Currently, 86% of all PLWHA are male, and approximately 95% of all PLWHA are in the 15–49 years age group.

*Table 1: Technical Working Group, estimated HIV/AIDS prevalence 2005 (medium scenario).*

Target group	2005 est.
# of cumulative HIV+	319,000
# of PLWHA	263,000
# of PLWHA: male	176,000
# of PLWHA: female	86,000
# of new HIV+ p.a.	37,000
# of AIDS cases: total	72,000
# of AIDS cases: male	56,000
# of AIDS cases: female	16,000
# of AIDS deaths: total	56,000
# of AIDS cases: current	16,000
% 15–49 years HIV+	0.51
% male 15–49 HIV+	0.68
% female 15–49 HIV+	0.34
% IDU 15–49 HIV+	33.7
% SW 15–49 HIV+	17.0

Source: MoH 2005a. HIV/AIDS Estimations and Projections 2005–2010.

#### **(4) Demand for HIV/AIDS prevention**

Project outputs will be of most immediate value to the EA and its collaborating agencies, meeting a recognized demand for HIV preventive services. Indirectly, the Project will meet a demand for services that prevent the transmission of HIV from those people most at risk. While this cannot be regarded as a monetarily effective demand (even those most at risk are unlikely to pay for preventive services) it does reflect a social demand based on the need to halt the further spread of the epidemic. The aims of the Project are therefore to reduce the rate of HIV transmission, lower the social cost of treatment and care associated with HIV/AIDS, prevent a broader detrimental impact on the workforce, lower the burden on families, limit criminality and increase family welfare and security.

#### **(5) Economic analysis**

The economic analysis supporting the Project design therefore focuses on an estimation of the productivity gains from a reduction in the rate of HIV transmission, the consequent public and private savings in health care costs, and the improvements in family welfare.

### **B. Economic Rationale**

#### **(1) Non–marketed outputs**

Reducing the rate of HIV transmission is a strong public health concern. Project activities focus on a reduction in the rate of HIV transmission achieved through a range of preventive activities including Harm Reduction, Behavior Change Communication (BCC), and Interpersonal Communication (IPC). These activities fall mostly within the category of non–marketed outputs (or public goods provided through the public health system). For this reason, the economic analysis of the Project focuses on demand forecasts, the least cost alternatives for preventive activities, the value of benefits of HIV prevention, co–financing and affordability of

prevention and care activities, and the distribution of costs and benefits among the population.

Demand forecasts are based on the anticipated increase in HIV transmission should preventive activities not occur. Project activities designed to reduce the rate of transmission are selected as the least cost and the most effective alternatives to address the need for HIV prevention. Benefits are valued in terms of reduced transmission, increase productivity, and reduced health costs. An estimate of productivity losses due to HIV/AIDS infection and illness is based on the national average of work-days lost due to illness and an estimate of GDP losses. The savings that accrue as a result of HIV prevention are measured both in terms of increased output and the reduction of health costs associated with treatment and care of HIV/AIDS patients.

Private financing of HIV/AIDS care and treatment is very low, and the distribution of ARV therapy is extremely limited, due both to cost and accessibility. Public financing of HIV prevention is therefore the most cost effective intervention and is strongly associated with improvements in family welfare and equity. Due to the lack of monetarily effective demand for HIV prevention services, co-financing of preventive activities through user fees is not a viable option. However, there is room for cooperation between government, donors, and NGOs in the financing of preventive activities. Given the nature of HIV prevention as a public good, the proposed activities are not expected to crowd out private spending.

## **(2) Public goods and externalities**

The case for a strong role for government participation is based on the lack of effective private demand for HIV/AIDS preventive activities. Public funding of HIV/AIDS prevention is justified both as a public good and by positive externalities. The services provided to the community through HIV prevention activities (notably BCC and IPC) are public goods for which the consumption by a single individual or household does not in any way affect the consumption choice of other individuals or households. In the case of universal BCC (and some IPC materials) provided across the population through free-to-air broadcast media or unrestricted distribution of literature, the benefits gained by one consumer do not in any way diminish the opportunities of others to benefit as well. The one exception to this rule is the social marketing of condoms, for which a nominal fee may be charged to users.

The externalities associated with HIV prevention activities mean that the social benefits are greater than private benefits: HIV prevention simultaneously protects the individual (from infection) and the community (from increased rates of transmission). In general, effective prevention reduces both the social costs of and social spending on health due to HIV/AIDS-related care. The implementation of effective preventive activities now will significantly reduce the potential drain on government finances of treatment and care should the rate of HIV transmission not be reduced. Moreover, effective prevention activities have a long-term, inter-generational impact in protecting future generations from HIV infection both broadly by reducing the overall rate of transmission and more narrowly by reducing the rate of mother-to-child transmission. Improved child health means not only an increased survival rate into adulthood but also a more productive future generation that benefits from better educational opportunities and increased work capacity. Reducing the transmission of HIV/AIDS also provides externalities in the reduction of opportunistic infections and consequently reduces health costs further. In the case of a private good, like the use of condoms, the positive externalities (in reducing the risk of HIV transmission to others) are such that government subsidies for such activities are more than justified.

The nature of HIV prevention as a public good with positive externalities is reinforced by the absence of market mechanisms available to address the identified needs. Private provision of preventive services is unlikely, as argued above. Insurance markets likewise will not pro-

vide cover for preventive programs for the reasons already established here. There is as well very limited access to insurance markets for HIV/AIDS treatment and care. Even where insurance may be available in the private market it is accessible only to the wealthiest people. Additionally, it is the lack of perfect knowledge about the disease and the availability of services, and the widespread limitations on access to health services, especially among the poor, that severely restricts monetarily effective demand for prevention services.

### **(3) Equity and poverty reduction**

The economic effect of HIV/AIDS on households is severe. The justification for strong government participation therefore also reflects equity considerations by addressing issues that are particularly relevant to the poor (who suffer most from HIV/AIDS and who are the most at risk of infection). The benefits of economic growth have not been evenly distributed in Viet Nam and some social groups have missed out on the associated benefits. The maldistribution of these growth benefits is one of the causes of increasing IDU and SW numbers, but it has an effect also among the general population.

The costs of health care in general, and the costs of HIV/AIDS care in particular, are a major cause of impoverishment in Viet Nam. Figures from the Viet Nam Household Living Standards Survey 2002 indicate that household out-of-pocket spending on health care accounts for at least 62% of total health expenditure. Moreover, financial access to health services is much more limited for the poor than for the wealthy. VHLSS figures indicate that the poorest population income quintile spends on health care annually only 17% as much as the richest income quintile. Financial access for the poor to AIDS treatment (through ARVs for example) is even more limited. Equity is therefore a strong rationale for public spending on HIV prevention. A commitment to equity in the provision of HIV preventive activities is necessary not only to protect the poor from HIV transmission and to reduce the likelihood of impoverishment caused by health expenses related to HIV/AIDS treatment and care, it will also act to reduce the potential social and private costs of treatment and care should effective population-wide preventive activities not be carried out. The public provision of effective HIV preventive services also acts to increase feelings of social security and social solidarity that have a flow on effect in economic terms.

It is anticipated that the distributional effects of Project activities will especially benefit the poor and the vulnerable. Public distribution of preventive services has most benefit to those for whom the risks of HIV transmission are greatest, in this case the poor. By targeting youth, the Project covers the major proportion of HIV-infected people, and it covers the lowest income groups equally with the highest, consequently reducing the likelihood of impoverishment caused by health costs related to HIV/AIDS treatment and care. The major beneficiaries of the Project therefore include youth and the poor.

### **C. Poverty profile**

By all measures, poverty in Viet Nam has been falling in recent years as a result of strong economic growth, but it remains too high. According to the Five-Year Socio Economic Development Plan 2006–2010 (SEDP), in 1998 17.7% of the population lived below the poverty line measured as USD 1/day. The SEDP states that the number of poor households according to Viet Nam poverty standards applied for 2001–2005 period decreased by half from 17.5% in 2001 to 7% in 2005. The SEDP also states that according to international poverty standards the rate of poor households dropped by about one third from 33% in 2000 to about 22% in 2005.<sup>7</sup> Additionally, the depth or severity of poverty measured as the gap be-

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<sup>7</sup> Ministry of Planning and Investment, 2005 (September), Five-Year Socio Economic Development Plan 2006–2010, Hanoi, p4 (see also tables B.1 Some Main Targets, B.21 International Comparison in Social Standards).

tween the poverty line and the average expenditure of poor households has also been reduced over the last decade to almost one-third of its 1993 level.

Poverty remains concentrated in rural and remote areas, where 77% of the population lives. According to the CPRGS, more than 90% of the poor live in rural areas. Approximately 74% of the heads of poor households are employed in the primary sector (agriculture, forestry and fishing) according to the VHLSS. Poverty is greatest in remote, highland and upland areas that include mainly ethnic minorities. Approximately 64% of the poor live in the northern mountainous region for example, in the north, poverty levels according to GSO figures for 2002 were 39% in Vinh Phuc and 32% in Ninh Binh, and 37% in coastal Thai Binh.

Real per capita consumption expenditure is 2.4 times higher in urban than in rural areas according to GSO data for 2002 (based on VHLSS). While the greatest reduction in poverty has been in urban areas, agricultural reform has been one of the main drivers of the decline in poverty rates along with the increase in non-agricultural employment. Even so, rural-urban migration is a major cause of poverty in urban areas. It has been estimated that 40% of the population in HCMC and 25% in Hanoi are 'unregistered', indicating the recent arrival of low-paid laborers from the country side. Consequently, in Hanoi the proportion of heads of poor households employed in manufacturing (where wages paid to rural immigrants are low) is about twice the national average.

There is no strong evidence of gender bias in poverty, though female-headed households remain more vulnerable. While male-headed households have recorded a slightly higher level of average expenditure, there is not a corresponding gender bias in literacy or school enrolment levels. According to VHLSS figures, the poverty rate is consistently lower among female-headed households than male-headed, averaging 31% and 20% respectively in 2002. However, these figures reflect a process of self-identification of 'household head' that may be misleading. Localized research (for example, participatory research by MARD in the Red River delta) shows that single-female-headed households where there was no husband may well suffer greater poverty.

Despite the decline in poverty rates, disparities in the distribution of income are growing – from a ratio of the richest-to-poorest income quintile of 4.6 in 1993 to 6.2 in 2002 (GSO figures based on VHLSS 2002). The national Gini coefficient has increased in the same period from 0.34 to 0.37. This increasing disparity is widest in large urban areas, including Hanoi.

Ill health is commonly cited as a significant cause of poverty (and impoverishment), both due to lost income-earning capacity and the high costs of health care (from out-of-pocket payments). With an average 59% of household income spent on food there are very few reserves on average to meet the costs of chronic or catastrophic illness. Health expenditure has been increasing as a proportion of household expenditure, reaching more than 6% for the richest quintile and more than 5% for the poorest in 2002 (VHLSS data). Children under six are entitled to free primary health care, ethnic minorities receive some free services at commune centers and government hospitals, and the poor benefit from reimbursement of health costs or health insurance cards. However, only 18% of people qualify on average for fee reductions or exemptions due to poverty, leaving many genuinely poor people without coverage. The continued levying of unofficial fees at health facilities accentuates the problem of financial access for the poor. As the income of a large proportion of the population lies just above the poverty line, the high costs of health care can drive these families into poverty.

The poor typically have more restricted access to health care than the rich, often for financial reasons. According to the Viet Nam National Health Survey 2001–2, of those people who are ill and choose self-treatment rather than attend a clinic, 17% of poor people cite economic reasons for doing so, compared to 3% overall. Poor families rely more on commune

health centers than the rich and have much lower access to government hospitals. This is especially true for the rural poor who also face travel to facilities over long distances, and who believe (rightly or wrongly) they receive better care for their money at commune centers. Of all those who access health services, approximately 26% choose government hospitals, 11% commune centers, and 18% private facilities (GSO data based on VHLSS 2002).

The poor are more likely than the rich to be unable to work during illness (13.4% of the poor who are ill compared to 6.7% of the rich according to VHLSS 2002), indicating both a greater severity of illness and a greater loss of income. The poor are also less likely to make use of health facilities: 46.3% of poor people will seek care compared to 56.3% of the rich. The poor will spend on average less than VND 300,000 a year on out-of-pocket payments health costs compared to VND 1,614,000 for the rich. As yet, the operation of health insurance and health cards does not work sufficiently well to cover the needs of the poor adequately.

The increasing rate of HIV infection is a constraint on the further reduction of poverty and is a significant cause of impoverishment of previously non-poor families that include PLWHA. And HIV/AIDS is more likely to affect disadvantaged groups. HIV/AIDS has a significant financial impact on poor families both through the loss of income and economic security and through the cost of medical expenses. The costs of HIV/AIDS treatment may be up to 25 times the average per capita health expenditure and consume six months of average household income according to the experience in similar countries, such as Thailand. The decline in household income due to AIDS is 30% greater than from any other cause. HIV/AIDS causes increased stress and is especially a burden on female-headed households and families with children. By 2001, 22,000 children under 15 had lost one parent due to AIDS. Often, children are forced to become care givers, drop out of school, and are less likely to complete their education for financial reasons. The stigma associated with HIV/AIDS, IDU and SW causes marginalization and employment discrimination.

Under Vietnamese law, HIV/AIDS-infected people are eligible for regular social assistance from the government. But research indicates that this social assistance is inadequate for households that lose a primary income earner or sustain a chronic health problem. The Government has moved to alleviate this problem, though constraints remain. While up to 18 million people are covered by fee reimbursement or government-funded health insurance, the decision to provide HIV coverage has not yet been made (though there may be some coverage for opportunistic illness). The poor may generally receive hospital care in the case of AIDS-related illness, but there is no comprehensive care and treatment program, and health insurance coverage is limited. Social protection facilities for up to 8000 children plus support of VND 270,000 per day (double the usual rate) have been made available under the law to children and families with HIV. However, the lack of trained community social workers means that little effective can be done for children living with HIV in the community.

The evidence therefore indicates that the household costs associated with ill health and with health care, and particularly the financial burden of HIV/AIDS, are a significant cause of poverty and impoverishment. It is also clear that poverty is a major risk factor for HIV infection. Consequently, the fight against poverty and the battle to reduce HIV transmission rates go hand in hand.

#### **D. Cost-effectiveness of prevention and harm-reduction activities**

The prevention of HIV/AIDS is more cost-effective than treatment and care. The cost-effectiveness of reducing HIV transmission through preventive and harm-reduction activities has been demonstrated in a number of places internationally. There are both microeconomic (individuals and families) and macroeconomic (productivity and output) costs of HIV/AIDS that may be avoided by successful preventive programs. At the microeconomic level the

costs of HIV transmission are high, particularly as the disease almost entirely affects working-age adults. HIV/AIDS initially reduces both the quantity and the quality of household labor (domestic and commercial) as the productivity of household members with HIV is affected and again later when AIDS leads to death. These microeconomic costs are represented by foregone earnings, exacerbated by additional earnings foregone when family members become care-givers, and when there are multiple HIV infections in one family.

Preventive and harm-reduction activities have been widely recognized as particularly effective means of reducing HIV transmission. The experience in Thailand where the incidence of HIV was significantly reduced during the 1990s is a case in point. The benefit-cost ratio of Thailand's 100% condom promotion was almost 15:1.<sup>8</sup> Similar results are evident in Cambodia. It is accepted that harm-reduction activities are more effective in reducing HIV transmission in countries like Viet Nam where the epidemic is growing than in countries where it is stable or declining. The situation in Viet Nam, where HIV/AIDS is concentrated currently in high-risk groups including IDUs and SWs and in the 20–29 years age group, is particularly appropriate for the implementation of cost-effective preventive and harm-reduction activities. High-risk groups provide a focus for activities, and, by limiting the spread of the epidemic to the general population, the future potentially high costs of prevention, treatment and care for a rapidly expanding epidemic might be avoided.

The Project is situated within the context of the recently adopted National Strategy on HIV/AIDS Prevention and Control. Already, there are a number of donor-supported HIV/AIDS programs in Viet Nam, including the World Bank Viet Nam HIV/AIDS Prevention Project. The proposed HIV/AIDS Prevention among Youth Project will collaborate with the Government and other donors to avoid duplication of activities by choosing locations and activities that are not currently receiving adequate donor funding. The Project will consequently focus its activities on those areas where the impact is greatest, particular on IDUs and SWs through behavior change communication and harm reduction and to non-infected youth who are potentially at risk. The most cost-effective approach is to focus on those groups most in danger of HIV infection.

The Project will directly benefit youth and vulnerable groups (particularly IDUs and SWs) by restricting the transmission of HIV. This will be achieved through direct intervention in harm reduction, IPC activities and the proposed BCC package broadcast to the general population. Taken together, the package of activities proposed by the Project will act to reduce risky behaviors among high-risk groups and to educate the wider population about the dangers of HIV transmission.

## **E. Benefit-cost assessment**

This economic analysis uses a benefit-cost approach to measure the potential impact of Project activities. The analysis is based on epidemiological data presented in the HIV/AIDS Estimations and Projections 2005–2010 using the framework developed by the Viet Nam Technical Working Group on HIV Estimates and Projects. The Benefit-cost model is based on a program-design approach that involves choosing the least-cost methods for meeting the social demand for preventive and harm-reduction activities by targeting youth and those most at risk. The approach then determines whether economic benefits exceed economic costs, considering future benefits, gains in productivity, economic growth, and improved standards of living. The analysis also considers the distribution of benefits with regard to the high-risk groups.

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<sup>8</sup> World Bank, 2005 (March 7), Project Appraisal Document on a Proposed Grant to the Socialist Republic of Viet Nam for the Viet Nam HIV/AIDS Prevention Project, Human Development Unit, East Asia and Pacific Region, Report No. 30319-VN, p.65.

The World Bank recently conducted a benefit–cost simulation for harm–reduction activities for the preparation of its Viet Nam HIV/AIDS Prevention Project using an approach and data similar to those required for the ADB HIV/AIDS Prevention among Youth Project. The Bank’s calculations indicated a benefit–cost ratio of between 4:1 and 8:1 over five years 2006–2010. While there are differences between the two projects, the similarities are such that the Prevention among Youth Project can be expected to achieve outcomes of the same order. This is consistent with benefit ratios found in other countries.

The World Bank bases its assessment on the epidemiological model developed by the Viet Nam TWG on HIV Estimates and Projections (MoH 2005a). The estimates made by the TWG are accepted as a counterfactual progression of the disease in the absence of the proposed intervention. The Bank accepts an adult prevalence rate of 0.44% in 2003 as the starting point, and apparently bases its calculations on prevalence in the 15–49 year age group (which covers 95% of HIV/AIDS cases and includes the economically active section of the population).

The TWG epidemiological model produced an estimate of 144,982 new infections in the period 2005–2010. The Bank’s analysis produces a mean of 21,904 infections averted (across a range of 10,555 minimum to 30,449 maximum) or an overall 15.1% reduction in infections due to its harm–reduction activities. These numbers imply reduced HIV prevalence in the order of 7.3% to 21.1% as a result of Project interventions. The resulting prevalence rates following Project activities would therefore be across the range illustrated in Table 2.

*Table 2: Estimates of project impact (World Bank HIV/AIDS Prevention Project): Fall in adult HIV prevalence 2005–2010.*

Range of estimates:	Reduction in number infected due to project activities %	Prevalence rate in 2010 (15–49 y.o.) %
Without Project interventions	Zero reduction	0.628*
Low scenario	7.3%	0.604
Medium scenario	15.1%	0.592
High scenario	21.0%	0.581

Note: \* figure taken from TWG estimates (MoH 2005a)

The Bank’s calculations assume the impact of project activities would be a conservative 25% reduction in infections in the project provinces during 2006–2010. It is also assumed that the impact of project activities on the national rate of HIV transmission would be a conservative 2.5% reduction in infections. The Bank calculates the monetized benefits for reduced HIV infection as the costs of medical treatment foregone, plus the value of lost earnings of PLWHA due to increased mortality, plus the value of lost earnings of typical familial and unpaid care givers.

Other assumptions include: the number of productive work years lost due to HIV death is 20 across all individuals; life expectancy for PLWHA is 5 years; as an average 2/3 IDUs are unemployed prior to infection, their income losses due to HIV/AIDS are calculated as 1/3 of average male earnings; income losses due to HIV/AIDS for SW are calculated at average earnings for urban female workers; wages growth averages 2% p.a.; 2/3 of PLWHA require a care giver; 74% of care givers are women (mother, sister, wife) providing an average 5 hours a day care; 1/4 of care givers must give up a job; the annualized income of caregivers who give up a job is USD 396 and a further one–third of care givers reduce working hours equaling an annual loss of USD 382; the loss of income by care givers and increased medical costs for PLWHA occur in the final year of the illness. Based on the UNDP qualitative study and a household out–of–pocket spending rate equal to 62% of total health costs (VNHS 2001–2), the average per capita health expenditure per PLWHA would be USD 104

in the first four years of illness and USD 714 in the last year of life. Therefore, average annualized loss for caregivers in USD 228.28 and care occurs in final year of life of PLHWA.

After applying a discount rate of 10% (which is conservative for health projects), the World Bank estimates that the total Project expenditure of USD 35m will have a net present value (NPV) of USD 28.2m (based on the disbursement schedule). It calculates the median NPV of total costs averted at USD 114.6m for a benefit–cost ratio 4:1. Additionally, the median NPV of savings to the health care system due to reduced expenditure on PLHWA is estimated at USD 13.8m., resulting in a net project cost of USD 14.3m and a net benefit–cost ratio of 8:1.

The benefit–cost calculations made for the ADB HIV/AIDS Prevention among Youth Project are based on these assumptions and cost calculations provided by the World Bank and the data presented in HIV/AIDS Estimates and Projections 2005–2010. The results of calculations made using these parameters for the targeted provinces are summarized in the table below. The data must be treated with care. Sufficient data was not available to the design mission to calculate the value of benefits and costs with a high degree of accuracy. A simple calculation was made using the World Bank assumptions and MoH estimates, national averages for prevalence, and population numbers from the provinces targeted by the Project. Two scenarios were calculated, the first based on the assumption (consistent with World Bank calculations) of a 25% reduction in HIV infections in target provinces and a 2.5% reduction in the rest of the country. The calculation produced a benefit–cost ratio of 11:1. A more modest scenario assuming a reduction only in new infections (25% in target provinces and 2.5% nationally) produced a benefit–cost ratio of 3:1. Even with this more limited assumption, the project should proceed. Table 3 summarizes the results of the benefit–cost assessment for the upper scenario.

*Table 3: Anticipated outcomes by end of Project and benefit–cost ratio*

Indicator	Outcome by end of Project 2010
Total national population 15–49 years	57,574,707
Population of target provinces 15–49 years	14,944,057
Population of non–target provinces 15–49 years	42,627,609
Est. national prevalence w/o Project (% of population 15–49)	0.54%
Est. national prevalence with Project (% of population 15–49)	0.50%
Est. # of infections w/o Project	313,206
Est. # of infections averted due to the Project	25,125
NPV of total costs saved (benefit) in all provinces due to Project	USD 195,306,760
NPV of total Project expenditures (cost) incl. ADB and GoV	USD 17,811,923
Benefit–cost ratio	11:1

## **F. Financial analysis**

The Bank is providing US\$20 million in funding to the Executing Agency, the VCPFC, as a grant, managed through a program approach to implementation. The GoV will provide an additional US\$4.3 million as an in–kind contribution to Project funding, for a total Project budget of US\$24.3 million. Sections 2(h) Economic and Financial Analysis, 3(d) Cost Estimates, and 3(c) Financial Plan summarize the financial characteristics and main estimates of the Project. Full budget tables are included in Appendix D Budget Tables.

Indicative Project budget:

The budget presented here is an indicative budget covering the five years of anticipated Project activities. The budget is based on the implementation schedule for Project activities and reflects the best estimate of the distribution of Project funding across the main components for the five–year duration of the Project in line with the implementation schedule. As a program, the proposed activity will remain flexible in its implementation. In the first place, fund-

ing will be provided in tranches and will be dependent upon the satisfactory performance of the Executing Agency and the achievement of nominated performance milestones. Secondly, the scheduling and implementation of Project activities remains flexible and subject to review and redesign over the course of the Project depending on changes in circumstances and the experience gained from implementing Project activities. It is possible, therefore, that the indicative budget presented here may be subject to revision in light of changing circumstances or changes in the design and implementation of activities. All such revisions of the schedule of activities, implementation schedule, and/or budget figures must be negotiated and agreed through the Executing Agency and the Bank.

The following tables summarize Project funding by component and by year. The main part of the funding is allocated to BCC activities included in Component 2 Mass Media and IPC Materials (46% of total funding) and Component 3 Community-based HIV Prevention (31% of total funding). Funding under Component 2 includes the production and broadcast of national television and radio programming, which will be offered as a sub-contract to a selected enter-educate mass media agency. Twenty nine per cent of Project funding is expended in the first two years, which comprises an initial funding tranche of approximately US\$6 million, and 52% of the budget or US\$12.5 million is expended in years three and four, when the bulk of activities will be implemented across the 15 selected provinces. A second funding tranche of approximately US\$5 million will be paid to cover activities in Year 3, and a third tranche of US\$9 million will be paid for the final two years.

#### Budget summary by component and by year in US\$

Component	Y1	Y2	Y3	Y4	Y5	Total
ADB Base Costs						
1. Advocacy	161,500	169,000	340,500	354,500	152,000	1,177,500
2. Mass Media and IPC Materials	744,507	2,486,395	2,687,805	2,404,835	1,604,393	9,927,935
3. Community-based Prevention	45,000	1,087,150	1,618,400	2,017,400	1,333,265	6,101,215
4. Project Management	571,749	172,597	155,244	105,426	187,712	1,192,728
Total ADB Base Costs	1,522,756	3,915,142	4,801,949	4,882,161	3,277,370	18,399,378
GoV contribution (incl. taxes and duties)	484,804	521,640	841,930	1,141,601	1,098,076	4,088,051
Physical and price contingencies	148,322	363,485	452,998	488,365	363,038	1,816,208
Total Project Budget	2,155,882	4,800,267	6,096,877	6,512,127	4,738,483	24,303,636
Per cent of total budget	9%	20%	25%	27%	19%	100%

Notes: a. Includes taxes and duties: VAT (5% and 10%), MV tax, income tax; b. Based on latest ADB data.  
Source: Government staff and estimates.

#### Budget summary by component, local and foreign currency, investment and recurrent costs in US\$

Component	Local currency	Foreign currency	Investment costs	Recurrent costs	Total budget	Per cent of total budget
Base Costs						
1. Advocacy	140,000	1,327,149	1,177,500	289,650	1,467,150	6.0%
2. Mass Media and IPC Materials	2,005,560	8,012,375	9,557,515	460,420	10,017,935	41.2%
3. Community-based Prevention		6,832,215	6,101,215	731,000	6,832,215	28.1%
4. Project Management	671,400	2,917,528	967,000	2,621,928	3,588,928	14.8%
Total Base Costs	2,816,960	19,089,267	17,803,230	4,102,998	21,906,228	90.1%
Taxes and duties		581,201		581,201	581,201	2.4%
Physical and price contingencies	186,533	1,629,675	1,525,464	290,474	1,815,938	7.5%
Total Project Budget	3,003,493	21,300,142	19,328,693	4,974,673	24,303,366	
Per cent of total	12%	88%	80%	20%		100.0%

Notes: a. VAT (5% and 10%), MV tax, income tax; b. Based on latest ADB data.  
Source: Government staff and estimates.

Annual budget allocation have been made on the assumption that the Project will commence in five provinces in years one and two, expand to 10 provinces in year three subject to satisfactory outcomes, and expand again to 15 provinces in years four and five, also subject to satisfactory performance. All line items listed in Component 2 that relate directly to the production and broadcast of national and provincial television and radio materials are to be packaged as a single Request for Tender and offered to a selected enter-educate media agency with experience in the production of HIV/AIDS-related media materials. While the sub-contract will be subject to negotiation with the successful bidder, the activities and costs included in the Project budget are indicative of the required Project activities to be sub-contracted and are based on similar activities in neighboring countries. This sub-contract will be offered with a total contract value of approximately US\$10 million.

Contingencies have been estimated for variations in the extent of activities and the quantity of mass media and IPC materials required and for variations in price of inputs due to inflation and other price-effective events. These contingencies have been estimated on relevant line items at the established ADB rate of 5% for quantity contingencies, 6% for price contingencies in Vietnam, and 1.9% for international price contingencies. As a development activity, the Project is exempt from government duties and charges, which have been included as a GoV contribution. All project equipment and supplies will be purchased from local suppliers and will therefore not be subject to import duties.

As the Executing Agency, the GoV will provide an in-kind contribution to the project totaling US\$4.3 million over five years, or 22% of Bank funding. Project expenditure will be placed almost entirely within country. Of the total program budget, 87% will be expended in local currency and 13% in foreign currency. Funding for the Project comprises predominantly an investment cost (82% of budget) that will finance all Project activities for five years. Recurrent costs associated with the Project mainly include expenditures by the VCPFC and partner ministries for the management of the PMU and PPMUs and support for the implementation of Project activities through establish structures. These recurrent costs are funded as an in-kind contribution from the GoV and do not constitute an ongoing burden for the implementing agencies beyond the scope of the Project. Project activities should therefore be financially sustainable. Recurrent costs therefore comprise a range of office, administrative and management activities in support of the implementation of the Project, including appropriate office space, utilities, telecommunications, supplies, and staff time for those involved in the management and supervision required to carry out the responsibilities of the EA during Project implementation.

#### **Financial management arrangements:**

The Project budget was prepared in consultation with the staff of the VCPFC, which will manage and administer the financial and accounting requirements of the grant. The VCPFC will work according to the accounting regulations of the Government of Viet Nam and the Bank's disbursement procedures.

Funds for Component 2 Mass Media and IPC Materials are earmarked for a contracted enter-educate mass media provider, which will implement all activities under the component under sub-contract to the EA. There are three exceptions to this: funding under Component 2 for the establishment and operation of the Resource Centre, the design and maintenance of the website, and the publication of newspapers, magazines and articles will all be expended directly by the EA. Additionally, the production of IPC materials will be sub-contracted by the EA to an appropriate supplier (separate from the contracted mass media agency).

Funds have also been earmarked under Component 3 Community-based HIV Prevention to sub-contract different Non-Government Organizations to establish and operate VCT ser-

vices, to train and supervise community collaborators, and to supervise peer education activities.

Project management and administration is the responsibility of the national and provincial PMUs working under the direction of the VCPFC. Funds have been allocated to capacity building activities to strengthen the ability of the EA to manage the Project. The amount of international technical assistance has been kept to a minimum, with short term advisors contracted only for capacity building, monitoring and evaluation tasks, and advising on youth-related HIV/AIDS issues. International technical assistance required for mass media production has been packaged within the sub-contract to be allocated to a selected mass media agency. Technical assistance required for the implementation of Community-based harm reduction and HIV prevention activities under Component 3 will be included within the sub-contract arrangements with contracted NGOs.

To facilitate efficient financial management, the Project will fund the VCPFC to purchase common accounting software for the national and provincial PMUs and provide training for all accounting staff in its use. The software will be tailored specifically to the financial recording and reporting needs of the Project and a uniform system enforced at national and provincial level. These financial management and accounting procedures will be carried out in accordance with the requirements of the GoV and the procurement regulations of the Bank. The national and provincial PMU accounts will be audited annually by an independent external auditor.

## d. Review of International BCC “Enter–Educate” Initiatives

### Introduction

The term “Enter–Educate”, often credited to the Johns Hopkins University Center for Communication Programs, is a contraction of the words “entertainment” and “education” which describes any communication presentation that delivers a pro–social educational message in an entertainment format. The highly popular enter–educate approach has proven itself a very persuasive means of communicating a pro–social message. The feelings that emotional performances convey can make enter–educate messages resonate at a personal level and often elicit passionate participation from the receivers of the messages.<sup>1</sup>

Every enter–educate product consists of two equally important parts: the format (entertainment) and the message (education). The purpose of entertainment is to attract and hold the attention of the audience by engaging their emotions. The purpose of education is to enhance the knowledge and skills of the learners so that they can make informed choices.

Delivering information via entertainment programming has proven to be a strong force for public health. In countries around the world health professionals have worked with TV producers to include HIV/AIDS prevention messages in dramas, comedy and soap opera. The result is that hundreds of millions of people are reached every week with messages on public health issues—including HIV/AIDS—that they actively listen to and are that delivered by people just like themselves — people they can relate to. An early indication of the enormous potential of enter–educate programming came in 1986, when a character on Venezuela’s *Cristal* was diagnosed with breast cancer. The episode led to an avalanche of female patients getting check–ups in Venezuela and in Spain, where the series was also aired.<sup>2</sup>

According to research carried out by the Johns Hopkins Population Communication Services Program, health promotion by means of entertainment can help to capture audience attention, create role models, show the consequences of behavior, and provide an emotional impact that helps clients to understand and remember the advice that is given. While enter–educate program story lines may be exaggerated renditions of real–life dramas, many viewers see their own lives reflected in the characters and identify themselves and others they know with various characters. Thus, modeling a behavior they see on screen is almost natural.<sup>3</sup>

### The Process

The success of a multi–media enter–educate program is not accidental. A long–term investment in time, talent and financial resources is necessary in order to develop programming that will attract and influence target audiences. A successful enter–educate series requires in–depth research on audience preference, strategic decisions on talent, scripting and positioning of the issues to be covered, pre–testing, media promotion and monitoring and evaluation.

Of critical importance is the selection of a highly skilled design team responsible for crafting the overall focus, tone and messages to be included in the program. A design team is usually comprised of stakeholders, scriptwriters, media experts and health professionals. Together they work to prepare a creative brief which spells out messages to be included in each episode and serves as a blueprint for the scriptwriter(s) whose task is to create an entertaining story.

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<sup>1</sup> Under The Green Umbrella: Social Dramas For Health, presented at the Fourth International Entertainment Education Conference, Cape Town, 2004

<sup>2</sup> Perspectives in Health Magazine, The Magazine of the Pan American Health Organization; Volume 8, Number 2, 2003

<sup>3</sup> Ibid.

Essential to the success of an enter–educate program is the development of realistic and believable characters. The target audience must identify with the characters so that they will be inspired by positive role models to change their behavior and be discouraged by negative behavior and its consequences.

Finally linking mass media enter–educate programs to interpersonal communication interventions such as outreach work by health workers and peer education among high–risk groups can enhance the reach and impact of television and radio based programming.

In short, the process involved in developing a successful and influential enter–educate program involves:

1. formative research investigating the knowledge, attitudes, practice and beliefs of the target audiences;
2. formation of a highly skilled design team including stakeholders, scriptwriters, media experts and health professionals;
3. development of believable, realistic characters and story lines;
4. involvement by a skilled and creative, full–service production agency in the design and production of the program and supporting interpersonal communication materials;
5. participation by well known TV/film actors;
6. development and delivery of linked interpersonal communication activities; and,
7. full government and sponsor support to ensure prime time placement

### **Examples**

Enter–educate approaches are used today in communication at various levels including popular music, street theatre, puppet shows, community drama and the like. But above all, they are incorporated in television and radio. There is increasing evidence from many projects that enter–educate approaches are effective in reaching people, increasing their knowledge and influencing their behavior (see examples below).

Enter–educate program experience in Viet Nam includes the 30 part television soap opera, “Wind Blows through Light & Dark”, which had HIV story lines, as well as the ongoing 26 part television drama “Overcoming Challenges”, promoting preventive health issues such as home and traffic safety, HIV/AIDS, family planning, drug abuse, nutrition, immunization and sanitation. The following of internationally recognized and evaluated enter–educate interventions hopes to build on this Vietnamese enter–educate experience and serve as a model for the development of similar approaches in Viet Nam.

### **BBC World Service Trust — Phnom Penh, Cambodia**

The BBC World Service Trust (BBCWST) is the international charity of the BBC which uses media and innovative communications methods to advance development worldwide through the innovative use of media. The Trust’s work seeks to raise awareness among mass and opinion–former audiences; affect behavior change; influence policy and transfer skills and knowledge.

The BBCWST is funded by many organizations including DFID and USAID, UN agencies, private foundations and others. BBCWST is currently working in thirty countries around the world in places as diverse as Iraq, Indonesia, India, Angola, Cambodia, Ukraine and Nigeria. Within health the Trust has worked on many issues including leprosy, polio, trachoma, maternal and child health, and most importantly HIV. The Trust is running HIV/AIDS mass media campaigns in India, Cambodia, Nigeria, Tanzania and Angola—with more projects due to start soon.

In Cambodia the Trust has worked with the Ministry of Health to produce *Taste of Life*, a major new TV drama spearheading the mass media health campaign in Cambodia. The series follows the stories of the young doctors and nurses as they confront health matters in their working lives.

The BBCWST Cambodia project represents the first-ever mass media campaign in the country to integrate HIV education with other national health priorities, including reproductive, maternal and child health. All messages and outputs have been created and produced in close collaboration with the Royal Government of Cambodia's Ministry of Health. In addressing HIV/AIDS, the campaign seeks to recognize the linkages between general health, livelihoods, gender relations and life skills in the development of health-seeking norms and behaviors at both an individual and community level. The project includes 17 waves of TV and radio spots, four radio phone-in programs and a TV drama series produced entirely in Cambodia. There is also an extensive research element to the campaign, in which all outputs are pre-tested and monitored. Production and research elements include capacity building of local staff of the BBCWST, staff of media partners, and institutional capacity building for partner institutions.

The media campaign integrates vital HIV/AIDS information with other national health priorities, such as maternal and child health, by using the television drama, radio phone-in programs, and radio and television advertising to convey the messages to the Cambodian audience.

Four radio call-in programs are broadcast every week, each focusing on different types of audiences. Radio call-in shows are used both to provide direct health-related information and to facilitate community discussion about health issues introduced in the *Taste of Life* TV drama.

Pregnancy, drug use, STI and HIV/AIDS prevention and testing are just some of the topics that have been discussed on the youth sexual health radio phone-in. Calls to the program often reach capacity; the show that addressed HIV/AIDS was particularly open and frank with young callers raising a gamut of sexual health issues. Unprecedented in Cambodian radio phone-in programs, there has been an excellent response from female listeners, with over 50% of calls from women whereas most shows get a majority of calls from men.<sup>4</sup>

TV and radio "spots" developed by BBCWST and linked to the TV drama provide direct health information while others address attitudes and encourage community discussion. TV spots are broadcast in "waves", each wave including between three and five different thematically related spots broadcast over a seven week period on two TV stations. Each spot is broadcast 77 times in each wave. Radio spots are produced by local media partners, with 490 spots broadcast every week.

In addition to electronic mass media production the BCCWST produces a comic based on the *Taste of Life* television drama. A total of 66,000 copies are produced on a monthly basis with 30,000 being inserted into the *Popular* magazine (a local, youth-focused bi-weekly publication) and the balance being used in interactive (face-to-face) education by UNICEF, Population Services International (PSI), CARE and government health promotion partners including the Ministry of Education, Youth and Sports (a total of 36 organizations including those listed and many local NGOs).

### **Soul City TV and Radio Drama — South Africa**

A notable success story is that of The Soul City Institute for Health and Development Communication. This South African NGO, established in 1992, uses the power of mass media for

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<sup>4</sup> [http://www.bbc.co.uk/worldservice/trust/news/story/2005/04/050408\\_cambodiaroundup.shtml](http://www.bbc.co.uk/worldservice/trust/news/story/2005/04/050408_cambodiaroundup.shtml)

social change. The enter–educate methodology used by Soul City weaves social issues (HIV/AIDS and a variety of other topics including tobacco, tuberculosis and domestic violence, etc) into television and radio entertainment programs and supporting print materials.

Its key vehicles are the prime time television dramas *Soul City* (aimed at the general public) and *Soul Buddyz* (aimed at 8–12 year olds and their caregivers), accompanied by radio drama programs and print materials for use in schools, youth groups, community groups and other interpersonal communication settings.

The supporting interpersonal communication materials for use in groups are based on the enter–educate story presented in the television dramas. Materials explore issues raised in the series in greater depth. Because they are linked to the television and radio drama these materials have been found to be more powerful and credible than unlinked materials.<sup>5</sup>

The enter–educate methodology used by the Soul City Institute for Health and Development Communication weaves social issues (HIV/AIDS and a variety of other topics including tobacco, tuberculosis and domestic violence, etc) into the television and radio entertainment programs and supporting print materials.

The Soul City project has become a household name in South Africa, where its combination of electronic and print media reaches millions of people. As a result, the project has gained a high level of credibility in the spheres of government and civil society. This has allowed the project to expand on its original function and engage increasingly in advocacy work, focusing on appropriate policies and legislation necessary to create an enabling environment for social change and the protection of human rights.<sup>6</sup>

The sixth series of Soul City consisted of television drama, radio drama and print materials dealing with a variety of issues including AIDS and children, xenophobia, asthma, depression and adult learning. An evaluation carried out in 2005 found that the recognition and reach of Soul City products were quite high; 53.5% of adults and 61.5% of children had watched the television, while a third of adults and 26% of children had listened to the radio.<sup>7</sup>

More importantly, the evaluation indicated that Soul City had a direct impact on people's attitudes and behaviors regarding HIV/AIDS.

The aim of the HIV and AIDS message in Soul City 6 was to draw attention to the effect of the epidemic on children; it intended to increase the intention and positive caring and supportive behaviors towards affected people and especially children. Research revealed that when asked whether AIDS in a family affects children emotionally, there was a significant change from before the intervention when 74.4% agreed or strongly agreed that AIDS in a family affects children emotionally. After Soul City 6, 80.5% agreed or strongly agreed. Talking about HIV and AIDS is an important step in assisting children to cope with the trauma of dealing with HIV and AIDS. Parents exposed to Soul City TV and radio were more likely to talk to their children about HIV and AIDS, illness, death and dying than parents not exposed. Medium exposure to Soul City print material increased the likelihood of parents talking to children about these issues by 66%.<sup>8</sup>

A complete set of evaluation reports on the reach and impact of Soul City over the years can be found at <http://www.soulcity.org.za/>.

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<sup>5</sup> <http://www.soulcity.org.za/01.01.asp>

<sup>6</sup> Mass Media and Beyond: Exploring the Links—Expanding Impact; Penny Dlamini, presented at the Fourth International Entertainment Education Conference, Cape Town, 2004

<sup>7</sup> Evaluation of Soul City—Series 6; Social Surveys (Pty) Ltd., 2005

<sup>8</sup> Ibid.

### **Shabuj Shathi — Dhaka, Bangladesh**

Shabuj Shathi, a 13-episode television drama serial, was launched in September 1996 as a part of the Green Umbrella campaign by the Bangladesh Ministry of Health. The Green Umbrella campaign focused on promoting integrated maternal and child health and family planning services in the country. The main objective of Shabuj Shathi was to encourage audiences to develop trust and confidence in field workers (health workers) as sources of information on health and family planning services. In addition, the drama aimed at reinforcing the efforts of the field workers themselves by providing them a role model as the heroine.

The story of Shabuj Shathi revolves around Bokul, a young female field worker, who overcomes many challenges in her efforts to provide services to her community members. The drama scripts were written in a manner that acknowledged the social realities of rural areas and addressed important health questions.

Shabuj Shathi was quantitatively evaluated as a part of the 1998 National Media Survey, conducted in May 1998. Nationally, the television drama was watched by 35% of Bangladeshis 15 years and older. However, 79% of the Bangladesh population in urban areas and 65% in rural areas with access to television watched Shabuj Shathi. More than 50% of these viewers watched at least half the episodes and almost all indicated that they would like to watch a rebroadcast of the drama. The quality of the writing and production was such that Lever Brothers sponsored the drama by paying for airtime and contributing to production costs.<sup>9</sup>

Overall health knowledge was found to be significantly related to the number of episodes watched and number of messages recalled. Visiting a family planning or health facility was also significantly related to watching the drama. Almost 35% of married women who watched the drama said that they had visited a family planning or health facility within the last 6 months compared to 23% of those who did not watch the drama. Married women who saw the drama were found to be 1.8 times more likely to have visited a health facility and 1.6 times more likely to use a modern contraceptive than women who did not watch Shabuj Shathi.<sup>10</sup>

Other results indicate that:

- About two-thirds of the audiences who had watched Shabuj Shathi advised someone in their community to adopt family planning.
- Over half of the audiences who had watched the drama visited health centers to obtain individualized health services after watching the serial.
- Over half of the people who had watched the drama advised a pregnant woman to seek prenatal care.

### **Balbir Pasha HIV/AIDS Campaign — Mumbai, India**

The Balbir Pasha HIV/AIDS Campaign, executed from November 2002 to February 2003, was aimed at urban men aged 18–34 in the lower socioeconomic groups in Mumbai, India. The campaign sought to dispel HIV/AIDS myths, increase risk perception, generate discussion, and motivate people to access HIV/AIDS hotlines and voluntary counseling and testing (VCT) services.

The strategy consisted of linking mass media (hard-hitting television and radio messaging, comprehensive newspaper exposure and posters in trains and on bus shelters) with services such as an HIV/AIDS help line (phone) and VCT.

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<sup>9</sup> [http://www.jhuccp.org/topics/enter\\_ed/eeprojects/02-18.shtml](http://www.jhuccp.org/topics/enter_ed/eeprojects/02-18.shtml)

<sup>10</sup> Ibid.

Despite the short duration of the campaign and the objections to the directness of the messages, results were very impressive: the proportion of target audience going to commercial sex workers and feeling that they are at high risk for HIV if they had unprotected sex with a non-commercial partner increased from 17 per cent to 43 per cent. More than half (54 per cent) of the respondent population recalled having discussed the campaign with somebody else, an indicator of the strategy having brought the topic into the public domain. More than a fourth of respondents (28 per cent) recalled the name of the confidential Saadhan HIV/AIDS helpline that was featured as part of the campaign, and 60 per cent of respondents stated that they might call in the future. Actual calls to the helpline showed a 250 per cent increase following the campaign. Individuals reporting having used a condom on their latest visit to a commercial sex worker rose from 87 per cent to 92 per cent. As a proxy indicator, retail sales of condoms in the “red light” district, the priority focus area for the campaign, tripled after the launch of the campaign as compared to before the campaign started. A significant qualitative indicator of success was that the character created for the campaign—Balbir Pasha—entered the idiom of the city and was featured in the advertising of other products, newspaper cartoons and TV shows.<sup>11</sup>

### **Aahat (An Approaching Sound) — Pakistan**

Aahat, a television drama of six one-hour episodes and an accompanying mass media campaign, is a good example of the success of the enter-educate concept in disseminating family planning messages. It is a story of a young couple, their dreams, social pressures and the consequences of having too many children too soon. The overwhelmingly positive response that the drama received gave high visibility to family planning.

Formative research carried out to develop the drama series showed that awareness of family planning in Pakistan was high (above 80%), but contraceptive prevalence was quite low (below 15%) among the primary target group—Pakistan’s emerging middle and lower classes who are high consumers of mass media.

Message development for the television drama was carried through focus group discussions and in-depth interviews among middle income married men and women of reproductive age, as well as family elders, religious leaders, service providers and traditional medical practitioners. Ethnographic research on the process of family planning communication, particularly husband-wife communication, was carried out through a series of four socio-anthropological case studies.

The campaign consisted of two distinct components working in tandem to achieve increased husband-wife communication about family planning. One component was the television production, Aahat, which conveyed indirect messages about family planning interwoven into a social drama. In support of the drama, interpersonal communication materials and advertisements with direct family planning messages were developed, pre-tested and disseminated.

The drama and IPC materials had significant impact. Aahat swept the national media, making it the subject of numerous articles and cover-page stories. The key persons involved in the project became national celebrities, and the drama placed family planning at the forefront of the nation’s agenda. An evaluation revealed the following:

60% of final survey respondents viewed Aahat.

- Awareness of family planning methods increased from 87% to 94%;
- Positive attitudes about family planning increased from 65% to 75%;
- Viewer’s strongly approving of spacing increased from 69% to 79%;

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<sup>11</sup> Balbir Pasha: HIV/AIDS Campaign is the Talk of Mumbai", Population Services International, August 2003

- Over half of the viewers said they strongly agreed with messages about the economic impact of family planning, the need for husband–wife communication, the need for spacing children, the importance of the child and mothers health, and the need for small family size;
- Reports of talking “often” with one’s spouse about family planning increased from 46% to 54%;
- There was a 12% increase in discussion of contraceptive methods between those highly exposed to the drama and baseline respondents;
- 9% of viewers said they visited a clinic after seeing the film.

Aahat was viewed by an estimated 30 million people, and was among the most popular prime–time shows on Pakistan TV’s fall season. The drama was discussed on television talk shows and covered extensively in press.<sup>12</sup>

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<sup>12</sup> [http://www.jhuccp.org/topics/enter\\_ed/eeprojects/05–19.shtml](http://www.jhuccp.org/topics/enter_ed/eeprojects/05–19.shtml)

## **e. Gender Strategy**

### **Introduction**

#### **Approach to Gender Analysis and Strategy**

ADB's Policy on Gender and Development (GAD)<sup>1</sup> says gender should be treated as a 'cross-cutting theme' in ADB projects to 'correct gender disparities and promote the empowerment of women'. Design teams should consider the differential impact of the project, formulate strategies for equal involvement, and ensure that 'gender concerns and women's needs and perspectives are explicitly considered in all ADB operations, and that women participate in the decision-making process in development activities.' Whilst gender disparities persist in Viet Nam, HIV/AIDS is overwhelmingly a male epidemic, fundamentally influenced by masculine gender norms. Hence, it is vital that these norms be identified and challenged, and that males are involved in Project implementation, particularly given the difficulties in reaching and communicating effectively with marginalized young men. This is especially pertinent given the overrepresentation of women in the EA workforce, and among community collaborators. Because of women's relationships to HIV-positive men, they face special risks and burdens; a Project focus on gender norms for both sexes is one strategy to promote women's 'empowerment' and address their 'needs.' The Project will also promote gender equity through involving women in its implementation.

#### **Preparation Phase (Consultation and Review)**

Gender issues, gender balance, and mainstreaming of gender were prominent throughout the Design process. A gender focus was explicitly required by ADB for the TA; the Design team included 5 members with gender expertise. Both the expatriate and domestic teams had a gender balance. The Team Leader and Deputy were women. The Executing Agency, the VCPFC, is led by a female minister. A man leads the department that hosted the TA. The Steering Committee included a range of ministries with special responsibilities for the welfare of women, girls and youth in general.

The first half of the Design period was allocated to (a) conducting a situation analysis of youth HIV/AIDS transmission risk in Viet Nam through broad consultation and document review, and (b) developing potential interventions to address the underlying influences on transmission risk uncovered in the situation analysis. Discussions were held with over 600 people from about 150 organizations in large cities, provincial capitals, small towns and worksites in most geographic regions. Most informants were women, and the preponderance of organizations consulted had primary focus on women's lives and roles. The TA team addressed this disparity by requesting meetings with male youth, including unemployed school drop outs.

The situation analysis revealed the key role of normative gender expectations in creating HIV transmission risk for both sexes. Norms are enduring and associated with a range of health risks (Dang Nguyen Anh 2005; Morrow M, et al 2002; NCFAW 2002). Interventions to address these norms were developed, and then refined through an iterative process with the EA, Steering Committee, ADB, INGOs, NGOs, PLWHA, and the Design team.

#### **Project Design and Implementation**

The Project calls for representation from male and female youth in all phases, beginning with Formative Research. This initial phase will enable the elucidation of gender norms, as well

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<sup>1</sup> Asian Development Bank. 2003. Gender and Development in ADB Operations. Operations Manual Bank Policies. OM Section 2C/BP. Operational Procedures 2C/OP. 29 October 2003.

as the different circumstances and opportunities for young men and young women, which is crucial for the development of Component 2 mass media and targeted IPC materials, as well as for Component 3 gender training. Gender balance will be the sought for Project Management Units, master trainers and peer educators. Both young men and young women are needed to reach their peers (and will benefit from training and skills development). It is expected that the majority of teachers and collaborators involved in Project implementation will be women (efforts will be made to recruit men for these roles, where appropriate and feasible). NGOs with expertise in gender will be sought for some Project activities. Gender awareness training will take place across most of Component 3. Gender balance will be sought for those involved in M & E.

### **Monitoring and Evaluation**

The M & E plan will ensure that sex-disaggregated data is collected at baseline (Formative Research), and through regular monitoring and evaluation to assess the impact of the Project on knowledge, attitudes, practices and beliefs of male and female youth, including gender norms. Monitoring will enable implementers to consider whether, and how, to modify the Project for the purposes of gender equity. Attention will be paid to identifying culturally-appropriate ways to challenge harmful gender norms through different approaches during the life of the Project. This is important because these norms are widely accepted, and not easily changed. Indeed, an earlier project evaluation concluded it should not be assumed that implementers share concepts of gender (Reerink A, et al 2003); therefore, Project M & E will need to manage this potential risk. Lessons learned in this regard will be disseminated through conferences, reports and articles. The midterm review and all main progress reports will be required to include information on (a) involvement of both males and females in Project implementation, including M & E; (b) impact of Project on gender equity (in terms of HIV risk as well as employment and decision-making within the Project); and (c) evidence about the extent to which harmful gender social norms have altered. The Project will require TA from gender specialists. TORs and Logframes make this explicit.

### **Gender Issues and HIV/AIDS in Viet Nam**

#### **Equity Profiles and HIV/AIDS<sup>2</sup>**

In its Viet Nam Country Strategy and Program Update 2005–2006, ADB notes (along with concrete achievements) areas of weakness relevant to youth HIV prevention, and to gender. These include:

- low quality of education;
- social issues such as drug addiction;
- weak managerial capacity in public administration, particularly at the grassroots level; and
- an incomplete monitoring and evaluation system.

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<sup>2</sup> Sources for this section include the following:

- ADB. 2004. Socialist Republic of Viet Nam. Country Strategy and Program Update 2005–2006.
- ADB JFPR Project draft report. 2005. Evaluation of Effectiveness of Project “Community Action for Preventing HIV/AIDS”. ADB JFPR: REG–9006. Hanoi, March 2005.
- Dang Nguyen Anh. 2005. Ibid. MoH, General Department of Preventive Medicine and HIV/AIDS Control. 2005.
- HIV/AIDS Estimates and Projections 2005–2010. MoH, UNAIDS, Hanoi.
- MoH. Survey Assessment of Vietnamese Youth. 2005. (with GSO, Unicef, WHO) Hanoi. MoH, NIHE, FHI, USAID.
- What can we do to control the HIV epidemic in Viet Nam? What high-risk groups have to tell us.
- National Committee for the Advancement of Women in Viet Nam. 2002.
- UNDP Viet Nam. 2005. Basic Facts about Viet Nam. March 2005. UNDP Viet Nam. <http://www.undp.org.vn/undp/fact/base.htm> (accessed 6 Sept 2005).
- UNICEF. 2003. The Situation of Families and Children Affected by HIV/AIDS in Viet Nam: a national overview. Final Report, August 2003. UNICEF Viet Nam.
- UN Country Team. 2004. United Nations Common Country Assessment for Viet Nam. Hanoi.

Unequal workloads, limited roles in community life, and discriminatory practices continue to affect women.

ADB has supported GAD in Viet Nam in a number of ways, e.g., through a new gender strategy for agriculture and rural development, and a gender equity law for National Assembly consideration in 2005. Indirectly, ADB has offered further support for gender equity by assisting provinces to incorporate the Comprehensive Poverty Reduction and Growth Strategy targets into their annual planning process.

Gender inequality persists in Viet Nam, although legal safeguards exist and the position of women is higher than in many countries. In 2003 Viet Nam's ranking among nations was 87/144 on the 'gender-related development index' and 112/177 on the 'human development index'. Life expectancy in 2002 was 66.7 years for men and 71.4 for women. While illiteracy levels are just 9%, about 2/3 are women; drop out rates continue to be higher for girls. In 2002, net primary enrolment was 93.9% and lower secondary enrolment was 65%. Net upper secondary enrolment in 2000 was 38%. In other words, most of today's youth did not complete high school, and over 2/3 did not complete lower secondary. Ethnic minority girls are most at risk of not completing primary school.

Female parliamentary representation, at 27.3%, is Asia's highest. However, their involvement is concentrated in social, ethnic and education committees. Women comprise just 8.5% of central Communist Party Committee members, and average 4.5% in Commune, and 6.4% in District, People's Committees. Women constitute 22% of central and 35% of district court justices.

Women greatly outnumber men employed in livestock (>70% vs < 50%) and slightly outnumber those in cultivation (82% vs 80%), but receive just 25% and 10%, respectively, of extension training. Women are more likely than men to work > 60/week, and undertake the vast majority of housework, with disparities increasing with age. Girls aged 11–14 work nearly twice as many hours as boys; for those aged 18–24, women average 500 hours of housework, and men 200 hours, per year.

In 2004 the UN estimated that about 26% of youth were under-employed, with highest unemployment (16%) in cities. Young women had slightly higher unemployment rates. Surveys show wages are higher for males at every education level, with the disparity greatest for the most highly educated. Many young women work in textile, footwear and food processing factories, where shifts are up to 11 hours, 7 days/week, and wages may be less than USD40/month. Many work for low wages in restaurants and bars.

Migration presents significant HIV risks for both young men and young women since they lack parental constraint and protection; loneliness, poor education, immaturity and poor Life Skills may lead to unsafe behaviors. For young male migrants, HIV risk arises within a sub-culture where commercial sex and injecting drugs are relatively common. Female migrants working as street vendors and housemaids may be sexually exploited or lured into the sex industry, with its increased risks of STIs and HIV. Poverty and indebtedness propel others into sex work (domestic and international), which offers far more lucrative income than factories. Anti-trafficking legislation has been promulgated, but it needs stronger enforcement. Street Children, many of them migrants, are highly vulnerable to sexual violence and exploitation. Often unregistered, migrants may not be reached by services and HIV interventions, including harm reduction, VCTs and ART.

MoH estimates that 86% of PLWHA are male, primarily through male injecting drug use and (to a lesser extent) involvement with sex workers. Because male–male sex is taboo, it does not feature in most HIV campaigns, contributing to ignorance and high risk behavior among MSM. Girls and women are vulnerable to infection because of biological factors, and be-

cause STIs tend to be less symptomatic, and less often treated, in women. About 18% of known AIDS deaths in 2002 were in women. Women comprise about ¾ of those caring for PLWHA (forcing some to leave employment), and increasingly are sole supporting parents as husbands become ill or die. By 2001, 22,000 children under 15 had lost one parent from AIDS. As noted elsewhere, all but the richest families with HIV-positive members will fall below the poverty line. HIV/AIDS is a disaster not just because of medical costs and lost income, but because stigma reduces family employability, sometimes necessitating relocation. Destitution leads women to reduce expenditure on self-care or education, increase workloads, and, for some, undertake sex work. Children may drop out of school for reasons of discrimination, or to care for PLWHA; as family income declines, pressure rises to leave school, thus reducing employment prospects, and making some vulnerable to sexual exploitation.

### **HIV/AIDS and Gender Norms<sup>3</sup>**

Traditional normative expectations for males and females are enduring and highly relevant for HIV transmission risk. While awareness of gender equity is high in Viet Nam, there is little awareness of the health risks from gender roles. These roles originate in Confucianism, are sharply delineated, and acquired early in life.

Females should be refined and gentle, obedient (to fathers, husbands and sons, in turn), sublimate themselves to the family, and take responsibility for home and children. Refinement extends to behaviors such as smoking (female rates are <4%, vs >50% for males) and drinking, as well as sexuality. Unemployed young women spend much of their time at home, not only for housework but because parents permit them less freedom; therefore, they are less likely to engage in risky behavior. Women should be virgins at marriage, and know little or nothing about sex. One rationale for male infidelity voiced during consultations is SWs' 'superior sexual skills'; couples with sexual problems rarely address these because they have never spoken about sex from the start. For the same reason, wives cannot easily ask husbands to use condoms, even when they fear contracting HIV/STIs. Women are also held responsible for family social and moral conduct; a traditional saying asserts that children become 'rubbish' (e.g., drug users) through bad mothering. There was nearly universal agreement among female informants that women are to blame for male infidelity by not maintaining their attractiveness and/or not creating a happy home for husbands.

From an early age, boys have more freedom, fewer household chores, and as they get older, are expected to be active outside, make key decisions, and engage socially with other men. As elsewhere, concepts of masculinity promote risk-taking (e.g., drug use) and discourage self-care. Unemployed young men are particularly vulnerable, as they spend more time outside of home and make easier targets for peers and for drug pushers, and usually lack skills to resist. Pre-marital and extra-marital relationships are not openly tolerated, but implicitly excused for men (but not for women). Sex workers, but not clients, are compulsorily detained. Current HIV and anti-drugs campaigns never mention sex-disparities in drug use, or gender norms linked to condom non-use. SAVY (2005) found youth had negative attitudes towards condoms; few mothers interviewed during consultations had spoken to sons about condoms. SAVY (2005) also found that while most youth of both sexes had fairly good

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<sup>3</sup> Sources for this section include the following:

- Courtenay WH. 2000. Constructions of masculinity and their influence on men's well-being: a theory of gender and health. *Social Science & Medicine*; 50:1385-1401.
- Jamieson, N. 1993. *Understanding Viet Nam*. Berkeley: University of California Press.
- MoH. 2005. *Survey Assessment of Vietnamese Youth*. 2005.
- Morrow M, et al. 2002.
- UN Country Team. 2004.

knowledge about HIV transmission, gaps and myths persist, and over 40% claimed not to have heard of homosexuality.

The target population for this Project is vulnerable not only through gender norms, but also because of their age. Youth as a life phase is an HIV risk internationally, but some Vietnamese cultural norms exacerbate this risk, as they require youth to be obedient, not challenge authority, and place service of the family above personal desires. These may inhibit children from confiding in parents or seeking information about sensitive issues such as sexuality or abuse. Young SWs typically undertake this dangerous work from a sense of filial duty. These norms also leave many parents uncertain about handling child discipline, as well as dialogue. The media barrage that portrays radically different youth lifestyles, as well as inter-generational relationships, has created a number of social challenges along with opportunities.

## **Project Benefits**

### **Impact of Achievement of Goal and Purpose**

This Project will expend a substantial proportion of its efforts towards challenging harmful gender norms, and through mainstreaming gender within implementation and M & E processes. Achievement of Project Goal and Purpose (reducing transmission and transmission risk) will confer direct and indirect benefits on both sexes, including vulnerable girls and women. A reduction in HIV transmission among men and boys will be beneficial for themselves, and release girls and women from the costs of caring, and losing, family members, and from the financial, emotional and psychological harm of stigma. It will further prevent male-female and mother-child transmission, with profound implications for productivity and earning capacity, as well as emotional health.

### **Impact of Components**

To the extent that Project Advocacy strengthens the implementation of the National Strategy, and introduction of harm reduction, VCTs and STI treatments, female sex workers and sexually active women will benefit from reduced HIV transmission risk (and the sequelae of untreated STIs). Men and boys will benefit from reduced transmission.

The drama series will seek to alter attitudes towards gender, youth, marginalized populations and PLWHA, over time, for a mass audience through a high-quality product. If effective, women and girls will benefit from a reduction in male risk behavior, and from more open, and equal, personal relationships (including across generations). Boys and men will benefit from safer practices and more positive attitudes towards women. The IPC activities will focus on vulnerable youth, and include a strong focus on gender training and gender awareness through workshops, peer education, outreach, classroom settings, and workplace programs. If effective, both sexes will be beneficiaries.

Through other Component 3 activities, young men (including MSM) and women will be at decreased risk of transmission from improved HIV knowledge, Life Skills, facilitation skills, harm reduction and vocational opportunities. Employment will help mitigate the risk of drug taking and commercial sex work.

### **Impact of Implementation**

Young men and women (including PLWHA) involved in implementing the Project will benefit from the acquisition of useful skills for future employment, and, for some, paid work during the Project's lifetime. Through involvement in M & E they will learn new skills, and, through

data gathering and analysis, achieve a deeper understanding of the role of gender and effective ways of decreasing its harmful impact.

## f. Implementation Schedule

Activities	Year 1				Year 2				Year 3				Year 4				Year 5			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
<b>Component 1 — Advocacy</b>																				
At National level																				
Appointment of the Youth Policy & HIV/AIDS Advisor	■																			
Development of the advocacy plan for the first two years		■																		
Youth related issues published in magazines and websites			■																	
National dissemination workshop				■																
Youth Information Packages				■			■				■			■						
Young people attend international conferences on youth						■				■				■					■	
2nd SAVY study											■									
2 research studies							■	■				■	■							
At provincial level																				
Awareness-raising workshop with provincial authorities		■								■										
Workshops with project implementing partners			■				■				■				■					■
Workshops with service providers at all levels				■			■				■				■					■
Policy makers forum	■				■					■				■					■	
Radio/TV talk shows in province		■	■		■			■		■			■		■			■		■
Community leaders/youth meetings			■				■				■			■				■		■
Young people attend regional or national level conferences				■			■				■			■				■		■

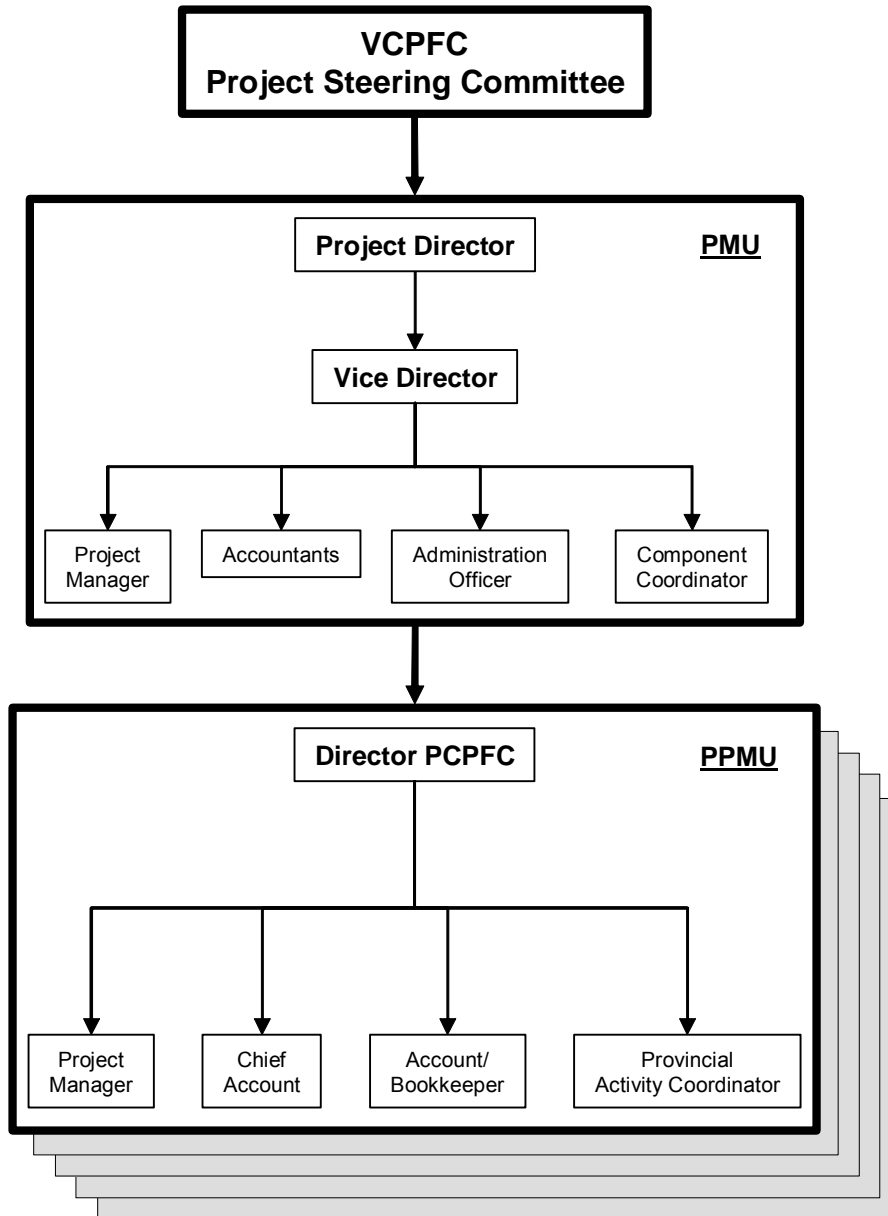
Activities	Year 1				Year 2				Year 3				Year 4				Year 5			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
<b>Component 2 — Mass Media and IPC Materials</b>																				
Contract agency to implement/manage Component 2	■																			
Formative/baseline Research		■	■																	
Report/disseminate findings				■																
Develop annual mass media and IPC material production plans			■				■				■			■						
Liaise with national television, provincial radio and publications	■	■	■																	
Recruitment and training of TV production staff		■	■																	
TV drama story development																				
TV drama script development		■	■																	
Production TV drama																				
Broadcast of TV drama																				
Monitoring of TV drama/qualitative research																				
Provincial radio phone-in program development			■	■																
Recruitment and training of radio production staff			■	■																
Broadcast of provincial radio phone-in program																				
Monitoring of radio phone-in & qualitative research																				
Contract publications to publish feature articles & columns			■	■																
Regular publication of articles and columns																				
Monitor publications/qualitative research																				
Design and production of first tranche of IPC materials				■	■															
Monitor distribution, use and impact of IPC materials																				
Design and production of second tranche of IPC materials																				
Monitor distribution, use and impact of IPC materials																				
Design and production of third tranche of IPC materials																				
Monitor distribution, use and impact of IPC materials																				
Contract company to develop and manage website			■	■																
Website operational																				
Monitor use of web site																				
Establishment of IPC Materials Clearinghouse				■	■															
IPC Materials Clearinghouse operational																				
Training of EA staff for Clearinghouse management				■	■															
Orientation/training for Project partners in IPC material use																				
Training for print, TV and radio journalists																				
Orientation/training for phone hot-line management/staff																				

Activities	Year 1				Year 2				Year 3				Year 4				Year 5			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
<b>Component 3 — Community Based HIV/AIDS Prevention</b>																				
Formative studies																				
Community based VCT services establishment																				
Identify and contract with NGO(s) to establish and manage VCT services by the end of the first year																				
VCT service operation in the first five provinces by the end of the first quarter of the second year.																				
VCT service operation in the second five provinces by the end of the first quarter of the third year																				
VCT service operation in the third five year provinces by the end of the first quarter of the fourth year																				
Identify and contract with NGO(s) to establish and manage the training by the end of the first year																				
HIV prevention education and harm reduction for vulnerable youth, school youth, parents and community collaborators introduced in the first five provinces, second year																				
HIV prevention education and harm reduction for vulnerable youth, school youth, parents and community collaborators introduced in the first five provinces, third year																				
HIV prevention education and harm reduction for vulnerable youth, school youth, parents and community collaborators introduced in the first five provinces, fourth year																				

Activities	Year 1				Year 2				Year 3				Year 4				Year 5			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
<b>Component 4 — Project Management</b>																				
PMU staff recruited, management and financial systems established																				
Provincial PMUs established, staff recruited, & systems established																				
Bank accounts opened																				
Approve annual budgets and transfer funds to agencies and PPMU accounts																				
Appoint 2 International Advisers – Youth Policy /HIV/AIDS Adviser and M&E Adviser																				
Bid and contract agencies to implement different groups of sub-components in Phase one, two and three																				
Prepare Project Implementation Plan and budget for each Phase																				
Develop project monitoring and evaluation framework in first year																				
PMU and PPMU develop and implement a monitoring plan																				
Reporting system developed																				
Six month reports prepared by PMU for ADB																				
Phased completion reports prepared by PMU for ADB																				
Baseline Survey, Mid term and Final evaluation report submitted by PMU to ADB																				

**g. Organizational Diagram**

**Indicative Organizational Diagram**



## h. Provincial Selection Matrix

#	Province	Urban/Rural (classified) <sup>1</sup>					Young people in school <sup>2</sup>		% of people ages 15–24 <sup>3</sup>	HIV/AIDS situation <sup>4</sup>				05/06 Center <sup>5</sup>		Migration rate <sup>6</sup>		Industrial zone	Tourism	Previous ADB project	# of donors currently working	Provincial priority order	Province
		I	II	III	IV	V	Upper secondary (person)	Univ, colleges, technical schools (person)		HIV prevalence (reported cases)	Prevalence per 1,000,000 people	Ranking by prov	Registered IDU (person)	IDU (person)	CSW (person)	In (per thousand)	Out (per thousand)						
<b>North West</b>																							
1	Dien Bien				X		13,140	3,094	20.5	340	53.98	44	4,951	72	35	+16.7	-11.4		X	X	0	10	Dien Bien
<b>North East</b>																							
2	Quang Ninh			X			37,170	8,124	19.9	6,894	641.41	2	1,931	193	—	+30.5	-21.1	X	X		4	5	Quang Ninh
3	Phu Tho				X		52,350	6,878	18.7	495	36.67	36	1,535	302	86	+12.3	-23.4	X	X		1	11	Phu Tho
4	Vinh Phuc			X			45,660	6,265	20.6	135	11.55	55	960	150	+18.5	-34.8	X				0	17	Vinh Phuc
<b>Red River Delta</b>																							
5	Ha Noi	X					100,084	481,555	21.3	6,828	238.81	3	13,813	5,451	3,800	+77.0	-20.7	X	X		5	2	Ha Noi
6	Ha Tay					X	107,170	11,891	19.4	789	30.89	26	3,847	406	106	+16.8	-28.7	X	X		4	12	Ha Tay
7	Ha Nam				X		25,800	1,067	17.2	464	54.78	37	919	919	143	+17.0	-45.7	X			1	18	Ha Nam
8	Hai Duong			X			61,670	6,170	18.2	1,700	96.3	11	1,504	209	45	+10.3	-10.3	X			3	14	Hai Duong
9	Hai Phong	X					63,460	30,302	17.7	6,534	365.01	4	4,438	4,438	652	+16.2	-21.9		X		3	3	Hai Phong (World Bank)
10	Bac Ninh			X			45,200	8,898	19.3	643	63.83	32	1,182	287	40	+14.9	-34.5	X			1	9	Bac Ninh
<b>North Central Coast</b>																							
11	Thua Thien–Hue		X				36,740	38,072	18.7	229	20.48	51	137	73	30	+20.7	-34.5		X		2	19	Thua Thien–Hue
12	Quang Tri					X	24,160	2,229	17.2	49	7.99	61	10	32	—	14.7	-27.7		X	X	0	23	Quang Tri
<b>South Central Coast</b>																							
13	Da Nang	X					26,710	61,051	20.7	437	59.7	39	665	359	64	+54.7	-38.0	X	X		4	8	Da Nang
14	Quang Nam				X		54,480	1,857	17.9	273	18.59	48	181	181	54	+11.0	-30.1	X			2	20	Quang Nam

<sup>1</sup> Source: MOC

<sup>2</sup> Source: GSO

<sup>3</sup> Source: MoH/MoLISA

<sup>4</sup> Source: MoLISA

<sup>5</sup> Source: GSO

<sup>6</sup> Source: MoH

#	Province	Urban/Rural (classified) <sup>1</sup>					Young people in school <sup>2</sup>		% of people ages 15–24 <sup>3</sup>	HIV/AIDS situation <sup>4</sup>				05/06 Center <sup>5</sup>		Migration rate <sup>6</sup>		Industrial zone	Tourism	Previous ADB project	# of do-ctors currently working	Provincial priority order	Province
		I	II	III	IV	V	Upper secondary (person)	Univ, colleges, technical schools (person)		HIV prevalence (reported cases)	Prevalence per 1,000,000 people	Ranking by prov	Registered IDU (person)	IDU (person)	CSW (person)	In (per thousand)	Out (per thousand)						
15	Quang Ngai					X	44,190	2,958	19.2	124	9.74	56	82	82	—	+6.5	–38.2	X			1	22	Quang Ngai
	<b>Central Highlands</b>																						
16	Lam Dong			X			36,320	18,481	19.2	381	35.74	43	462	38	25	+79.4	–27.5		X		2	16	Lam Dong
	<b>Southeast</b>																						
17	HCMC	X					147,730	308,943	20.9	15,638	290.14	1	30,000	25,490	2,899	+88.5	–19.3	X	X		3	1	HCMC
18	Binh Duong				X		24,120	4,720	22.2	964	125.76	24	1,108	206	54	+91.4	–32.5	X			1	7	
19	Binh Phouc					X	20,280	468	18.6	414	59.20	42	542	524	80	+111.7	–23.5				1	21	Binh Phouc
20	Ba Ria–Vung Tau		X				30,400	3,830	19.0	2,429	283.55	7	823	823	250	+69.2	–35.2	X	X		2	4	Ba Ria–Vung Tau
	<b>Mekong Delta</b>																						
21	Dong Thap				X		36,380	3,144	21.3	1,839	109.82	10	401	401	75	+15.5	–22.9		X	X	3	13	Dong Thap
22	Long An				X		34,010	1,631	20.8	1,076	76.99	22	1,233	222	90	+21.8	–32.4	X			1	15	Long An
23	Can Tho	X					40,350	43,231	22.3	2,372	122.4	8	1,941	647	150	+21.6	–23.1	X			4	6	Can Tho

## **i. Consulting Services**

Terms of Reference for three international advisers and implementing agencies is presented below.

**International Adviser Position:**  
Youth Policy & HIV/AIDS Adviser

**Inputs in Years:**  
2 years (one year full time followed by three months per years for four years)

**Location:**  
Hanoi (with travel to provinces)

**Reports to:**  
Director of the PMU

### **Position Objective:**

- i) To advocate for a focus on youth issues related to HIV/AIDS prevention programs among leaders at national and provincial levels. and
- ii) To participate in existing youth and HIV/AIDS technical working groups of International Organizations and Vietnamese Civil Society Organizations and NGOs to assist them in their advocacy activities.
- iii) As a Youth and HIV/AIDS Adviser to ensure that all implementers of project components develop strategies to involve youth and PLWHA in their programs.

### **Main tasks:**

- i) Ensure that youth and HIV/AIDS related issues are emphasized in all project activities;
- ii) Work with VCPFC and partners to identify specific topics related to youth and HIV/AIDS for inclusion in the Information Packs and the Project web site.
- iii) Provide quality assurance over publications in magazines/newspapers and the Project web site as well as advocacy activities on radio/TV at the provincial level;
- iv) Provide expertise in design and conduct of youth workshops/forum in a participatory manner at the national and provincial levels;
- v) Identify topics for further research on youth issues in relation to reproductive health and HIV/AIDS;
- vi) Coordinate/liaise with UNAIDS, UN Youth Task Force, other donors and relevant project offices;
- vii) Participate in the selection of and support for young people/PLWHA to attend national and international conferences on Youth and HIV/AIDS.

### **Required Qualifications and Experience:**

- i) A degree in Mass Media Communication, Social Sciences, International Development or related discipline;
- ii) Good understanding of strategies for HIV/AIDS harm reduction and anti-stigma interventions;
- iii) Advanced skills in mass media and BCC;
- iv) At least 3 years of experience working in projects targeting youth and/or reproductive health;

- v) Good facilitation skills;
- vi) Demonstrated capacity to work as a member of a multi-disciplinary team;
- vii) Excellent written and oral communication skills;
- viii) Cross cultural communication skills;
- ix) Under 35 years old is preferable;
- x) Experience working in a developing country.

**International Adviser Position:**

Monitoring and Evaluation Adviser

**Inputs in Years:**

20 months over 5 years (Y1: 9 months; Y2 & 3: 3 months; Y4: 2 month and Y5: 3 months)

**Location:**

Hanoi (with travel to provinces)

**Reports to:**

Director of the PMU

**Position Objective:**

To establish and maintain monitoring & evaluation systems for the efficient and effective implementation of the Project.

**Main tasks:**

- i) Develop and maintain a M & E system for the Project;
- ii) Revise and update the list of project indicators in line with the National M & E Framework;
- iii) Provide technical assistance to the design, conduct and supervision of the base–line study, mid–term review and final evaluation;
- iv) Provide training and coaching in M&E systems at the provincial level (project planning, monitoring and evaluation) for Partner organizations;
- v) Provide training and mentoring in monitoring and evaluation for PMU and PPMU staff through formal training session and on the job coaching;
- vi) Conduct monitoring visits to project sites and implementing agencies to support project implementation at all levels;
- vii) Coordinate/liaise with AIDS Division/MoH, UNAIDS, other donors and relevant projects to ensure the M & E indicators are consistence with national indicators.

**Required Qualifications and Experience:**

- i) A Master Degree in Social Sciences, Public Health, Statistics or related disciplines;
- ii) At least 5 years of working as an M&E adviser for donor assisted projects in developing countries;
- iii) Experience in working with government counterpart at the national level
- iv) Competent in social research and survey methods;
- v) Advanced skills in data management and data analysis;
- vi) Experience of working in HIV/AIDS related projects, particularly community–based projects is an asset;
- vii) Demonstrated capacity to work in a multi–disciplinary team;
- viii) Cross cultural communication skills.

**International Adviser Position:**

Institutional Capacity Building Adviser

**Inputs:**

15 months in Phase One (12 months in Y1, and 3 months in Y2, Q 4)

Phase Two & Phase Three inputs to be determined in Phase One

**Location:**

Hanoi (with travel to provinces)

**Reports to:**

Director of the PMU

**Position Objective:**

To build the institutional capacity of staff of the PMU and PPMUs to implement donor funded programs effectively.

**Main tasks:**

- i) To conduct a management training needs analysis for PMU and PPMU staff;
- ii) Using results of the management TNA, develop a Capacity Building Improvement program for staff and organize an in house training program for staff at the PMU in the first six months of the Project;
- iii) Develop a Capacity Building Improvement for PPMU staff in the five provinces and conduct a series of training workshops at the provincial level in the first six to twelve months of the project;
- iv) Providing mentoring, coaching, training and skills transfer to PMU partners in health service management; and
- v) Assist PMU senior staff in the review of Phase one and in the preparation of the Phased Completion Report.

**Required Qualifications and Experience:**

- i) Tertiary qualifications in management and/or health services management;
- ii) Experience in financial and/or human resource management
- iii) Proven practical project management experience, preferably of development assistance projects;
- iv) Experience in working with government counterpart at the national level
- v) Competent in administrative and financial systems development;
- vi) Demonstrated leadership skills working in a complex environment with multiple stakeholders and interests;
- vii) Negotiation, mediation and problem solving skills;
- viii) Excellent cross cultural and interpersonal skills and a commitment to working collaboratively; and
- ix) Sensitivity to other cultures and social systems and genuine interest in gender and equity issues.

## **Terms of Reference for Implementing Agency**

### **Program Area:**

Mass Media and IPC Materials Development (Component 2)

### **Inputs:**

Five years

### **Location:**

Hanoi

### **Report to:**

Director of PMU

### **Position Objective:**

To guide the production of high quality, mass media Behavior Change Communication (BCC) programming and supporting Interpersonal Communication (IPC) materials for their use in IPC interventions carried out under Components 1 and 3.

### **Primary Responsibilities**

The successful Agency will work with the PMU to implement Component 2 of the Preventing HIV/AIDS among Youth Project. The Agency will have the following responsibilities:

#### **Mass Media**

- i) Undertake all necessary research/data collection for the design and production of suitable story lines and scripts for a 30-minute, weekly television drama (30 episodes per year)
- ii) Undertake all necessary research/data collection for the production of 60-minute, weekly provincial radio phone-in programs
- iii) Undertake all necessary research/data collection for the production of television and radio spots
- iv) Carryout all pre-production, pre-testing and post-production aspects of all electronic mass media including arranging for the nationwide prime broadcast of television drama series, provincial radio phone-in programs and television and radio spots
- v) Oversee design and development of collateral mass media materials including (to be handled under separate contract):
  - vi) Weekly newspaper column
  - vii) Monthly newspaper and magazine features
  - viii) Press releases, as required
- ix) Updates to the Project website (to be developed under separate contract), post new information and documents and oversee enhancements to the site

#### **IPC Materials**

- i) Undertake all necessary research/data collection for the design and production of suitable print materials<sup>1</sup> for advocacy and IPC activities outlined in Components 1 and 3 respectively (to be handled under separate contract)
- ii) Carryout all pre-production, pre-testing and post-production aspects of all print media

### **Qualifications**

The agency selected through a bidding process shall demonstrate a wide breadth and depth of mass media and interpersonal communications skills:

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<sup>1</sup> For example, leaflets, flipcharts, posters, booklets, etc.

- i) The selected agency will have the necessary technical skills, human resources, and equipment to perform this task. The contract will be performed in close coordination with the VCPVC and a Working Group formed to preview scripts and contribute to story ideas.
- ii) Minimum of 10 years professional experience in production of television dramas and radio phone-in programming focusing specifically on health and social development issues in Asia.
- iii) Minimum of 10 years of professional experience in documentary and television and radio spot production focusing on health and social development issues in Asia.
- iv) Demonstrated understanding of project requirements and experience with projects of a similar scope and delivery:
- v) Previous experience in carrying out a similar assignment in a similar setting (i.e., Southeast Asia)
- vi) Good knowledge of HIV/AIDS, reproductive health and other related issues facing youth in Viet Nam.
- vii) Excellent communication and writing skills, with an aptitude for working in a multicultural environment.

## **Terms of Reference for Implementing Agency**

### **Program Area:**

Voluntary Testing and Counseling (Component 3)

### **Inputs:**

Phase One: 12 months,  
Phase Two: 12 months and  
Phase Three: 24 months

### **Location:**

Phase One: Five provinces in Northern Viet Nam  
Phase Two and Three: Additional ten provinces in central and South Viet Nam.

### **Report to:**

Director of PMU at national level and in each province to chairperson of PPMU

### **Objective:**

To establish and manage one community based VCT service in each selected province commencing in five provinces in the north in the first phase of the project.

### **Experience and Capabilities:**

The agency contracted through a bidding process to implement the VCT services will have to demonstrate experience and capabilities in:

- i) Establishing a standard VCT service in a community setting to provide HIV prevention counseling and testing services.
- ii) Providing technical guidance as well as training for counselors/nurses and laboratory personnel.
- iii) Supporting social marketing of HIV voluntary counseling and testing—including improving understanding and valuing the service as well as advertising it. The marketing should include addressing issues of stigma, discrimination, barriers to access, etc.
- iv) Assuring the on-going quality of VCT through periodic reviews, observation, reporting and re-training of staff.
- v) Establishing linkages to other support programs/activities, including health services, community and home-based care.
- vi) Provision of condoms, needles, syringes and IPC materials provided by the Project.

## **Terms of Reference for Implementing Agency**

### **Program Area:**

Peer Education and Life Skills programs (Component 3)

### **Inputs:**

Phase One: 12 months,  
Phase Two: 12 months and  
Phase Three: 24 months

### **Location:**

Phase One: Five provinces in Northern Viet Nam (One IA contracted)  
Phase Two and Three: Additional ten provinces in central and South Viet Nam. (One IA contracted for each region)

### **Report to:**

Chairperson of PPMU in each of the five provinces and to PMU at the national level

### **Objective:**

- i) To establish and implement a peer education program for vulnerable youth in the following categories: IDUs, street youth, youth working in services industries and factory workers in five project provinces in the north of Viet Nam.
- ii) To implement a life skills training program for youth attending vocational training or job recruitment centers in five project provinces in the north of Viet Nam.

### **Experience and Capabilities:**

The agency or agencies contracted through a bidding process to implement the Peer education and Life skills program will have to demonstrate experience and capabilities in:

- i) Preparing Peer Education curriculum and plan of action for each training group based on foundation of formative studies and existing PE curricula;
- ii) Demonstrated capability to organize and implement participatory training course for training peer educators at provincial and district levels;
- iii) Managing and implementing peer education programs at the community level in a variety of setting;
- iv) Capable of supervising the peer educators and providing on-going support and in-service training;
- v) Preparing Life Skills for HIV/AIDS curriculum and plan of action for each training group based on foundation of formative studies and existing LS curricula;
- vi) Demonstrated capability to organize and implement participatory training course for students in vocational and job recruitment centers at provincial and district levels;
- vii) Ability to conduct regular monitoring and evaluation and
- viii) Provision of monthly reports to PPMU.

## **Terms of Reference for Implementing Agency**

### **Program Area**

Training community collaborators from VCPFC and Civil Society Organizations (Component 3)

### **Inputs:**

Phase One: 18 months, (Five IAs contracted – one per province)

Phase Two: 12 months and (Five more IAs contracted – one per province)

Phase Three: 24 months (Five more IAs contracted – one per province)

### **Location:**

Phase One: Five provinces in Northern Viet Nam

Phase Two and Three: Additional ten provinces in central and South Viet Nam.

### **Report to:**

Chairperson of PPMU and to PMU at the national level.

### **Objective:**

To establish and implement a training program for community collaborators in the following subjects: interpersonal communication skills, counseling, HIV/AIDS/STI prevention, community based care and support for PLWHA, effective parenting skills, gender awareness in one of the project selected provinces.

### **Experience and Capabilities:**

The agency or agencies contracted through a bidding process to implement the Collaborator training program will have to demonstrate experience and capabilities in:

- i) Preparing curriculum, planning and managing a training program for trainees working at the community level;
- ii) Providing effective training courses using participatory methods and ability to provide suitable trainers across a range to different topics;
- iii) Using evaluation methods that ensure the training programs are relevant for participants and that they are learning new skills.

## **j. Component Activity Details**

### **Component 1 — Support for national and provincial leadership and strategy implementation for HIV/AIDS and youth**

#### **Objective**

To work with Party and State leaders and Project implementers at all levels to support the implementation of the National Strategy on HIV/AIDS Prevention, and to raise the profile of youth issues.

#### **Description**

The focus of this component will be to increase awareness of and support for Project concepts and activities, the National HIV/AIDS Strategy (especially endorsement of harm reduction services BCC, and stigma reduction) and to develop a youth focus in HIV prevention programs.

The Project will recruit a Youth Policy and HIV/AIDS Adviser who will advocate for a focus on youth issues related to HIV/AIDS prevention programs among leaders at national and provincial levels. At the national level the Adviser will participate in existing youth and HIV/AIDS technical working groups of International Organizations and Vietnamese Mass Organizations and NGOs to assist them in their advocacy activities. It will also be the role of the Adviser to ensure that all implementers of project components develop strategies to involve youth and PLWHA in their programs.

At the national level, the project through the Youth Policy and HIV/AIDS Adviser will work closely with ongoing advocacy projects on HIV/AIDS prevention and adolescent reproductive health, such as the Reproductive Health Program implemented by the MoH and VCPFC, Promotion of Healthy Living Skills implemented by the Youth Union, and Involvement of the Communist Party in the HIV/AIDS Prevention activities implemented by the Committee of Ideology and Culture.

Advocacy messages will go beyond HIV/AIDS education to encompass the broader context of Healthy Youth Development and Gender Equality. The communication approach will not only use awareness-raising through mass campaigns but also interpersonal communication channels and should provide a trusting environment for young people to express their needs and concerns. Youth and HIV/AIDS prevention can be more effective if linked to Reproductive and Sexual Health education. Issues to be advocated for include:

- viii) Better understanding of concerns and needs of youth;
- ix) Understanding of healthy youth development in the current context of Viet Nam;
- x) Recognition of the State's role in supporting families and youth in coping with emerging problems;
- xi) Openness towards sexual health education in education settings;
- xii) Reduction of stigma against PLWHA;
- xiii) Understanding of and support for harm reduction programs; and
- xiv) Support for the implementation of the Labor Law to ensure the occupational health of workers, especially young workers in industrial zones.

Advocacy materials will be developed based on research findings, data and information on the needs and concerns of youth. The SAVY 2005 report is an example of existing data on which the materials could be developed. Areas for further research studies will be identified during the project baseline/formative research phase. It will be the responsibility of the Youth Policy and HIV/AIDS Adviser to work with PMU to identify research projects to be conducted

through the Project. Advocacy materials and information will be widely distributed through Party channels, such as websites and magazines, through Government channels, Parliament and through the network of mass organizations.

Funds will be provided through the Project to MoH to support the conducting of the 2<sup>nd</sup> SAVY in 2008.

Advocacy efforts at the national level will be linked to advocacy activities carried out at provincial and community levels. This comprehensive approach will support the implementation of Project interventions at the grassroots level. The Project will contribute to creating an enabling environment for the implementation of Project components on HIV/AIDS prevention among youth, including BCC, harm reduction, anti-stigma against PLWHA and VCT services at community settings, by promoting positive attitudes and gaining support among decision-makers, government authorities, leaders and managers of mass organizations at provincial, district and commune levels.

The Project rationale and content, with a focus on youth, as linked to the National HIV/AIDS Strategy, will be clearly presented to the provincial leaders in orientation workshops at the beginning of the Project life. Implementation partners should provide supportive instruction and supervision to their personnel in implementing the guidelines on HIV/AIDS prevention in order to gradually improve the quality of care and services for adolescents and youth. Awareness raising activities will also be given to the service providers, both public and private, in order to increase young people's access to youth-friendly services. Advocacy programs will also use a wide range of opportunities to raise awareness on HIV/AIDS, for instance, by inviting VIPs or well-known artists to talk shows (on radio and TV), forums and workshops.

The fact that youth and PLWHA are often not involved in designing and implementing preventive programs means that these programs are often not responsive to their needs. Too often, youth are considered to be beneficiaries rather than active participants. Therefore, one of the most important aspects of advocacy is to involve youth and PLWHA by providing them with opportunities to convey their concerns and needs and by developing mechanisms for them to participate in decision making related to matters of reproductive health and HIV/AIDS. These opportunities can take the form of dialogue between leaders and youth/PLWHA in forums or meetings, or the indirect feedback from youth/PLWHA through a consultation mechanism. The image of young people will be strengthened through their active participation in national and international conferences with a youth focus.

### **Rationale**

In recent years, the GoV has paid increasing attention to issues relating to young people, especially to the rising prevalence of HIV/AIDS among youth. This increased concern was reflected in the establishment of the Strategy for Youth Development for the period 2001–2010 and in the development of the Youth Law which has been submitted to the National Assembly for review and approval. The National Strategy on HIV/AIDS Prevention that was approved in 2004 highlighted the importance of BCC activities targeting high risk groups. Despite increased public concern over sexual health problems such as unwanted pregnancies, abortion, sexually transmitted diseases and HIV infection among young people, awareness of the needs and concerns of adolescents and young people for information, education and services on HIV/AIDS prevention is still limited among government leaders and decision makers.

The National HIV/AIDS Strategy endorses some measures that are new to the Vietnamese context, but known to be highly effective in reducing HIV transmission among high risk groups. However, these measures are difficult for some sections of Vietnamese society to understand and support, e.g. "Harm Reduction" (especially needle/syringe exchange, drug substitution and promotion of 100% condom use). Many leaders consulted during the TA's

provincial visits were not aware of the content and programming objectives of the National HIV/AIDS Strategy, and were unclear about the meaning of “Harm Reduction”.

The lessons learned from other HIV/AIDS prevention efforts in Viet Nam show that a widespread acceptance of the specific content of the National HIV/AIDS Strategy by Party officials, policy makers, government authorities, leaders of mass organizations and influential community members is necessary to ensure that targeted and effective youth HIV prevention interventions take place, especially those which have not been widely practiced in the Vietnamese context. As the support and involvement of Party and State leaders in HIV/AIDS prevention for youth is a key requirement for the Project’s success, it is essential to focus on advocacy. The involvement of leaders in the programming process is critical for the following outcomes:

- v) HIV/AIDS is a complex issue, directly and indirectly affecting many sectors, thus requiring the attention and efforts of a large number of groups;
- vi) An enabling environment permits the introduction of new policies and contributes to their sustainability, thus offering new opportunities for more effective HIV/AIDS interventions in the Vietnamese context;
- vii) Harm Reduction and Anti–Stigma campaigns are far likelier to succeed if decision–makers are informed, knowledgeable and confident, making the achievement of the National Strategic Objectives more likely; and
- viii) Promoting placement of VCT centers in community settings.

In addition, the Project can capitalize on the gains of other projects working for the political and social support of Party and Government leaders at the national level toward activities related to youth sexual and reproductive health and HIV/AIDS prevention. Examples include the active participation of the UN Youth Taskforce in the revision of the Youth Law through dialogue with the Committee of Social Affairs of the National Assembly; the integration of issues related to Population and Reproductive Health into the curriculum of the Ho Chi Minh National Political Academy with the support of the UNFPA; the involvement of the Committee of Ideology and Culture and the Committee of Science and Education of the Communist Party in the revision of Decree 52 for strengthening the role of the Communist Party in HIV/AIDS prevention program.

## **Outputs**

Component 1 will result in a number of outputs including:

- Research on youth issues conducted and disseminated. ( national activity)
- Advocacy materials developed and distributed nationwide through appropriate channels( National activity)
- Youth participation mechanism established and implemented through existing networks (National and provincial levels).
- Youth and HIV issues mainstreamed into existing and planned policies and programs by GoV and large donors (National and provincial levels).

## **Methods**

In order to accomplish the outputs listed above the following steps will be carried out:

National Level:

- Conduct two research studies on youth related issues identified in the formative research. Topics for these studies will be identified from the baseline survey.
- Provide support to WHO/UNICEF to conduct the 2nd SAVY study.
- Development and dissemination of information packages including legal documents/policies concerning youth and reproductive health and HIV/AIDS targeting leaders at all levels, in all provinces;

- Work with the UNDP supported project and UNAIDS to integrate mass media and IPC advocacy interventions developed under Component 2 (i.e., articles in newspaper, radio and television discussion programs or documentaries);
- Good models and lessons learned documented and disseminated during the Project life;
- Appoint a 'youth HIV adviser' to raise awareness of youth HIV–prevention issues across GoV and international organizations;

#### Provincial Level:

- Organize orientation workshops for the provincial authorities to present the project rationale emphasizing its focus on youth and link to the National Strategy on HIV/AIDS Prevention.
- Organize workshop with implementing partners and service providers at provincial level to advocate for a better understanding of and positive attitude toward the needs and concerns of young people and especially those living with AIDS.
- Organization of “advocacy meetings” with State and Party officials at provincial level specifically to discuss effective HIV/AIDS prevention among youth in line with National Strategy;
- Organize forums between youth, PLWHA and policy makers at provincial levels on relevant policy/strategy issues; and
- Identify opportunities for build capacity of young people from all project provinces, through participation in youth conference at the international and national levels.

#### Target Groups

- Party leaders, government authorities;
- Parliament and People’s Council at all levels;
- Leaders of the mass organizations, local NGOs;
- Community leaders including religious leaders and other respected individuals;
- Leaders of related institutions at the national and provincial levels.

#### Potential Partners for Implementation

VCPFC will be the implementing agency for this component.

#### Consulting Inputs

The following consulting inputs will be required for the implementation of activities under Component 1.

Position	Person months	Outline ToR
Youth Policy & HIV/AIDS Advisor	24	<ul style="list-style-type: none"> <li>• Coordinate/liaise with UNAIDS, UN Youth Task Force, other donors and relevant project offices</li> <li>• Work with EA and partners to identify topics and provide input to the content of the information packs and the Project web site</li> <li>• Provide comments and/or draft articles for publication in magazines/newspapers and the Project web site</li> <li>• Provide expertise in design and conduct of the workshops/forum at the national and provincial levels</li> <li>• Identify topics for further research on youth issues in relation to reproductive health and HIV/AIDS</li> <li>• Reporting</li> </ul>

#### Implementation Schedule

Component 1 activities will be carried out as illustrated in the Implementation Schedule below.

Activities	Year 1				Year 2				Year 3				Year 4				Year 5			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
At National level																				
Appointment of the Youth Policy & HIV/AIDS Advisor	■																			
Development of the advocacy plan for the first two years		■																		

Activities	Year 1				Year 2				Year 3				Year 4				Year 5			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Youth related issues published in magazines and websites																				
National dissemination workshop																				
Youth Information Packages developed and distributed nationally																				
Young people attend international conferences on youth																				
2nd SAVY study																				
2 research studies																				
At provincial level																				
Awareness-raising workshop with provincial authorities																				
Workshops with project implementing partners																				
Workshops with service providers at the province/district/community levels																				
Policy makers forum																				
Radio/TV talk shows in province																				
Community leaders/youth meetings																				
Young people attend regional or national level conferences																				

## Component 1 — Advocacy Logframe

**Objective —** *To work with Party and State leaders and Project implementers at all levels to support the implementation of the National Strategy on HIV/AIDS Prevention, and to raise the profile of youth issues.*

Objectives/Outputs	Indicators	Means of Verification	Assumptions
1.1 National Level Researches on youth issues conducted and disseminated	<ul style="list-style-type: none"> <li>• 2nd SAVY study received funding</li> <li>• 2 research studies completed</li> <li>• One national dissemination workshop organized in the end of Year 1</li> </ul>	<ul style="list-style-type: none"> <li>• Study reports</li> <li>• Workshop report</li> </ul>	<ul style="list-style-type: none"> <li>• Government officials support the conducting of a 2<sup>nd</sup> SAVY study</li> </ul>
1.2 National level Advocacy materials developed and distributed through appropriate channels	<ul style="list-style-type: none"> <li>• 500 Youth Information Packages distributed</li> <li>• 120 articles on youth related issues published in the Party magazines, newspapers and on their websites</li> </ul>	<ul style="list-style-type: none"> <li>• Project reports</li> </ul>	<ul style="list-style-type: none"> <li>• Government agreeable to content of the information packs</li> <li>• Publishers of Party Newspaper agreeable to publish articles on youth related issues.</li> </ul>
1.3 Provincial Level Youth participation mechanism established and implemented through existing networks	<ul style="list-style-type: none"> <li>• 1 policy maker forum per year held in each province</li> <li>• 2 radio/TV talk shows held in each province in each year</li> <li>• Two community leaders/youth meetings held each year in each province</li> <li>• 10 young people annually attend regional or national level conferences.</li> <li>• In five year a total of 10 young people attend international conferences on youth</li> </ul>	<ul style="list-style-type: none"> <li>• Minutes of meetings,</li> <li>• Project reports</li> <li>• Conference reports</li> </ul>	<ul style="list-style-type: none"> <li>• Government officials allow youth to participate in and contribute in meeting and in conferences</li> </ul>
1.4 Provincial Level Youth and HIV issues mainstreamed into existing and planned policies and programs by GoV and large donors.	<ul style="list-style-type: none"> <li>• 2 awareness-raising workshops conducted per province in the Year 1 and 3.</li> <li>• 1 workshop per year per province held with project implementing partners</li> <li>• 1 workshop per province per year held with service providers at the provincial/district/communes levels</li> </ul>	<ul style="list-style-type: none"> <li>• Workshop reports</li> </ul>	<ul style="list-style-type: none"> <li>• Government and IO support the inclusion of a Youth Adviser to support an increased emphasis on youth</li> </ul>

## Component 1 — Advocacy Activities

**Objective — To work with Party and State leaders and Project implementers at all levels to support the implementation of the National Strategy on HIV/AIDS Prevention, and to raise the profile of youth issues.**

Objectives/Outputs	Activity	Indicators
1.1 National Level: Researches on youth issues conducted and disseminated	<ul style="list-style-type: none"> <li>Contribute technically and financially to the 2<sup>nd</sup> SAVY jointly done by WHO/UNICEF</li> <li>Conduct 2 research studies following the identification of topics during the project baseline/ formative research phase</li> <li>Organize a dissemination workshop to present the results of the formative research</li> </ul>	<ul style="list-style-type: none"> <li>2nd SAVY study received funding</li> <li>2 research studies completed</li> <li>One national dissemination workshop organized in the end of Year 1</li> </ul>
1.2 National Level: Advocacy materials developed and distributed through appropriate channels	<ul style="list-style-type: none"> <li>Design and produce the Information Packs including data and information from the Formative research and baseline survey to be distributed to the leaders at the national and provincial levels</li> <li>Organize and provide the update information among policy makers on the youth and HIV/AIDS related issues through Party and State channels</li> <li>Update the project website with update information of project implementation progress and policy/</li> </ul>	<ul style="list-style-type: none"> <li>500 Youth Information Packages distributed</li> <li>120 articles on youth related issues published in the Party magazines, newspapers and on their websites</li> <li></li> </ul>
1.3 Provincial Level: Youth participation mechanism established and implemented through existing networks	<ul style="list-style-type: none"> <li>Appoint an Youth Policy &amp; HIV/AIDS Adviser according to the ToR</li> <li>Youth Policy &amp; HIV/AIDS Adviser actively participate in regular meetings of the AIDS Committee, UN Youth Task Force to share concerns on youth issues in relation to RH and HIV/AIDS and to reinforce the advocacy support to the project implementation</li> <li>Organize advocacy meeting with State and Party officials at the community level to discuss effective HIV/AIDS prevention among youth in line with National Strategy</li> <li>Organize forums between youth, PLWHA and policy makers on relevant policy/strategy/decreed issues</li> <li>Select topics and organize radio/TV talk shows on</li> </ul>	<ul style="list-style-type: none"> <li>Youth Policy &amp; HIV/AIDS Adviser appointed in the first three months</li> <li>1 policy maker forum per year held in each province</li> <li>2 radio/TV talk shows held in each province in each year</li> <li>Two meetings between community leaders and youth held each year in each province</li> <li>10 young people annually attend regional or national level conferences.</li> <li>In five year a total of 10 young people attend international conferences on youth</li> </ul>

Objectives/Outputs	Activity	Indicators
	youth/PLWHA concerns and needs inviting youth/PLWHA themselves, youth preferred people, VIPs, etc. <ul style="list-style-type: none"> <li>• Select and support young people, including PLWHA, to attend regional or national conferences on youth and HIV/AIDS</li> <li>• Select and support young people, including PLWHA, to attend international conference on youth and HIV/AIDS</li> </ul>	
1.4 Provincial Level: Youth and HIV issues mainstreamed into existing and planned policies and programs by GoV and large donors.	<ul style="list-style-type: none"> <li>• Design and conduct the awareness-raising workshops in province to present Project rationale and content, and to present National HIV/AIDS Strategy and its link to youth.</li> <li>• Conduct workshops for project implementing partners at provincial level leading to inclusion of HIV/AIDS prevention and youth friendly activities in their annual action plans</li> <li>• Organize workshops for service providers at the provincial/district/communes levels, using IPC materials, and involving youth and PLWHA</li> </ul>	<ul style="list-style-type: none"> <li>• 2 awareness-raising workshops conducted per province in the Year 1 and 3.</li> <li>• 1 workshop per year per province held with project implementing partners</li> <li>• 1 workshop per province per year held with service providers at the provincial/district/communes levels</li> <li>•</li> </ul>

## Component 1 — Advocacy Logframe

**Objective —** *To work with Party and State leaders and Project implementers at all levels to support the implementation of the National Strategy on HIV/AIDS Prevention, and to raise the profile of youth issues.*

Objectives/Outputs	Indicators	Means of Verification	Assumptions
1.1 Researches on youth issues conducted and disseminated	<ul style="list-style-type: none"> <li>• 2nd SAVY study received funding</li> <li>• 2 research studies completed</li> <li>• One national dissemination workshop organized in the end of Year 1</li> </ul>	<ul style="list-style-type: none"> <li>• Study reports</li> <li>• Workshop report</li> </ul>	<ul style="list-style-type: none"> <li>• Government officials support the conducting of a 2<sup>nd</sup> SAVY study</li> </ul>
1.2 Advocacy materials developed and distributed through appropriate channels	<ul style="list-style-type: none"> <li>• 500 Youth Information Packages distributed</li> <li>• 120 articles on youth related issues published in the Party magazines, newspapers and on their websites</li> </ul>	<ul style="list-style-type: none"> <li>• Project reports</li> </ul>	<ul style="list-style-type: none"> <li>• Government agreeable to content of the information packs</li> <li>• Publishers of Party Newspaper agreeable to publish articles on youth related issues.</li> </ul>
1.3 Youth participation mechanism established and implemented through existing networks	<ul style="list-style-type: none"> <li>• 1 policy maker forum per year held in each province</li> <li>• 2 radio/TV talk shows held in each province in each year</li> <li>• Two community leaders/youth meetings held each year in each province</li> <li>• 10 young people annually attend regional or national level conferences.</li> <li>• In five year a total of 10 young people attend international conferences on youth</li> </ul>	<ul style="list-style-type: none"> <li>• Minutes of meetings,</li> <li>• Project reports</li> <li>• Conference reports</li> </ul>	<ul style="list-style-type: none"> <li>• Government officials allow youth to participate in and contribute in meeting and in conferences</li> </ul>
1.4 Youth and HIV issues mainstreamed into existing and planned policies and programs by GoV and large donors.	<ul style="list-style-type: none"> <li>• 2 awareness-raising workshops conducted per province in the Year 1 and 3.</li> <li>• 1 workshop per year per province held with project implementing partners</li> <li>• 1 workshop per province per year held with service providers at the provincial/district/communes levels</li> </ul>	<ul style="list-style-type: none"> <li>• Workshop reports</li> </ul>	<ul style="list-style-type: none"> <li>• Government and IO support the inclusion of a Youth Adviser to support an increased emphasis on youth</li> </ul>

## Component 1 — Advocacy Activities

**Objective — To work with Party and State leaders and Project implementers at all levels to support the implementation of the National Strategy on HIV/AIDS Prevention, and to raise the profile of youth issues.**

Objectives/Outputs	Activity	Indicators
1.1 Researches on youth issues conducted and disseminated	<ul style="list-style-type: none"> <li>• Contribute technically and financially to the 2<sup>nd</sup> SAVY jointly done by WHO/UNICEF</li> <li>• Conduct 2 research studies following the identification of topics during the project baseline/ formative research phase</li> <li>• Organize a dissemination workshop to present the results of the formative research</li> </ul>	<ul style="list-style-type: none"> <li>• 2nd SAVY study received funding</li> <li>• 2 research studies completed</li> <li>• One national dissemination workshop organized in the end of Year 1</li> </ul>
1.2 Advocacy materials developed and distributed through appropriate channels	<ul style="list-style-type: none"> <li>• Design and produce the Information Packs including data and information from the Formative research and baseline survey to be distributed to the leaders at the national and provincial levels</li> <li>• Organize and provide the update information among policy makers on the youth and HIV/AIDS related issues through Party and State channels</li> <li>• Update the project website with update information of project implementation progress and policy/</li> </ul>	<ul style="list-style-type: none"> <li>• 500 Youth Information Packages distributed</li> <li>• 120 articles on youth related issues published in the Party magazines, newspapers and on their websites</li> <li>•</li> </ul>
1.3 Youth participation mechanism established and implemented through existing networks	<ul style="list-style-type: none"> <li>• Appoint an Youth Policy &amp; HIV/AIDS Adviser according to the ToR</li> <li>• Youth Policy &amp; HIV/AIDS Adviser actively participate in regular meetings of the AIDS Committee, UN Youth Task Force to share concerns on youth issues in relation to RH and HIV/AIDS and to reinforce the advocacy support to the project implementation</li> <li>• Organize advocacy meeting with State and Party officials at the community level to discuss effective HIV/AIDS prevention among youth in line with National Strategy</li> <li>• Organize forums between youth, PLWHA and policy makers on relevant policy/strategy/decreed issues</li> <li>• Select topics and organize radio/TV talk shows on youth/PLWHA concerns and needs inviting youth/PLWHA themselves, youth preferred people, VIPs, etc.</li> <li>• Select and support young people, including PLWHA, to</li> </ul>	<ul style="list-style-type: none"> <li>• Youth Policy &amp; HIV/AIDS Adviser appointed in the first three months</li> <li>• 1 policy maker forum per year held in each province</li> <li>• 2 radio/TV talk shows held in each province in each year</li> <li>• Two meetings between community leaders and youth held each year in each province</li> <li>• 10 young people annually attend regional or national level conferences.</li> <li>• In five year a total of 10 young people attend international conferences on youth</li> </ul>

Objectives/Outputs	Activity	Indicators
	attend regional or national conferences on youth and HIV/AIDS <ul style="list-style-type: none"> <li>• Select and support young people, including PLWHA, to attend international conference on youth and HIV/AIDS</li> </ul>	
1.4 Youth and HIV issues mainstreamed into existing and planned policies and programs by GoV and large donors.	<ul style="list-style-type: none"> <li>• Design and conduct the awareness-raising workshops in province to present Project rationale and content, and to present National HIV/AIDS Strategy and its link to youth.</li> <li>• Conduct workshops for project implementing partners at provincial level leading to inclusion of HIV/AIDS prevention and youth friendly activities in their annual action plans</li> <li>• Organize workshops for service providers at the provincial/district/communes levels, using IPC materials, and involving youth and PLWHA</li> </ul>	<ul style="list-style-type: none"> <li>• 2 awareness-raising workshops conducted per province in the Year 1 and 3.</li> <li>• 1 workshop per year per province held with project implementing partners</li> <li>• 1 workshop per province per year held with service providers at the provincial/district/communes levels</li> <li>•</li> </ul>

## **Component 2 — A National Mass Media production for behaviour change and improved interpersonal communication related to reducing HIV infection risk among youth**

### **Objective**

To produce high quality, mass media<sup>1</sup> Behavior Change Communication programs, based around a television drama series that utilizes the ‘enter(tain)-educate’ model of behavior change theory along with supporting Interpersonal Communication (IPC) materials to be disseminated and utilized through various media and youth-focused venues.

### **Description**

The Mass Media & IPC Materials Component offers an integrated BCC strategy based on the coordinated and reinforcing use of a professionally developed television drama series, radio phone-in programs, youth-focused documentaries and television and radio spots.

Messages delivered via these mass media interventions will be supported and reinforced by a variety of high-quality, professionally developed print materials for use in IPC activities (Component 3) designed to stimulate behavior change among high-risk youth and maintain preferred behaviors among mainstream and vulnerable youth.

Audience-based research will be used to inform the development of all outputs under Component 2. This will include: 1) formative research for the development of messages, scripts and visual ideas; 2) rapid feedback assessment to gauge audience responses to outputs in the near-final stages of production; 3) quantitative KAP surveys for baseline analysis; and 4) audience feedback panels, randomly sampled from target groups members, for structured interviews after mass media outputs have been broadcast.

All outputs under Component 2 will be developed in close consultation with target group members following the model promoted by the United Nations Country Team.<sup>2</sup> Such an approach will ensure that messages and information presented will appeal to youth and PLWHA and will lead to action. The participation of youth and PLWHA in the development of messages, scripts and visual ideas and in the production of outputs is considered essential. The agency contracted to develop outputs under Component 2 will be required to hire youth and PLWHA to work on story development, script and message development and on the design and production of mass media programming and IPC materials.

Activities and outputs under Component 2 are considered to be overarching and encompassing, linking mass media, IPC interventions, promotional and education efforts and advocacy at all levels in the variety of settings addressed by Components 1 and 3. In addition to providing materials for use in IPC and advocacy interventions Component 2 will offer orientation and training on the appropriate use of multi-media IPC materials by provincial and community-level users of materials such as teachers and peer educators, and training for media designers and journalists in the development of appropriate mass media and IPC materials targeting youth.

Three sub-components have been developed to achieve the objective of this component. Each one will be presented separately below:

- To produce and broadcast a television drama series, radio phone-in programs, youth-focused television documentaries and television and spots.

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<sup>1</sup> Television drama, radio phone-in and television and radio discussion programs, documentaries and spots.

<sup>2</sup> See Development of Youth Communication Messages on HIV/AIDS, Workshop Report, Quality of Life Promotion (LIFE) Center, February 2005.

- To produce a variety of IPC materials for use in advocacy and IPC interventions to be undertaken in Project components 1 and 3.
- To establish an “IPC Clearinghouse” to facilitate the distribution and use of IPC materials produced under Component 2 by non–Project groups.

## **Sub–Component 1**

The production and broadcasting of an integrated package of BCC materials based around a long-running television drama series with complementary radio phone-in programs, youth-focused television documentaries and television and radio announcement spots.

### **Description**

The television and radio mass media interventions follow the “Entertainment–Education” (enter–educate) approach in which social messages are incorporated into entertainment programs with the intention of increasing audience members’ knowledge about social issues, creating favorable attitudes and stimulating behavior change. In countries around the world, this approach has been effectively used to address HIV/AIDS, stigma and discrimination, drug and alcohol abuse, teenage pregnancy, domestic violence and other social and health issues.<sup>3</sup>

Sub–Component 1 will include the production of a high quality, national level television drama series to be broadcast nationwide during prime time and weekly provincial level radio phone–in programs. This will be augmented by television documentaries and television and radio information spots to be broadcast nationally.

In addition, the regular publication of newspaper and magazine articles targeting various target groups (e.g., youth, government leaders, influential community leaders) will provide targeted and detailed information on HIV/AIDS and other health and social issues. It is also planned that a web site, linked to the content and messages presented in the television drama and radio phone–in programs will be developed. The link to the web site will be publicized through the television drama series, radio phone–in programs and newspaper and magazines. The Project will collaborate with existing phone “hot–lines” to ensure the inclusion of information presented in the television drama and radio phone–in programs. Around the world HIV/AIDS hot–lines have been successful in providing counseling on STI’s, sexuality, reproductive health and promoting awareness among youth.

The enter–educate television drama series and radio phone–in programs will not only deal with HIV/AIDS and its impact on youth, families and society, but it will also address a variety of health, gender, social and development issues and promote healthy lifestyles. This mass media programming will help the majority of Vietnamese youth maintain their good behavior while educating those youth practicing risky behaviors on ways to change. The television and radio drama will impart information, challenge harmful social norms, attitudes and practice, tackle stigma and discrimination and help to influence the overall socio–political environment. Articles and commentary published in selected publications will reinforce information presented in the television drama and radio phone–in programs while the web site will allow individuals to seek answers to sensitive questions while maintaining their anonymity.

Sub–Component 1 will provide for the training of journalists and media managers form national and provincial levels in the ethics and proper reporting of HIV/AIDS.

### **Outputs**

Sub–Component 1 will result in a number of outputs including:

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<sup>3</sup> For example, Johns Hopkins Center for Communication Programs has successfully carried out Entertainment–Education initiatives in countries in Africa, Asia, Latin America and the Middle East (see [http://www.jhuccp.org/topics/enter\\_ed/eeprojects/index.shtml](http://www.jhuccp.org/topics/enter_ed/eeprojects/index.shtml))

- Formative research findings — investigating the Knowledge, Attitude and Practice (KAP) of all target groups including mainstream, vulnerable and high risk youth as well as parents, influential adults and community leaders — for use in the design of mass media programming;
- Professionally produced national level TV drama series, provincial radio phone-in programs, television documentaries and television and radio spots;
- Interactive web site — linked to television and radio program content; and,
- Regular publication of newspaper and magazine articles — given the high levels of literacy in Viet Nam, the strategic use of newspapers and magazines can be an effective way to reach young people with targeted and detailed information on HIV/AIDS and other health and social issues.

## **Methods**

In order to accomplish the outputs listed above, the following steps will be applied:

- Design and conduct BCC formative research;
- Develop plans for mass media programming, clarifying goals, objectives, topics, themes, key messages and target production timelines;
- Develop tender document for contracting of agency to carry out development and production of television drama series, documentaries, radio phone-in programs and television and radio spots;
- Contract agency to develop and manage the broadcast of television drama series, documentaries, radio phone-in programs and television and radio spots;
- Monitor broadcast of television drama series, documentaries, radio phone-in programs and television and radio spots to ensure compliance;
- Identify web site content, based on results of the formative research as well as an investigation into current web site habits of youth;
- Develop tender document and contract company to develop and manage web site linked to the television drama;
- Monitor technical content and use of web site;
- Identify and select topics for publication in youth targeted publication(s);
- Develop tender document and contract youth targeted publication(s) to publish feature articles and columns on a regular basis;
- Provide training for journalists and media designers at the national and provincial levels on the ethics of and proper ways of reporting on HIV/AIDS; and
- Provide training for field level staff (outreach staff, peer educators, teachers, etc.) on the proper use of IPC materials developed under Component 2.

## **Target Groups**

Sub-Component 1 target groups include:

- Mainstream youth including youth in secondary, tertiary, vocational and continuing education that are not practicing risk behaviors will be reached by mass media interventions (television drama series and radio phone-in programs, newspaper and magazine articles).
- Vulnerable youth including youth working in industrial zones, service industry, school drop-outs, unemployed, migrant and military recruits will be reached by mass media interventions (television drama series and radio phone-in programs, newspaper and magazine articles).

- High risk youth including SWs and IDUs, will be reached by mass media interventions (television drama series and radio phone-in programs, newspaper and magazine articles).
- Decision Makers/Leaders including officials at the central, provincial and community levels will be reached by mass media initiatives (television drama series and radio phone-in programs) as well as by targeted newspaper and magazine articles.
- Parents will be reached by mass media initiatives (television drama series and radio phone-in programs, newspaper and magazine articles).
- General Public will be exposed to the mass media initiatives (television drama series and radio phone-in programs, newspaper and magazine articles).

### **Potential Partners**

Under the overall management of the EA, a professional mass media production agency with extensive experience in the design and production of enter-educate/social programming will be contracted to develop the technical outputs of Sub-Component 1. The firm to be contracted will be required to have experience in all elements of mass media programming design and production from formative research to broadcast. Moreover the firm will be expected to have a proven track record in the involvement of target group members (youth and PLWHA) in the design and production of outputs.

The contracted firm will be required to contract youth and PLWHA to participate in story development, script and message development, visual design, acting and production tasks. The contracted firm will build skills training into their involvement of youth. Emphasis will be placed on including PLWHA in the design and production of outputs.

## **Sub-Component 2**

Production of interpersonal communication (IPC) materials based around the themes and messages of the materials in sub-component 1, to be used in advocacy, peer-education and youth outreach services.

### **Description**

Behavior change will be stimulated by targeted interpersonal communication interventions carried out under Component 3 by utilizing IPC materials developed under Sub-Component 2.

The themes, key messages and information presented in the television drama series and radio phone-in program will form the basis for a wide range of multi-media IPC materials to be developed for use in interpersonal communication and training activities carried out in Component 3. IPC materials will be used to effectively reach and influence a wide range of target groups including students, parents, teachers and individuals at high risk such as IDUs and SWs.

It is envisioned that materials to be produced will include, but not be limited to, flipcharts, posters, leaflets, booklets, comics, teaching cards, etc. (The final decision on materials to be produced will be based on formative research/needs assessment results to be carried out during the first year of the Project.)

Hard copies of materials will be provided to all Project partners. In addition electronic copies of materials will be distributed in "kit" form, on CD-ROM, to provincial groups/authorities responsible for managing the implementation of activities being carried out under Components

3. This will allow provincial level partners to reproduce additional materials as needed. The CD-ROM will contain all files necessary for the adoption and reproduction of materials.

IPC materials will also be made available to non-Project affiliated groups and projects working in HIV/AIDS prevention through an “IPC Materials Clearinghouse” to be established within the EA (see Sub-Component 3).

Training in the proper use and distribution of IPC materials will be provided to provincial level partners by Provincial Health Promotion/Education Units (to be organized by the EA).

## **Outputs**

Sub-Component 1 will result in a number of outputs including:

- Formative research findings<sup>4</sup> — investigating the Knowledge, Attitude and Practice (KAP) of all target groups including mainstream, vulnerable and high risk youth as well as parents, influential adults and community leaders — for use in the design of IPC materials.
- Broad range of professionally produced IPC materials — as print IPC materials need to compete with high quality commercial advertising materials (originating from both Viet Nam and overseas sources) it will be essential to engage highly skilled media professionals to design, produce quality print materials. Materials to be produced will be conceptually linked to the messages, information and visuals of the mass media outputs developed under Sub-Component 1.

## **Methods**

In order to accomplish the outputs listed above, the following steps will be applied:

- Design and conduct BCC formative research;
- Develop plans for IPC materials, clarifying goals, objectives, topics, themes, key messages and target production timelines;
- Develop tender document and contract agency to carry out development and production of IPC materials;
- Monitor the content, placement and use of IPC materials; and
- Provide orientation and training for appropriate use of IPC materials.

## **Target Groups**

Sub-Component 2 target groups will include:

- Mainstream youth including youth will be reached through IPC activities carried out under Component 3, supported by materials developed under Sub-Component 2.
- Vulnerable youth including youth working in industrial zones, service industry, school dropouts, unemployed, migrant and military recruits will be reached through IPC activities carried out under Component 3, supported by materials developed under Sub-Component 2.
- High risk youth including SWs and IDUs will be reached through IPC activities carried out under Component 3, supported by materials developed under Sub-Component 2.
- Decision Makers/Leaders including officials at the central, provincial and community levels will be reached by activities to be implemented under Component 1, supported by materials developed under Sub-Component 2.

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<sup>4</sup> BCC formative research carried out under Sub-Component 1.

- Parents will be reached by activities to be implemented under Component 3, supported by materials developed under Sub-Component 2.

### **Potential Partners**

Under the overall management of the EA, a professional media production agency with extensive experience in the design and production of enter-educate programming and materials will be contracted to develop the technical outputs of Sub-Component 2. *It is strongly recommended that the media production agency to be contracted for both Sub-Components 1 and 2 be the same in order to facilitate message and visual continuity between materials and assure high quality production.*

The firm to be contracted will be required to have experience in IPC materials design and production from formative research to printing and dissemination. Moreover the firm will be expected to have a proven track record in the involvement of target group members (youth and PLWHA) in the design and production of outputs.

The contracted firm will be required to contract youth to participate in message development, visual design and production tasks. The contracted firm will build skills training into their involvement of youth. Emphasis will be placed on including PLWHA in the design and production of outputs.

## **Sub-Component 3**

Establish a clearinghouse to facilitate the distribution and use of IPC materials produced under Sub-component 2 by non-Project groups working in HIV/AIDS prevention..

### **Description**

An "IPC Materials Clearinghouse" will be established by the EA. The Clearinghouse will serve as a central point for collecting, classifying, displaying and distributing the television drama and IPC materials developed under Component 2 to non-Project groups involved in HIV/AIDS prevention activities in Viet Nam. Non-Project organizations including government offices, NGOs, projects and donors will be able to view samples and order copies of Project mass media and IPC materials for their use. In addition, the IPC Materials Clearinghouse will undertake the collection of HIV/AIDS prevention print and electronic materials produced by other donors/projects.

### **Outputs**

A dedicated space in the EA, renovated to provide a convenient environment for the cataloguing and display of Project and other IPC materials.

### **Methods**

In order to accomplish the outputs listed above, the following steps will be applied:

- EA to identify appropriate site for IPC Materials Clearinghouse
- EA to assign staff to organize and manage the clearinghouse
- EA staff cooperate with media production agency contracted to produced mass media and IPC materials under Component 2 in the establishment of the clearinghouse.
- Necessary presentation equipment procured and installed.
- EA staff trained as necessary (training to be provided by media production agency contracted to produced mass media and IPC materials under Component 2).

## Target Groups

- The Clearinghouse will serve the IPC material needs of government agencies, NGOs and projects working in HIV/AIDS prevention in Viet Nam.

## Potential Partners

The EA will collaborate with the media production agency contracted to produce mass media and IPC materials under Component 2 in the establishment, management and promotion of the clearinghouse.

## Overall Component Rationale

There are a variety of reasons for applying an integrated BCC strategy built around high quality mass media programming and supporting IPC materials.

Foremost is the recognition that “Entertainment–Education” programs, linked with targeted IPC initiatives, help to maximize attitude and behavior change. Experience shows that reinforcing information presented through a sustained mass media intervention by high quality IPC activities and materials has an impressive impact on influencing attitudes and behavior among target groups.<sup>5</sup> For over six years, the South African BCC program “Soul City” has been at the forefront of the “Entertainment–Education” genre by integrating creative television and radio drama series with quality print media for interpersonal use with youth and adults in South Africa’s fight against HIV/AIDS. This integrated approach, combining mass media programs with IPC materials used in a variety of IPC activities, has not only led to an increase in knowledge of the HIV/AIDS epidemic among youth but has also stimulated dialogue among community leaders, fostering an “enabling environment” in which innovative BCC activities and effective HIV/AIDS prevention initiatives can take root. (Coulson, 2004).

Evidence shows that successful BCC programs have certain features in common. Both UNAIDS (2004) and CDC (2004) agree that best results rely on a “systems approach” which combines multiple mass media approaches, along with community collaborations, training as needed and activities by local groups that “have credibility” with target groups. Using several approaches and channels simultaneously, in a coordinated manner, conveys a sense of vigor that adds to the sustainability and impact of the overall program. It also allows for the use of different approaches to serve different needs, which are mutually reinforcing. For example, print materials are good to raise awareness and as reminders, while television and radio reach millions quickly. Interpersonal communication between peers, or between youth and those who influence them, is helpful in persuading individuals to try new services or adopt different behaviors. Advocacy through communication channels is also crucial to build support for policies and programs. These, along with peer education programs, training videos and leaflet distribution can happen at the same time.

Surveys show that youth in Viet Nam access mass media, particularly television and radio, on a regular basis. Television viewership is high, particularly among youth. Television is the major source of information on reproductive health issues for youth with nearly 94% of youth having received information related to reproductive health from the mass media.<sup>6</sup>

Television can effectively reach 75% of the entire population. Responses from government staff and community members interviewed during the TA team’s provincial visits indicated that the majority of people regularly view entertainment and information programming, such as films, quiz shows, news and documentaries on television. An impressive 86.5% of youth

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<sup>5</sup> As demonstrated by television and radio dramas produced by Soul City Institute for Health & Development Communication in South Africa, the Taste of Life television series produced by the BBC World Service Trust in Cambodia, and the New Dawn Radio Serial Drama produced in Nigeria with support from Johns Hopkins Center for Communication Programs.

<sup>6</sup> MoH, Ministry of Health 2005b, Survey Assessment of Vietnamese Youth (SAVY) (with GSO, Unicef Viet Nam, WHO Viet Nam) Hanoi

nationwide watch television at least twice a week and 50% watch television on a daily basis. Moreover, 73% of rural youth have a television in their households, while 85% of them watch television regularly. Youth reported that favorite television programming includes movies and soap operas (29.4%), news (23.9%) and music (23.2%).<sup>7</sup>

From the perspective of project sustainability, investing in a high quality television drama and radio phone-in programs can attract advertising revenue which helps to cover production and broadcast costs, acts as an incentive for the broadcaster to place programs on prime-time and enhances the possibility of programming to continue beyond the life of the Project.

As an indicator of the popularity and “value” of television in reaching people in Viet Nam, it is notable that the total national advertising expenditure on broadcasting, print media, and outdoor advertising escalated from less than US USD 20 million in 1993 to over US USD 116 million in 1999 (based on published rates). In 2000, advertising on television made up 53.5% of ad turnover, with print media at 24.5%; and outdoor advertising at 21%.<sup>8</sup>

Finally, Component 2 builds on ongoing VCPFC interventions—such as the multi-episode serial drama aired on VTV3 that is supported by the Johns Hopkins/Center for Communication Programs. This 26-part drama series explores a number of health and social issues. Program content forms the basis for discussions among youth and adults via forums organized by the Youth Union, Farmer’s Union and Women’s Union.

### **Monitoring and Evaluation**

Monitoring and evaluation of mass media and IPC efforts is a complex task and will be considered from the very beginning of the Project. The agency contracted to develop mass media programming and IPC materials will be required to ensure that process and impact evaluations are valid and reliable.

Information to be gathered for Component 2 should be linked to the Project’s overall M&E system. Monitoring will be part of the ongoing management of communication activities, focusing on the process of developing, distributing and using materials. The following will be closely monitored:

- Production of materials — are materials designed, pre-tested, and produced according to schedule?
- Distribution of materials — are materials being distributed on schedule and in sufficient quantities? What is the rate of distribution?
- Usage of materials — are materials being used as planned? What are the most widely used materials? Is supply enough?
- Quality — is the quality of materials as planned?
- Feedback — are changing needs of target groups being met?
- Impact — are there any indications of attitudinal or behavioral change which may be attributed, in part, to the mass media and IPC interventions?

To monitor the course of Component 2 properly, it will be necessary to establish effective information gathering systems. These will include reports, site visits and reviews of materials. Reporting tools and protocols will be standardized to ensure consistency. In addition periodic focus group discussions and in-depth interviews will be held to assess the perceptions of target groups. Staff using IPC materials will collect responses from target groups to help identify changes that may have to be made in the materials produced.

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<sup>7</sup> Ibid.

<sup>8</sup> [http://www.aseanindia.net/asean/countryprofiles/vietnam/mark\\_ent.html](http://www.aseanindia.net/asean/countryprofiles/vietnam/mark_ent.html)

## Consulting Inputs

The following consulting inputs will be required for the implementation of activities under Component 2.

Position	Person months	Outline ToR
Component Manager	48	<ul style="list-style-type: none"> <li>• Overall technical, administrative and financial management of Component 2</li> <li>• Coordination/liaison with EA and government offices</li> <li>• Coordination/liaison with mass media agencies</li> <li>• Reporting</li> </ul>
Executive Producer, TV Drama and Documentaries	36	<ul style="list-style-type: none"> <li>• Technical and creative guidance in design and development of TV drama and documentaries</li> <li>• Management of production schedule, production budget, talent and overall creative control</li> <li>• Training of production staff</li> </ul>
Executive Producer, Radio	24	<ul style="list-style-type: none"> <li>• Technical and creative guidance in design and development of provincial radio phone-in programs</li> <li>• Management of production schedule, production budget, talent and overall creative control</li> <li>• Training of production staff</li> </ul>
Executive Producer, TV Spots	30	<ul style="list-style-type: none"> <li>• Technical and creative guidance in design and development of TV spots</li> <li>• Management of production schedule, production budget, talent and overall creative control</li> <li>• Training of production staff</li> </ul>
Story Consultant	9	<ul style="list-style-type: none"> <li>• Development of TV drama storylines</li> <li>• Training of production staff</li> </ul>
Script Consultant	9	<ul style="list-style-type: none"> <li>• Development of TV drama scripts</li> <li>• Training of production staff</li> </ul>

## Implementation Schedule

Component 2 activities will be carried out as illustrated in the Implementation Schedule below.

Activities	Year 1				Year 2				Year 3				Year 4				Year 5			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Contract agency to implement/manage Component 2	■																			
Formative/baseline Research		■	■																	
Report/disseminate findings			■	■																
Develop annual mass media and IPC material production plans			■	■			■				■				■					
Liaise with national television, provincial radio and publications	■	■	■	■																
Recruitment and training of TV production staff		■	■	■																
TV drama story development		■	■	■																
TV drama script development		■	■	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Production TV drama			■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Broadcast of TV drama				■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Monitoring of TV drama/qualitative research				■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Provincial radio phone-in program development			■	■	■	■														
Recruitment and training of radio production staff			■	■	■															
Broadcast of provincial radio phone-in program				■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Monitoring of radio phone-in program/qualitative research				■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Contract publications to publish feature articles and columns			■	■																
Regular publication of articles and columns			■	■																
Monitor publications/qualitative research				■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Design and production of first tranche of IPC materials				■	■	■	■													
Monitor distribution, use and impact of IPC materials								■	■	■	■	■	■	■	■	■	■	■	■	■
Design and production of second tranche of IPC materials										■	■	■	■							
Monitor distribution, use and impact of IPC materials													■	■	■	■	■	■	■	■
Design and production of third tranche of IPC materials															■	■	■	■	■	■
Monitor distribution, use and impact of IPC materials																	■	■	■	■
Contract company to develop and manage website		■	■																	
Website operational				■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■

Activities	Year 1				Year 2				Year 3				Year 4				Year 5			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Monitor use of web site																				
Establishment of IPC Materials Clearinghouse																				
IPC Materials Clearinghouse operational																				
Orientation/training of EA staff for Clearinghouse management																				
Orientation/training for Project partners in IPC material use																				
Training for print, TV and radio journalists																				
Orientation/training for phone hot-line management/staff																				

## Component 2 — Mass Media and IPC Materials Logframe <sup>1</sup>

**Objective —** *To produce high quality, mass media<sup>2</sup> Behavior Change Communication programs, based around a television drama series that utilizes the ‘enter(tain)-educate’ model of behavior change theory along with supporting Interpersonal Communication (IPC) materials to be disseminated and utilized through various media and youth-focused venues.*

Three sub-components have been developed to achieve the objective of this component. Each one will be presented separately below.

**Sub-component 1 —** *The production and broadcasting of an integrated package of BCC materials based around a long-running television drama series with complementary radio phone-in programs, youth-focused television documentaries and television and radio announcement spots.*

Objectives/Outputs	Indicators	Means of Verification	Assumptions
<b>Formative Research</b> 2.1.1 To collect data necessary for the design of mass media and IPC materials	<ul style="list-style-type: none"> <li>Dissemination workshop</li> <li>Formative research report<sup>3</sup></li> </ul>	<ul style="list-style-type: none"> <li>Dissemination workshop report</li> <li>Research report</li> </ul>	<ul style="list-style-type: none"> <li>Can access high risk groups for research, interventions and evaluations</li> </ul>
<b>Electronic Mass Media</b> 2.1.2 To develop a variety of electronic mass media initiatives in support of the national response to HIV/AIDS	<ul style="list-style-type: none"> <li>Thirty episodes per year<sup>4</sup> of original 30 min television drama produced — national level</li> <li>Weekly, 60 min radio phone<sup>5</sup>-in shows — provincial level</li> <li>Two 30 min television documentaries produced each year — national level</li> <li>Twenty-five television spots and 50 radio spots produced each year<sup>6</sup> — national level</li> <li>Provincial level broadcasters training conducted in each Project province</li> </ul>	<ul style="list-style-type: none"> <li>Video and audio tapes of programming</li> <li>Audience panel feedback</li> <li>Monitoring reports of television and radio broadcasts</li> </ul>	<ul style="list-style-type: none"> <li>Government agreeable to sole-source contracting to implement Component 2</li> <li>Government agreeable to editorial content and creative approach</li> <li>National and provincial level television/radio producers and broadcasters able to meet</li> </ul>

<sup>1</sup> The Indicators, Means of Verification and Assumptions in this Log Frame draw heavily on Rehle T, Saidel T, Mills S and Magnani R. (Eds) (Family Health International). No date. Evaluating Programs for HIV/AIDS Prevention and Care in Developing Countries: A handbook for program managers and decision makers. FHI IMPACT.

<sup>2</sup> Television drama, radio phone-in and television and radio discussion programs, documentaries and spots.

<sup>3</sup> Formative research results will be used for the development of all Component 2 outputs. Formative research will be used to identify (a) province-specific knowledge, practices, awareness, and attitudes of all target groups (not only youth), (b) needs and preferences (content, approach, style) of target groups for all Project activities, (c) opportunities and constraints in accessing all targets, (d) levels of awareness and acceptance of Project concepts among implementers, (e) most appropriate partners for implementation of activities in each province, and (f) ethical considerations for all Project activities, including M & E.

Objectives/Outputs	Indicators	Means of Verification	Assumptions
			quality standards
<p><b>Print Mass Media</b></p> <p>2.1.3 To develop a variety of print mass media initiatives in support of the national response to HIV/AIDS</p>	<ul style="list-style-type: none"> <li>• Bi-weekly column published in youth focused newspaper and magazine<sup>7</sup></li> <li>• Monthly feature article published in youth focused newspapers and magazines<sup>8</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Copies of published materials</li> <li>• Monitoring reports of published materials</li> <li>• Audience panel feedback</li> </ul>	<ul style="list-style-type: none"> <li>• Government agreeable to editorial content and creative approach</li> <li>• National and provincial level journalists and publications able to meet quality standards</li> </ul>
<p><b>Internet and Phone Hot-Line</b></p> <p>2.1.4 To design, post, maintain an interactive web site — linked to television drama and radio phone-in content — national level</p>	<ul style="list-style-type: none"> <li>• Interactive web site posted by end of first year of Project</li> <li>• Web site updated on a monthly basis</li> </ul>	<ul style="list-style-type: none"> <li>• Monthly monitoring reports</li> <li>• Monthly site statistics</li> <li>• Audience panel feedback/on-line surveys</li> </ul>	<ul style="list-style-type: none"> <li>• Government agreeable to editorial content and creative approach</li> <li>• Web site designers able to meet quality standards</li> </ul>
<p>2.1.5 To link Project messages and information to existing phone hot-lines</p> <p>2.1.6 To promote use of phone hot-lines</p>	<ul style="list-style-type: none"> <li>• Existing phone hot-lines includes information presented through TV drama and reinforced in IPC activities</li> </ul>	<ul style="list-style-type: none"> <li>• Phone hot-line monthly monitoring reports</li> <li>• Audience panel feedback</li> </ul>	<ul style="list-style-type: none"> <li>• Government agreeable to editorial content</li> <li>• Management of existing phone hot-lines agree to cooperate with Project</li> </ul>
<p><b>Capacity building</b></p> <p>2.1.7 To train broadcast and print journalists in creative and ethical reporting on HIV/AIDS and RH issues affecting youth</p> <p>2.1.8 To orient staff of existing phone hot-lines to issues and information presented in TV drama &amp; radio phone-in programs</p>	<ul style="list-style-type: none"> <li>• One training held per year in each participating province</li> <li>• One orientation held per year with management and staff of existing phone hot-lines<sup>9</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Training reports</li> <li>• Training outputs</li> </ul>	<ul style="list-style-type: none"> <li>• Government journalists agreeable to alternative and new approaches in reporting on HIV/AIDS and RH issues targeting youth</li> </ul>

<sup>4</sup> Production to begin in year 1 following formative research with full broadcast to begin in year 2.

<sup>5</sup> Beginning in five provinces in year 2 and expanding to 10 provinces in the following year.

<sup>6</sup> Full production beginning year 2

<sup>7</sup> Full production beginning year 2

<sup>8</sup> Full production beginning year 2

**Sub-component 2 — Production of interpersonal communication (IPC) materials based around the themes and messages of the materials in sub-component 1, to be used in advocacy, peer-education and youth outreach services.**

<b>Objectives/Outputs</b>	<b>Indicators</b>	<b>Means of Verification</b>	<b>Assumptions</b>
<b>Formative Research</b> 2.2.1 Formative research <sup>10</sup>	<ul style="list-style-type: none"> <li>• Dissemination workshop</li> <li>• Formative research report</li> </ul>	<ul style="list-style-type: none"> <li>• Dissemination workshop report</li> <li>• Research report</li> </ul>	<ul style="list-style-type: none"> <li>• Can access high risk groups for research, interventions and evaluations</li> </ul>
<b>Production of IPC Materials</b> 2.2.2 To produce a broad range of high-quality IPC materials <sup>11</sup> for use in IPC activities under Component 3 and Component 1 advocacy activities	<ul style="list-style-type: none"> <li>• Production of required materials<sup>12</sup> on a quarterly basis — national level design and provincial level production/printing (if feasible)</li> </ul>	<ul style="list-style-type: none"> <li>• Final materials</li> <li>• Authenticated distribution lists</li> <li>• Observation of material use</li> </ul>	<ul style="list-style-type: none"> <li>• Government agreeable to editorial content and creative approach</li> <li>• Graphic designers and content developers able to meet quality standards</li> </ul>
<b>Capacity Building</b> 2.2.3 To train users of IPC materials (i.e., peer educators, collaborators) on the proper use of materials	<ul style="list-style-type: none"> <li>• One training held per year in each participating province</li> </ul>	<ul style="list-style-type: none"> <li>• Training report</li> <li>• Training outputs</li> </ul>	<ul style="list-style-type: none"> <li>• Peer educators and collaborators available for training</li> </ul>

<sup>9</sup> Training and orientation for both journalists and phone hot-line management/staff beginning in five provinces in year 2 and expanding to 10 provinces in the following year

<sup>10</sup> Part of formative research carried out under Sub-Component 1

<sup>11</sup> Including, but not limited to, leaflets, flipcharts, comics, workbooks, posters, etc.

<sup>12</sup> All IPC materials to be developed will be based on the material requirements in support of activities to be undertaken in Components 1 and 3

**Sub-component 3 — Establish a clearinghouse to facilitate the distribution and use of IPC materials produced under Sub-component 2 by non-Project groups working in HIV/AIDS prevention.**

Objectives/Outputs	Indicators	Means of Verification	Assumptions
<b>Site Identification</b> 2.3.1 To identify and renovate site for use as clearinghouse	<ul style="list-style-type: none"> <li>• Site made available for use as clearinghouse</li> <li>• Formative research report</li> </ul>	<ul style="list-style-type: none"> <li>• Renovated room</li> </ul>	<ul style="list-style-type: none"> <li>• EA has space available</li> </ul>
<b>Capacity Building</b> 2.3.2 To train EA staff in the management of IPC Clearinghouse	<ul style="list-style-type: none"> <li>• Training held for selected staff upon completion of site renovation.</li> </ul>	<ul style="list-style-type: none"> <li>• Training report</li> <li>• Training outputs</li> </ul>	<ul style="list-style-type: none"> <li>• EA agreeable to assigning staff responsibility for management of clearinghouse</li> </ul>

## Component 2 — Mass Media and IPC Materials Activities

**Objective — To produce high quality, mass media<sup>13</sup> Behavior Change Communication programs, based around a television drama series that utilizes the ‘enter(tain)-educate’ model of behavior change theory along with supporting Interpersonal Communication (IPC) materials to be disseminated and utilized through various media and youth-focused venues.**

Three sub-components have been developed to achieve the objective of this component and each one will be presented separately below.

**Sub-component 1 — The production and broadcasting of an integrated package of BCC materials based around a long-running television drama series with complementary radio phone-in programs, youth-focused television documentaries and television and radio announcement spots.**

Outputs	Activities	Indicators
<ul style="list-style-type: none"> <li>• Formative research<sup>14</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Determine specific target groups, research goals and objectives</li> <li>• Develop Terms of Reference (ToR) for formative</li> </ul>	<ul style="list-style-type: none"> <li>• Research proposal and ToR</li> <li>• Contract with research agency</li> <li>• Research tools</li> </ul>

<sup>13</sup> Television drama, radio phone-in and television and radio discussion programs, documentaries and spots.

<sup>14</sup> Formative research results will be used for the development of outputs for all Project Components. Formative research will be used to identify (a) province-specific knowledge, practices, awareness, and attitudes of all target groups (not only youth), (b) needs and preferences (content, approach, style) of target groups for all Project activities, (c) opportunities and constraints in accessing all targets, (d) levels of awareness and acceptance of Project concepts among implementers, (e) most appropriate partners for implementation of activities in each province, and (f) ethical considerations for all Project activities, including M & E.

Outputs	Activities	Indicators
	<p>research</p> <ul style="list-style-type: none"> <li>• Select and contract qualified research agency</li> <li>• Design formative research</li> <li>• Conduct formative research<sup>15</sup>: (1) situation analysis (demographic, epidemiological, economic, political &amp; cultural environment, &amp; nature/type/reach of other interventions in place or planned) and (2) audience analysis (in-depth ‘insider’ understanding of target audience segments and their KAP, harmful social norms, obstacles to change, factors to motivate change, communication preferences).</li> <li>• Develop BCC objectives that specify nature of change to be achieved by interventions</li> <li>• Report/disseminate findings</li> </ul>	<ul style="list-style-type: none"> <li>• Dissemination workshop</li> <li>• Research report</li> </ul>
<p><b>Electronic Mass Media</b></p> <ul style="list-style-type: none"> <li>• 30 min television drama (30 episodes per year) — national level</li> <li>• 60 min radio phone-in programs — provincial level</li> <li>• Television documentaries — national level</li> <li>• Television and radio spots — national level</li> <li>• Provincial level broadcasters training</li> </ul>	<ul style="list-style-type: none"> <li>• Formation of Component 2 Working Group responsible for previewing messages and themes proposed by agency contracted to produce Component 2 outputs. Working Group to be comprised of stakeholders (including youth and PLWHA), design/media experts and health professional<sup>16</sup></li> <li>• Develop annual plans for electronic mass media programming, clarifying objectives, topics, themes, key messages, target production timelines, channels, etc</li> <li>• Arrange for primetime broadcast of mass media products</li> <li>• Monitor broadcast of television and radio drama, documentaries, discussion programs and spots to ensure compliance to mass media plan (i.e., are adequate numbers of target group being reached;</li> </ul>	<ul style="list-style-type: none"> <li>• Component 2 Working Group formed</li> <li>• Number and type of involvement of youth and PLWHA</li> <li>• Mass media plans developed and approved</li> <li>• Tender documents prepared and published</li> <li>• Proposals received, reviewed and scored</li> <li>• Contract with agency/agencies signed</li> <li>• Broadcast schedule/contract for dramas, documentaries, discussion programs and promotional/informational spots</li> <li>• Monitoring reports of television and radio broadcasts — both national and provincial levels</li> <li>• Training reports</li> </ul>

<sup>15</sup> For further details, see Rehle T, Saidel T, Mills S and Magnani R. (Eds) (Family Health International). No date. Evaluating Programs for HIV/AIDS Prevention and Care in Developing Countries: A handbook for program managers and decision makers. FHI IMPACT. See esp. Chapter 3.

<sup>16</sup> Component 2 Working Group to provide guidance for the design of both electronic and print materials — creative/editorial control of content to be retained by agency contracted to implement Component 2.

Outputs	Activities	Indicators
	<p>are messages coordinated with IPC activities; are broadcasts taking place on schedule and at the planned frequency; are changing needs of target populations being captured?)</p> <ul style="list-style-type: none"> <li>• Provide training for broadcasters at the provincial levels on the development and broadcast of Project linked programming</li> </ul>	
<p><b>Print Mass Media</b></p> <ul style="list-style-type: none"> <li>• Regular publication of newspaper and magazine articles targeting youth</li> <li>• Journalist training</li> </ul>	<ul style="list-style-type: none"> <li>• Identify and select topics for publication in youth targeted publications<sup>17</sup></li> <li>• Develop annual plans for print mass media programming, clarifying objectives, topics, themes, key messages, target production timelines, publications, etc</li> <li>• Select youth targeted publications to publish feature articles and columns on a regular basis<sup>18</sup></li> <li>• Monitor publication of materials to ensure compliance to mass media plan and contracts (i.e., are articles being written and published as scheduled; are selected publications effectively reaching the target audience; is any feedback being received from target audience members? etc.)</li> <li>• Provide training for journalists at the national and provincial levels on the ethics of and appropriate ways of reporting on HIV/AIDS</li> </ul>	<ul style="list-style-type: none"> <li>• Topics selected and approved</li> <li>• Number and type of involvement of youth and PLWHA</li> <li>• Tender documents prepared and published</li> <li>• Proposals received, reviewed and scored</li> <li>• Contract with publications signed</li> <li>• Monitoring reports of published materials</li> <li>• Copies of published materials</li> <li>• Training reports</li> </ul>
<ul style="list-style-type: none"> <li>• Interactive website — linked to television and radio drama content — national level</li> </ul>	<ul style="list-style-type: none"> <li>• Analyze existing Vietnamese language HIV/AIDS focused web sites</li> <li>• Identify website content (for new site linked to mass media dramas)</li> <li>• Develop tender document and contract company to develop, obtain URL, upload and manage web-</li> </ul>	<ul style="list-style-type: none"> <li>• Report on analysis of web sites</li> <li>• Content selected and approved</li> <li>• Tender documents prepared and published</li> <li>• Proposals received, reviewed and scored</li> <li>• Contract with web site design/management company signed</li> </ul>

<sup>17</sup> Under the technical guidance of the Component 2 Working Group and identified through formative research.

<sup>18</sup> Articles to be authored by selected publications and independent writers under the technical guidance of the Component 2 Working Group and based on information needs identified by formative research.

<sup>19</sup> For example, usage statistics such as daily/monthly hits, files downloaded, pages visited, emails received, etc.

Outputs	Activities	Indicators
	<ul style="list-style-type: none"> <li>site</li> <li>Promote site via mass media interventions</li> <li>Monitor and update content of web site to ensure compliance to mass media plan</li> <li>Monitor use of web site<sup>19</sup></li> </ul>	<ul style="list-style-type: none"> <li>TV and radio spots and print ads promoting web site</li> <li>Monitoring reports</li> </ul>
<ul style="list-style-type: none"> <li>Support to phone hot-lines — linked to television and radio drama content</li> </ul>	<ul style="list-style-type: none"> <li>Promote phone hot-line use on mass media programming</li> <li>Orient/train phone hot-line management and staff on Project messages/information</li> </ul>	<ul style="list-style-type: none"> <li>TV and radio spots and print ads promoting phone hot-line</li> <li>Monitoring reports</li> <li>Orientation/training reports</li> </ul>

**Sub-component 2 — Production of interpersonal communication (IPC) materials based around the themes and messages of the materials in sub-component 1, to be used in advocacy, peer-education and youth outreach services.**

Outputs	Activities	Indicators
<ul style="list-style-type: none"> <li>Formative research<sup>20</sup></li> </ul>	<ul style="list-style-type: none"> <li>Determine research goals and objectives</li> <li>Select and contract qualified research agency</li> <li>Design formative research</li> <li>Conduct formative research<sup>21</sup>: (1) situation analysis (demographic, epidemiological, economic, political &amp; cultural environment, &amp; nature/type/reach of other interventions in place or planned) and (2) audience analysis (in-depth 'insider' understanding of target audience segments and their KAP, harmful social norms, obstacles to change, factors to motivate change, communication preferences).</li> <li>Develop BCC objectives that specify nature of change to be achieved by interventions</li> <li>Report/disseminate findings</li> </ul>	<ul style="list-style-type: none"> <li>Research proposal</li> <li>Contract with research agency</li> <li>Research tools</li> <li>Dissemination workshop</li> <li>Research report</li> </ul>
<ul style="list-style-type: none"> <li>Broad range of professionally produced IPC</li> </ul>	<ul style="list-style-type: none"> <li>Formation of Component 2 Working Group responsible for previewing messages and themes</li> </ul>	<ul style="list-style-type: none"> <li>Design Component 2 Working Group formed</li> </ul>

<sup>20</sup> Part of formative research carried out under Sub-component 1

<sup>21</sup> For further details, see Rehle T, Saidel T, Mills S and Magnani R. (Eds) (Family Health International). No date. Evaluating Programs for HIV/AIDS Prevention and Care in Developing Countries: A handbook for program managers and decision makers. FHI IMPACT. See esp. Chapter 3

Outputs	Activities	Indicators
materials	<p>proposed by agency contracted to produce Component 2 outputs. Working Group to be comprised of stakeholders (including youth and PLWHA), design/media experts and health professionals<sup>22</sup></p> <ul style="list-style-type: none"> <li>• Develop annual plan for IPC materials, (linked to IPC activities to be carried out under Component 3 and advocacy activities to be carried out under Component 1)<sup>23</sup> clarifying goals, objectives, topics, themes, key messages and target production timelines</li> <li>• Arrange for distribution of IPC materials</li> <li>• Monitor the content, distribution and use of IPC materials to ensure compliance to IPC materials plan (i.e., are adequate numbers of target group being reached; are messages coordinated with IPC activities; is distribution taking place on schedule and at the planned frequency; are changing needs of target populations being captured in the materials?)</li> <li>• Provide orientation and training for appropriate use of IPC materials to IPC intervention partners</li> </ul>	<ul style="list-style-type: none"> <li>• Number and type of involvement of youth and PLWHA</li> <li>• Plans developed and approved</li> <li>• Tender documents prepared and published</li> <li>• Proposals received, reviewed and scored</li> <li>• Contract with agency/agencies signed</li> <li>• Production scheduled agreed</li> <li>• Monitoring of production, distribution and use of IPC materials</li> </ul>

<sup>22</sup> Component 2 Working Group to provide guidance for the design of both electronic and print materials — creative/editorial control of content to be retained by agency contracted to implement Component 2.

<sup>23</sup> Component 2 Working Group to collaborate with Component 3 partners to determine appropriate IPC materials to be developed.

**Sub-component 3 — *Establish a clearinghouse to facilitate the distribution and use of IPC materials produced under Sub-component 2 by non-Project groups working in HIV/AIDS prevention.***

<b>Outputs</b>	<b>Activities</b>	<b>Indicators</b>
<ul style="list-style-type: none"> <li>• IPC Materials Clearinghouse</li> </ul>	<ul style="list-style-type: none"> <li>• EA to identify appropriate site for IPC Materials Clearinghouse</li> <li>• EA to assign staff to organize and manage the clearinghouse</li> <li>• EA staff cooperate with media production agency contracted to produced mass media and IPC materials under Component 2 in the establishment of clearinghouse.</li> <li>• Necessary presentation equipment procured and installed.</li> <li>• EA staff trained as necessary.</li> </ul>	<ul style="list-style-type: none"> <li>• Clearinghouse established and used by stakeholders</li> </ul>

## **Component 3 — Community Based HIV/AIDS Prevention for youth through improved access to services and primary prevention in youth-focused venues**

### **Objective**

To reduce HIV/AIDS infection risk among vulnerable and mainstream youth through BCC programs using materials and messages developed in component 2, through community based advocacy, peer education and life skills training.

### **Description**

This component is designed to implement a range of training activities and interventions at the community level that will reduce the risk of HIV/AIDS infection among vulnerable groups. The IPC materials developed in Component 2 will be used in all of the training and outreach activities in this component so that the linkage between the mass media programs and the IPC programs is developed and strengthened and so that consistent messages are presented. The strategy is to implement an integrated package of activities for vulnerable groups, as well as for mainstream youth in schools, and for parents and community collaborators so that an enabling environment is created to support youth in reducing their HIV infection risk.

To achieve the component objective, the Project will work with a number of different vulnerable groups including IDUs, youth working in exposed service industries and in factories, unemployed youth, mainstream youth and parents.. By having an integrated approach that combines harm reduction and peer education for specific groups with community education and support programs, it is anticipated that more effective models of HIV prevention can be introduced in the community.

Interlinked activities of this component include: harm reduction services; peer education and life skills programs for high risk and vulnerable youth groups, and training of community collaborators/networkers and teachers to provide primary prevention for mainstream youth and their parents. The activities will provide young people with information and knowledge, as well as with condoms and needle exchange, and will offer them the opportunity to have counseling and testing in a convenient and safe setting. Through awareness raising by community networkers, parents and community leaders will gain a greater understanding of how to sympathize with and relate to young people. Through the links with the TV drama, radio programs and IPC materials developed in Component 2, it is anticipated that more open discussion on HIV/AIDS issues and harm reduction will occur in families and in the community, and that there will be more tolerance and understanding of IDUs and PLWHA living in the community as a result of the Project activities.

The following three sub-components have been developed to achieve the objective of this component:

- iii) To implement comprehensive HIV and health harm-reduction outreach services incorporating voluntary counseling and testing (VCT), condom and needle provision and peer education outreach services for high risk groups.
- iv) HIV/AIDS prevention programs for vulnerable youth implemented in workplaces, vocational training centres and other youth focused venue and
- v) HIV/AIDS primary prevention programs implemented for mainstream youth, parents and community collaborators

### **Sub-Component 1**

Comprehensive HIV and health harm-reduction outreach services incorporating voluntary counseling and testing (VCT), condom and needle provision and peer education outreach services for high risk groups.

### **Description**

This sub-component focuses on the provision of harm reduction services for high risk groups.

### **Harm reduction services**

The promotion of harm reduction interventions is endorsed by the GoV and is one of the objectives of the National Strategy of HIV/AIDS Prevention and Control with the target of 100% safe injection and condom by all people with HIV/AIDS infection risk behaviours. Voluntary counseling and testing services are another aspect of harm reduction since counseling on safe sex practices can be provided to those who come for testing. The provision of youth friendly harm reduction services needs to take into consideration the issues of access. During the TA provincial visits it was found that young people do not go to health centres for information on sexual health, so there is a need to identify suitable facilities and location where young IUDs and other high risk youth are willing to go for advice and services. In Thanh Hao a harm reduction program managed by Burnet Institute located their services across the road from the commune health station rather than being inside it. As there are still very few VCT services in Viet Nam most of them are still located within the district health centres, integrated into family planning and reproductive health services or at the DoH preventative medicine centres. The target from the National HIV/AIDS strategy is to expand the VCT to 100% of provinces and 50% of all districts by 2010. One way to expand VCT services is to integrate services into health care programs, family planning, maternal and child care and protection and primary health care programs. However the National Strategy also emphasizes the need to mobilize the participation of the private sector in providing counseling and support services. It is through the use of the private sector, such as private doctor's clinics, and pharmacies linked with a peer education program that the Project will provide youth friendly harm reduction services for high risk youth such as IDUs, SWs and youth working as service girls in the entertainment and hospitality sector.

The services will be provided by an NGO experienced in service delivery of harm reduction, VCT and peer education programs for HIV/AIDS prevention. It is envisaged that the harm reduction program would have a static location in which the counseling and testing will take place alongside a mobile team of peer educators who will provide the condoms, needles and IPC materials to their peers through contact in the community.

The location of the harm reduction/VCT service will need to be determined in each province by the NGO in consultation with the PPMU, DoH and representatives from the high risk youth group. Once a suitable location is agreed the NGO will recruit and train 2-3 staff to do the counseling and testing. Only the rapid test kits are used at this type of location with referrals to the health centre if the result is positive or non specific. The peer educators will be recruited from among the IDU, SWs and service employees from the entertainment industry. They will receive training in HIV/AIDS prevention and in counseling and will be supervised by the NGO. They will be responsible to distribute condoms and to do the needle exchange program and to provide IPC materials. They will also provide information on the VCT services and encourage their peers to attend. The NGO and peer educators will work to develop trusting relationships with the owners of entertainment centres, hotel and bars so that they have permission to make contact with their staff.

The EA will identify and contract a suitably qualified NGO, either local or international, using the government regulated bidding process for establishing and developing harm reduction youth friendly services. It is planned that for the first phase, five programs will be established by the selected NGO within the first five provinces, followed by another 5 programs in the

second five project provinces at the beginning of the second phase and third phase. The project will supply to the NGOs free condoms, clean needles/syringes and IPC materials for distribution through the program.

### **Rationale**

- There is a growing acceptance by provincial authorities that harm reduction services including VCT services can help in early detection of HIV, therefore by making VCT services more accessible through community based services it will increase the accuracy of the number of youth that are HIV+;
- VCT services have become a national program approved by the National Strategy and the project can support this activity;
- Youth friendly services that are available in locations that high risk groups are willing to come to will increase the number of people receiving advice on harm reduction strategies.

### **Outputs**

Sub-Components 1 will result in a number of outputs including:

- Community based harm reduction services for high risk groups
- Peer education programs for IDUs, SWs and youth in exposed service industry occupations for RH and HIV/AIDS prevention and harm reduction.

### **Methods**

In order to accomplish the outputs listed above the following steps will be carried out:

- EA to identify and contract a suitably qualified NGO to implement community based harm reduction services in the project provinces.
- Provide the selected NGO with condoms, needles, and syringes.
- Peer education training program and supervision of high risks groups provided by the contracted NGO in the project provinces.

### **Target Groups**

- Vulnerable youth (IDUs, sex workers, youth in exposed service industry occupations).
- Community leaders, hotel, restaurant and bar owners, Potential Partners for Implementation

Potential implementing partners include:

- NGOs with experience in establishing and implementing harm reduction programs, VCT services and peer education programs.

### **Sub-Component 2**

HIV/AIDS prevention programs for vulnerable youth implemented in work-places, vocational training centres and other youth focused venues.

### **Description**

#### **Peer Education**

Models of proper peer education programs exist in Viet Nam and they have been successful in reaching the target groups with information and education and providing ongoing support to peers. In this activity, the identified strategy is through the development of peer education networks to reach different vulnerable groups of youth. During provincial consultations, it was observed that many so called peer education programs were not truly peer-to-peer

programs with the peer educator coming from a different social group to that of the person receiving the information.

The project strategy is to request suitable NGO(s) to develop and implement a comprehensive peer education/life skills (PE/LS) training programs for training of trainers, effective coaching and supervision of training activities at various levels of project implementation. This will be done through the EA contracting through a bidding process, a suitably qualified NGO to provide the PE/LS training programs for street youth, industrial workers and vocational trainees. The NGO is also responsible for coaching as well as supervising peer education and outreach activities to ensure the quality and appropriateness of the PE training/outreach activities.

In formative research during the first year, each selected province will identify whether any PE/LS programs already exist for any of these groups, in which case the project will offer to support those existing programs with IPC materials. Using existing materials and the project IPC materials developed through Component 2, several training courses will be conducted by the selected NGO for peer educators in each project province. For each course, 25 participants will be invited to attend, of whom ten will be selected to be peer educators for the program. After the training courses these peer educators will receive IPC materials regularly for distribution and use with their peers in discussion groups and in one-to-one meetings. Condoms will also be distributed as appropriate through the peer networks as this has been shown in other programs to be the effective route most favored by young people to receive these supplies.

### **Life Skills Training for Unemployed Youth and Street Youth**

Unemployment and underemployment rates are high among youth in both rural and urban Viet Nam. School drop-outs who are unemployed are more vulnerable to drug use and sex work; this social group is large because the majority of youth do not complete upper secondary school. Drop-outs are more likely to have inadequate understanding of HIV transmission and prevention, and less likely to have basic life skills to resist peer pressure, communicate effectively, have empathy and self-awareness, and to present themselves effectively to potential employers. Life skills training would act on two levels to build protective skills for (1) healthy youth development as well as (2) to reduce risk behaviors, both of which will contribute to HIV/AIDS prevention.

Many drop-outs and unemployed youth seek vocational training in Department of Labor, Invalids and Social Affairs (DoLISA)-supported centers. Vocational Training and Job Recruitment Centers are increasing rapidly in Viet Nam. The Ministry of Labor, Invalids and Social Affairs (MoLISA) has recently sought approval to expand its current system of 1,700 training schools/centers, which train about 1.1 million people annually (Viet Nam News, 28 July 2005). The proposed new system would permit the establishment of another 350 centers, largely through private investment, to extend training to 1.5 million students, while strengthening connections to mechanisms that identify specific labor needs. At present, life skills and HIV prevention education are not included in training, but managers in some provinces expressed interest in their inclusion. Vocational training and job recruitment centers also offer easier access to a population of unemployed youth that is otherwise dispersed and difficult to reach, thus providing economies of scale. In each of the project provinces, two Training Centers and Job Recruitment Centers will be selected to participate in the project. A training course will be held for 25 participants and 10 participants will be selected to become peer educators to carry out HIV/AIDS prevention for trainees in the two Vocational Training and Job Recruitment Centers.

In addition to the peer education training on HIV prevention to reach vulnerable youth, the project will provide basic life skills for street youth of 'Sympathy Houses and Classes' and trainees in vocational training and job recruitment centers. The contents will also be included

in the selected NGOs' comprehensive peer education/life skills (PE/LS) training programs for training of trainers, coaching and supervision of training activities at various levels of project implementation. In each of the project provinces, a 'Sympathy House' and a 'Sympathy Class' will be selected for participate. The sympathy Houses are centres established to provide accommodation, education and counseling for disadvantaged children/adolescents, especially for street/migrant children. Most of Sympathy Houses are managed by the VCPFC and are put in place in almost all districts of the cities.

### **Formative research**

Formative studies will be carried out in the beginning of the project, focusing on the vulnerable groups working in industrial zones, street youth and trainees in vocational training and job recruitment centres. These studies are aimed at identify the overall situation, assess current KAP, nature of risk behaviors, and specific needs of different youth groups for PE/LS training needs on HIV prevention. Findings from the studies will help identify most appropriate ways to reach and influence them.

### **Rationale**

- Youth communicate best with and trust other youth in the same social, economic and cultural group.
- Youth are often shy and embarrassed to discuss sexuality with their parents or other elders so there is a need to train youth to be able to speak to their peers on such issues and to be able to provide information and prevention methods such as condoms will help to reduce transmission of HIV/AIDS.
- Rapid social change, urbanization and lifestyle changes in Viet Nam present some risks for healthy youth development and family harmony;
- Young male drop-outs are at particular risk for drug use, and many lack skills to resist peer pressure;
- Young female drop-outs who lack self-esteem and other Life Skills may be at risk of early sex, as well as being involving in selling sex;
- Life skills training is not included in current programs in vocational training/job recruitment centers; and
- Current public awareness of youth employment and vocational training needs offers an opportunity to strengthen current models to contribute to healthy youth development and HIV prevention.

### **Outputs**

Sub-Component 2 will result in the following outputs:

- Formative research conducted to assess current KAP and appropriate PE/LS training needs on HIV/AIDS prevention for the target groups; Peer education programs for industrial zone workers for RH and HIV prevention;
- Life skills training for Vocational Training & Job Recruitment Center trainees provided.
- Life skills training programs for street youth implemented for RH and HIV/AIDS prevention.

### **Methods**

In order to accomplish the outputs listed above the following steps will be carried out:

- Conduct formative studies to identify the KAP among the vulnerable groups,.
- EA to identify and contract a suitably qualified NGO to implement peer education programs and life skills training programs for the identified vulnerable groups.
- Provide NGO with condoms for distribution through the peer education programs.
- Provide equipment (TV and VCD/DVD sets) if required, to factories, vocational training centers participating in the project in the selected provinces.

## Target Groups

- Vulnerable youth ( industrial zone workers, unemployed youth, school drop outs, street youth, rural youth registered with job recruitment centers).
- Community leaders, factory managers, directors of Vocational Training & Job Recruitment Centers.

### Participating Partners

- NGOs with experience in implementing peer education programs and life skills training programs for HIV/AIDS prevention.

## Sub-component 3

HIV/AIDS primary prevention programs implemented for mainstream youth, parents and community collaborators.

### Description

The objective of this sub-component is to provide primary HIV prevention for mainstream youth, their parents and community net workers. The aim is to improve communication, reduce family/community conflicts and increase empathy between parents and youth and raise awareness of harmful gender social norms for both young males and females. The intervention will support mainstream youth and their families, and contribute to HIV/AIDS prevention, by providing capacity building for CPFC collaborators and other community workers such as Women's Union, Youth's Union and Farmer's Union. All is aimed at enabling them to foster better communication, harmony between generations, effective parenting, awareness of harmful gender norms, and improved practical support for PLWHA, young drug users, and sex workers.

The advantages of working with CPFC collaborators and other community net workers and parents are:

- CPFC, WU, YU and FU collaborators/net workers extends to every level, offering excellent access to the community and individual households, and enabling rapid dissemination of new activities and new concepts;
- Women make up the large majority of collaborators, which means this intervention would make a positive contribution to gender equity through skills and knowledge development;
- Skills to be developed in this activity are useful for other work undertaken by community collaborators.
- Linkage and cooperation between CPFC staff that formerly worked in vertical programs (family planning, child protection, etc) can be consolidated with other community workers as they come together under the VCPFC umbrella.

Although CPFC collaborators are very active in population and family planning mobilization, they do not own much experience in family issues and in home-based HIV/AIDS care and support. For this reason, the project strategy will be for the EA to contract a suitably qualified NGO, either local or international, to provide training courses for the CPFC collaborators and other community workers in parenting skills, social welfare skills and advocacy. The NGO also provides technical assistance and training support to build capacity for CPFC collaborators and other community workers. In collaboration with the NGO, VCPFC will conduct monitoring of outreach activities at the community.

Through training courses and other activities, a vertical network of community collaborators from CPFC, WU, YU, FU can be strengthened. At the district and commune levels, these community collaborators will be trained and equipped with the following competencies:

- Interpersonal communication
- Counseling
- Training methods for adult learners
- HIV/AIDS/STI knowledge
- Communication and empathy
- Tools to reduce stigma and discrimination
- Effective parenting
- Gender awareness
- “First Aid” for drug users<sup>1</sup>
- Care and support for PLWHA
- Effective use of IPC materials

Following training, it is planned that 200 collaborators from each of the selected province will be selected as outreach workers for the project in the community. They will conduct several parental classes, including young parents, and carry out a program of home visits to support families in difficult circumstances especially those with youth IDUs, school drop-outs and PLWHA. They will also organize anti-stigma activities in the community to decrease discrimination towards IDUs, SWs and PLWHA and advocate for employment opportunities for these groups.

### **Prevention Program for Youth in Schools**

The Ministry of Education and Training has recently completed the developed of new curricula for HIV/AIDS prevention in schools by integrating the topic into a number of subjects. The MoET requires teaching aids to support the new curricula so that teachers can easily introduce the subject. For this reason, the project will develop appropriate teaching aids for the teachers, using the IPC materials developed in Component 2.

The provincial Department for Education and Training (DOET) will be appointed to provide training for teachers in the use of teaching aids and the IPC materials for HIV/AIDS prevention. Where appropriate, DoET can collaborate with provincial Centers for Health Education to train teachers coming from selected secondary schools and teacher education colleges in the use of IPC materials and teaching aids. To support the use of the teaching aids and the ongoing use of the IPC materials the project may also supply TV/Video and DVD sets to selected schools, if required, in each province.

### **Rationale**

- Good parenting skills foster family harmony and healthy youth development, and help prevent conflict, which may lead to school drop-out, depression, risky behavior and even youth self-harm;
- Gender norms sometimes blame women when men are unfaithful, and when youth practice risky behavior;
- Youth drug use presents enormous challenges to families and communities because there are few rehabilitation skills or services;
- Families face great difficulties in caring for members living with HIV/AIDS because of stigma, lack of services, and lack of knowledge about care and support;
- CPFC collaborators have good knowledge on family planning but need training on HIV/AIDS and referral for STIs;
- Youth need positive messages and self-esteem to resist drugs; and

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<sup>1</sup> Kitchener B and Jorm A. 2002. *Mental Health First Aid Manual*. Center for Mental Health Research, Australian National University, Canberra, pp. 44–60.

- CPFC collaborators and other community net workers are potential vehicles to organize community support & care for IDUs, SWs & PLWHA.
- The MoET has developed the new curricula for HIV prevention but is lacking suitable teaching aids. By development these materials for the MoET the project has the opportunity to provide teachers and students with materials that provide positive messages about HIV prevention and can assist in reducing stigma and discrimination towards IDUs and PLWHA.
- Materials can also influence students and teachers to be advocates for more open policies on condom availability and use and on harm reduction programs.

## Outputs

- Parenting skills, social welfare skills and advocacy provided for parents/collaborators at district and commune levels in project provinces.
- Support HIV prevention education and stigma reduction in secondary schools through use of project IPC materials and teaching aids by trained teachers in project provinces.

## Methods

- Provide IPC materials for trainers, collaborators and parents
- Conduct training-of-trainers courses on parenting skills, care and support skills and gender and use of IPC materials for district-level collaborators<sup>2</sup>
- Conduct district-level training courses on parenting skills and care ad support skills and use of IPC materials for commune-level collaborators
- Conduct parenting classes<sup>3</sup> at commune level<sup>4</sup>
- Implement monthly outreach parenting skills education/care and support program by trained collaborators to individual families with vulnerable youth and PLHWA
- Provide condoms through trained collaborators to families with vulnerable youth and PLWHA
- Provincial Department of Education and Training to train teachers in selected secondary schools in the use of the IPC materials and teaching aids.
- Supply IPC materials (teaching aids, student resources) for use in subjects that cover HIV education in secondary schools and teacher education colleges
- Conduct training courses for in-service teacher training in HIV prevention education, stigma reduction, and use of IPC materials in secondary schools

## Target Groups

- Young parents, adult parents, families with vulnerable youth, IDUs and PLWHA.
- Teachers in secondary schools

## Potential Partners for Implementation

Potential implementing partners include:

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<sup>2</sup> Collaborator networks exist at all levels. The most appropriate network/s will be identified in each district and commune, and are likely to include CPFC, Women's Union, Farmers' Union, Youth's Union and (where these exist) community-based organizations.

<sup>3</sup> Parenting skills classes, or parent-effectiveness-training, is a participatory course designed to give parents more effective ways of guiding, disciplining and communicating with their children. Classes use role plays and small group discussions of scenarios. Most parents will benefit from attending classes more than once in order to consolidate skills.

<sup>4</sup> Consider holding separate classes for parents who have youth in school, and for those who do not. Sensitivity is needed to ensure parents of school dropouts, or parents of misbehaving children, are not made to feel embarrassed, especially because these parents may have greater needs for parenting classes, and need encouragement to attend.

- NGOs with experience in training community workers in parenting skills, and social welfare training programs.
- CPFC collaborators, members of Women’s Union, Youth’s Union and Farmer’s Union workers at district and commune levels.
- MoET at national level and DoET at the provincial level.

### Consulting Inputs

The following consulting inputs will be required for the implementation of activities under Component 3.

Position	Person months	Outline ToR
Sub- component 1 NGO for Harm reduction services ( 1 NGO per set of five provinces)	(1)60 (2) 36 (3) 24 Total = 120	<ul style="list-style-type: none"> <li>• Establishing harm reduction service in a youth friendly setting to provide HIV prevention counseling and testing services, condoms and needle exchange programs.</li> <li>• Providing technical guidance as well as training for counselors/nurses and laboratory personnel.</li> <li>• Supporting social marketing of HIV voluntary counseling and testing—including improving understanding and valuing the service as well as advertising it. The marketing should include addressing issues of stigma, discrimination, barriers to access, etc.</li> <li>• Conduct training for peer educators for high risk groups.</li> <li>• Provide on-going supervision of peer educators program.</li> <li>• Establishing linkages to other support programs/activities, including health services, community and home–based care.</li> <li>• Provision of condoms, needles, syringes and IPC materials provided by the Project.</li> </ul>
Sub-coponent 2 NGO(s) for PE/LS training ( 1 NGO per set of five provinces)	(1)60 (2) 36 (3) 24 Totals = 120	<ul style="list-style-type: none"> <li>• Preparing Peer Education curriculum and plan of action for each training group based on foundation of formative studies and existing PE curricula;</li> <li>• Demonstrated capability to organize and implement participatory training course for training peer educators at provincial and district levels;</li> <li>• Managing and implementing peer education programs at the community level in a variety of setting;</li> <li>• Capable of supervising the peer educators and providing on–going support and in–service training;</li> <li>• Preparing Life Skills for HIV/AIDS curriculum and plan of action for each training group based on foundation of formative studies and existing LS curricula;</li> <li>• Demonstrated capability to organize and implement participatory training course for students in vocational and job recruitment centers at provincial and district levels;</li> <li>• Ability to conduct regular monitoring and evaluation and</li> <li>• Provision of monthly reports to PPMU.</li> </ul>
NGO(s) for training of CPFC and other community collaborators( One NGO or civil society organization per province)	(1)60 x 5 (2) 36x 5 (3) 24 x 5 C3 Total = 600	<ul style="list-style-type: none"> <li>• Preparing curriculum, planning and managing a training program for trainees working at the community level;</li> <li>• Providing effective training courses using participatory methods and ability to provide suitable trainers across a range to different topics;</li> <li>• Using evaluation methods that ensure the training programs are relevant for participants and that they are learning new skills.</li> </ul>

Note: Total per months of NGOs or civil society organizations contracted to deliver Component 3 is 840 person/agency months.

Component 3 activities will be carried out as illustrated in the Implementation Schedule below.

Activities	Year 1				Year 2				Year 3				Year 4				Year 5			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Formative studies																				
Identify and contract with NGO(s) to establish and manage harm reduction in services first services by the end of the first year																				
Harm reduction services operation in the first five provinces by the end of the first quarter of the second year.																				
Harm reduction services operation in the second five provinces by the end of the first quarter of the third year																				
Harm reduction services operation in the third five year provinces by the end of the first quarter of the fourth year																				
Identify and contract with NGO(s) to establish and manage the training of collaborators by the end of the first year																				

Activities	Year 1				Year 2				Year 3				Year 4				Year 5			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
HIV prevention education through PE & LS programs for vulnerable youth, in the first five provinces, second year					■	■	■	■												
HIV prevention education through PE & LS programs for vulnerable youth, introduced in the first five provinces, third year									■	■	■	■								
HIV prevention education through PE & LS programs for vulnerable youth, introduced in the first five provinces, fourth year													■	■	■	■				

## Component 3 — Community–Based HIV Prevention for youth through improved access to services and primary prevention in youth-focused venues - Logframe

**Objective — To reduce HIV/AIDS infection risk among vulnerable and mainstream youth through BCC programs using materials and messages developed in component 2, through community based advocacy, peer education and life skills training.**

**Sub–component 1 — To implement comprehensive HIV and health harm-reduction outreach services incorporating voluntary counseling and testing (VCT), condom and needle provision and peer education outreach services for high risk groups.**

Objectives/Outputs	Verifiable Indicators	Means of Verification	Assumptions
3.1.1 Community based harm reduction services established	<ul style="list-style-type: none"> <li>Number of HIV–infected individuals receiving specialized harm reduction services from project–funded centers in the past twelve months (to be stratified by age groups)</li> <li>Condoms, needles/syringes, VCT and STI treatment available and distributed as needed, and are actually used</li> <li>Increase 10% in the percentage of people accepting attitudes towards PLHWA</li> <li>Increase in the condom use among PLWHA living in the community</li> <li>Reduction in using injection drugs / sharing needles among frequent clients/visitors</li> </ul>	<ul style="list-style-type: none"> <li>Project report</li> <li>Special assessment among PLWHA and center clients/visitors</li> </ul>	<ul style="list-style-type: none"> <li>Authorities permit to set up harm reduction services, including VCT services run by capable and relevant NGOs</li> <li>Vulnerable groups can access to the VCT services. Anonymity must be warranted</li> <li>Condoms, quick–test and STI treatment available and distributed as needed, and are actually used</li> </ul>
3.1.2 HIV prevention education, harm reduction training for IDUs in project provinces	<ul style="list-style-type: none"> <li>Number of HIV/AIDS training courses with associated IPC materials developed, tested and available for IDUs in the community</li> <li>Increase in the percentage IDUs who can correctly identify ways of preventing HIV transmission</li> <li>Increase in the proportion of IDUs who report confidence in responding assertively to potentially harmful situations</li> </ul>	<ul style="list-style-type: none"> <li>Project report</li> <li>Special assessment among IDUs</li> </ul>	<ul style="list-style-type: none"> <li>Authorities permit IDU and harm reduction interventions</li> <li>Equipment reach target groups as planned and being used as intended</li> </ul>
3.1.3 HIV prevention education, harm reduction training for service industry employees in project prov-	<ul style="list-style-type: none"> <li>At least 80% of the workplaces visited by peer educators</li> <li>Increase in the proportion of service employees who can correctly identify ways of preventing HIV transmission and reject major misconceptions</li> </ul>	<ul style="list-style-type: none"> <li>Project report</li> <li>Special assessment among service employees in selected prov-</li> </ul>	<ul style="list-style-type: none"> <li>Authorities, employers, managers permit all interventions</li> <li>Time available for activi-</li> </ul>

Objectives/Outputs	Verifiable Indicators	Means of Verification	Assumptions
inices	<ul style="list-style-type: none"> <li>• Increase in the percentage of service employees who report able to refuse undesired sex and/or drug use</li> <li>• Reduction in the proportion of young males and females with non-regular partners</li> <li>• Increase in the proportion of young males who report having sex with sex workers and/or casual partners and using condoms</li> <li>• Increase in the proportion of employees who report confidence in responding assertively to potentially harmful situations</li> </ul>	inices	<ul style="list-style-type: none"> <li>• ties in workplace</li> <li>• Supplies and equipment reach target groups as planned and being used as intended</li> </ul>

**Sub-component 2 - HIV/AIDS prevention programs for vulnerable youth implemented in work-places, vocational training centres and other youth focused venues**

Objectives / Outputs	Verifiable Indicators	Means of Verification	Assumptions
3.2.1 Formative research conducted to assess current KAP and appropriate life skills training needs on HIV prevention move to 3.2.1	<ul style="list-style-type: none"> <li>• Three studies completed as planned</li> <li>• Study tools and reports</li> <li>• Results used for IPC material development and project planning</li> </ul>	<ul style="list-style-type: none"> <li>• Qualitative and quantitative studies</li> </ul>	<ul style="list-style-type: none"> <li>• Target groups willing to participate in research</li> <li>• Independent researchers with relevant skills and expertise available</li> </ul>
3.2.2 HIV prevention education, Life Skills training, trained for Street Youth through peer education & “sympathy houses and classes” in project provinces	<ul style="list-style-type: none"> <li>• Number of HIV/AIDS training courses with associated IPC materials developed, tested and available for Street Youth living in “sympathy houses and classes”</li> <li>• Increase in the percentage of the above street youth who can correctly identify ways of preventing HIV transmission and reject major misconceptions</li> <li>• Increase in the proportion of street youth who report confidence in responding assertively to potentially harmful situations</li> </ul>	<ul style="list-style-type: none"> <li>• Project report</li> <li>• Special assessment among street youth in “sympathy houses and classes” in selected provinces</li> </ul>	<ul style="list-style-type: none"> <li>• Authorities, employers, managers permit all interventions</li> <li>• Children/youth willing to become peer educators</li> <li>• Supplies and equipment reach target groups as planned and being used as intended</li> </ul>
3.2.3 HIV prevention education and harm reduction trained for industrial zone employees in project provinces	<ul style="list-style-type: none"> <li>• At least 60% of the workplaces visited by peer educators</li> <li>• Increase in the proportion of industrial zone workers who can correctly identify ways of preventing HIV transmission and reject major misconceptions</li> </ul>	<ul style="list-style-type: none"> <li>• Project report</li> <li>• Special assessment among industrial zone workers in selected prov-</li> </ul>	<ul style="list-style-type: none"> <li>• Authorities, and managers permit all interventions</li> <li>• Time available to con-</li> </ul>

Objectives / Outputs	Verifiable Indicators	Means of Verification	Assumptions
	<ul style="list-style-type: none"> <li>• Increase in the percentage of industrial zone workers who report able to refuse undesired sex and/or drug use</li> <li>• Reduction in the proportion of young male and female workers with non-regular partners</li> <li>• Increase in the proportion of young males who report using condoms when having sex with sex workers and/or casual partners and using condoms</li> <li>• Increase in the proportion of workers who report confidence in responding assertively to potentially harmful situations</li> </ul>	inches	<ul style="list-style-type: none"> <li>• consolidate skills</li> <li>• Supplies and equipment reach target groups as planned and being used as intended</li> </ul>
3.2.4 HIV prevention education, Life Skills training, and harm reduction trained for trainees in vocational and job recruitment centers in project provinces	<ul style="list-style-type: none"> <li>• At least 80% of trainees can correctly identify ways of preventing HIV transmission and reject major misconceptions</li> <li>• Increase in the proportion of trainees who can correctly identify ways of preventing HIV transmission and reject major misconceptions</li> <li>• Reduction in the proportion of male and female trainees with non-regular partners</li> <li>• Increase in the proportion of male trainees who report using condoms when having sex with sex workers and/or casual partners</li> <li>• Increase in the proportion of trainees who report confidence in responding assertively to potentially harmful situations</li> <li>• Reduction in the percent of trainees who would refuse casual contact with a PLWHA.</li> </ul>	<ul style="list-style-type: none"> <li>• Project report</li> <li>• Special assessment among trainees in selected vocational and job-recruitment centers</li> </ul>	

**Sub-component 3 - HIV/AIDS primary prevention programs implemented for mainstream youth, parents and community collaborators.**

Objectives / Outputs	Verifiable Indicators	Means of Verification	Assumptions
3.3.1 NGOs specializing in parental skills, social welfare, family and advocacy selected	<ul style="list-style-type: none"> <li>• At least 80% of the trained collaborators organizing parenting skills education and regular individual families with vulnerable children visited</li> <li>• At least 30% parents report conversations across generations about gender norms and sexuality</li> </ul>	<ul style="list-style-type: none"> <li>• Project report</li> <li>• KAP specially designed surveys among parents and youth</li> <li>• Baseline, mid-term, and final surveys</li> </ul>	<ul style="list-style-type: none"> <li>• Reported behavior is valid and reliable indicator of actual behavior</li> <li>• Parenting skills and collaborators skills training classes are taught well and able to consolidate</li> </ul>
3.3.2 Parenting skills, social welfare skills and advo-	<ul style="list-style-type: none"> <li>• At least 20% of youth reporting they have sought advice</li> </ul>		

Objectives / Outputs	Verifiable Indicators	Means of Verification	Assumptions
<p>cacy provided for parents/ collaborators at district and commune levels in project provinces</p>	<p>from a trusted adult</p> <ul style="list-style-type: none"> <li>• At least 80% parents and 50% youth report increased openness of communication across generations</li> <li>• Reduction in the percent of parents who report difficulties in disciplining children (aged 15–24)</li> <li>• Increase in the percent of parents who report increased success in disciplining their children without violence</li> <li>• Reduction in the percentage of youth stating it is morally more important for a woman to be a virgin at marriage than for a man</li> <li>• Reduction in the percentage of youth stating that a man should be sexually experienced prior to marriage</li> <li>• Increase in the percentage of adults who support education on condom use/needle-cleaning</li> </ul>		<p>skills in given timeframe</p> <ul style="list-style-type: none"> <li>• Trainers share Project understanding about harmfulness of some gender social norms</li> </ul>
<p>3.3.3 Support HIV education and stigma reduction trained for teachers in Lower and Upper secondary schools and Teacher education colleges</p>	<ul style="list-style-type: none"> <li>• At least 80% of the above trained teachers use IPC materials and HIV teaching aid in their regular teaching session in class.</li> <li>• 90% pre-service and in-service teachers answering correct answers in knowledge test</li> <li>• Increase in the percentage of pre-service and in-service teachers who are in favor of young people being educated about the use of condoms and clean needles in order to prevent HIV/AIDS</li> <li>• Increase in the percentage of pre-service and in-service teachers who report confidence and willingness to teach about HIV/AIDS</li> <li>• Increase in the condom use among pre-service and in-service teachers</li> <li>• Reduction in the percent of pre-service and in-service teachers expressing willing to discriminate against person living with HIV/AIDS.</li> </ul>	<ul style="list-style-type: none"> <li>• Project report</li> <li>• Special assessment among teachers in secondary schools and education colleges in selected provinces</li> </ul>	<ul style="list-style-type: none"> <li>• Time available to train teachers</li> <li>• Interest from teachers</li> <li>• Teachers use IPC materials supplied</li> <li>• Education about stigma leads to change in attitudes and behavior</li> <li>• Teachers share project views on definitions and harmfulness of stigma and discrimination</li> </ul>

## Component 3 — Community–Based HIV Prevention for youth through improved access to services and primary prevention in youth-focused venues: Activities

**Objective —** *To reduce HIV/AIDS infection risk among vulnerable and mainstream youth through BCC programs using materials and messages developed in component 2, through community based advocacy, peer education and life skills training.*

**Sub–component 1 —** *Comprehensive HIV and health harm-reduction outreach services incorporating voluntary counseling and testing (VCT), condom and needle provision and peer education outreach services for high risk groups.*

Outputs	Activities	Indicators
3.1.1 Community based harm reduction/VCT services established	<ul style="list-style-type: none"> <li>• Work with district authorities and representatives of high risk groups to identify appropriate sites for harm reduction/VCT services</li> <li>• Establish VCT services (This will be the EA's bidding process to subcontract a suitable NGO to establish one harm reduction/VCT service per province. The appropriate NGO will set up and equip centers, provide training and supplies and manage the centers with the participation of PLWHA as counselors</li> <li>• Provide IPC materials for VCT services</li> <li>• Provide condoms and identify appropriate distribution channel/s in the community</li> </ul>	<ul style="list-style-type: none"> <li>• Number of HIV–infected individuals receiving specialized VCT services from project–funded activities in the past twelve months (to be stratified by age groups)</li> <li>• Condoms, needles/syringes, VCT and STI treatment available and distributed as needed, and are actually used</li> <li>• Increase in the percentage of people accepting attitudes towards PLHWA Increase in the condom use among PLWHA living in the community</li> <li>• Reduction in using injection drugs / sharing needles among frequent clients/visitors</li> </ul>
3.1.2 HIV prevention education, harm reduction trained for IDUs in project provinces	<ul style="list-style-type: none"> <li>• Provide IPC materials</li> <li>• Conduct training courses for peer educators on HIV education, BCC methods, and use of IPC materials (one course for each province)</li> <li>• Provide IDUs peer educators with condoms, clean needles/ syringes and identify appropriate distribution channel/s to reach their peers</li> <li>• Implement monthly outreach peer education, and harm reduction programs among IDUs</li> </ul>	<ul style="list-style-type: none"> <li>• Number of HIV/AIDS training courses with associated IPC materials developed, tested and available for IDUs in the community</li> <li>• Increase in the percentage IDUs who can correctly identify ways of preventing HIV transmission</li> <li>• Increase in the proportion of IDU who report confidence in responding assertively to potentially harmful situations</li> </ul>
3.1.3 HIV prevention education, harm reduction	<ul style="list-style-type: none"> <li>• Provide IPC materials</li> </ul>	<ul style="list-style-type: none"> <li>• At least 80% of the workplaces visited by peer</li> </ul>

<b>Outputs</b>	<b>Activities</b>	<b>Indicators</b>
training for service industry employees in project provinces	<ul style="list-style-type: none"> <li>• Conduct training course for peer educators on HIV/AIDS education, BCC methods, and use of IPC materials</li> <li>• Implement outreach peer education, harm reduction program for service industry employees</li> <li>• Provide condoms to service industry employees</li> </ul>	<p>educators</p> <ul style="list-style-type: none"> <li>• Increase in the proportion of service employees who can correctly identify ways of preventing HIV transmission and reject major misconceptions</li> <li>• Increase in the proportion of young males who report having sex with sex workers and/or casual partners and using condoms</li> <li>• Increase in the proportion of employees who report confidence in responding assertively to potentially harmful situations</li> </ul>

**Sub-component 2 - HIV/AIDS prevention programs for vulnerable youth implemented in work-places, vocational training centres and other youth focused venues**

<b>Outputs</b>	<b>Activities</b>	<b>Indicators</b>
3.2.1 Formative research conducted to assess current KAP and appropriate life skills training needs on HIV prevention for various target groups with modifications where necessary (three specific studies)	<ul style="list-style-type: none"> <li>• Conduct a study to identify current KAP and Life Skills training needs on HIV intervention among vulnerable populations (street children, service employees, industrial workers, vocational and job recruitment trainees)</li> <li>• Conduct a study to identify current KAP and training needs on HIV intervention among pre-service and in-service teachers who will carry out HIV/AIDS prevention education in schools.</li> <li>• Conduct a study to identify current KAP and parenting skills, care and support skills on HIV interventions in the community.</li> </ul>	<ul style="list-style-type: none"> <li>• Three studies completed by end of 1st year</li> <li>• Study tools and reports</li> <li>• Results used for IPC material development and project planning</li> </ul>
3.2.2 HIV prevention education, Life Skills training, trained for Street Youth through peer education & “sympathy houses and classes” in project provinces	<ul style="list-style-type: none"> <li>• Provide IPC materials</li> <li>• Conduct training course for street youth peer educators on HIV/AIDS education, life skills, (and BCC,</li> </ul>	<ul style="list-style-type: none"> <li>• Number of HIV/AIDS training courses with associated IPC materials developed, tested and available for Street Youth living in “sympathy houses and classes”</li> </ul>

Outputs	Activities	Indicators
	as appropriate) and use of IPC materials <ul style="list-style-type: none"> <li>• Implement outreach peer HIV education for target groups, especially those living in “sympathy houses”<sup>1</sup></li> <li>• Implement HIV and Life Skills education for street youth<sup>2</sup> attending “sympathy classes”</li> </ul>	<ul style="list-style-type: none"> <li>• Increase in the percentage street youth who can correctly identify ways of preventing HIV transmission</li> <li>• Increase in the proportion of street children who report confidence in responding assertively to potentially harmful situations</li> </ul>
3.2.3 HIV prevention education and harm reduction trained for industrial zone employees in project provinces	<ul style="list-style-type: none"> <li>• Provide IPC materials</li> <li>• Conduct training course for peer educators on HIV/AIDS education, BCC methods, and use of IPC materials</li> <li>• Implement outreach peer education, harm reduction program for factory workers in worksites and residence</li> <li>• Provide condoms to industrial zone workers</li> </ul>	<ul style="list-style-type: none"> <li>• 90% of PEs functioning in their role 2 years after training</li> <li>• Increase in the proportion of industrial zone workers who can correctly identify ways of preventing HIV transmission and reject major misconceptions</li> <li>• Increase in the proportion of young males who report using condoms when having sex with sex workers and/or casual partners and using condoms</li> <li>• Increase in the proportion of workers who report confidence in responding assertively to potentially harmful situations</li> </ul>
3.2.4 HIV prevention education, Life Skills training, and harm reduction training for trainees in vocational and job recruitment centers in project provinces	<ul style="list-style-type: none"> <li>• EA to advertise and call for bidding proposals.</li> <li>• EA to select suitable and qualified NGO(s) through bidding process (one NGO for 5 provinces)</li> <li>• EA to sign contract with suitably qualified NGO(s) to work in project provinces.</li> <li>• NGO(s) to carry out peer education training, effective coaching and supervision of training activities at various levels of project implementation</li> </ul>	<ul style="list-style-type: none"> <li>• Proposals selected and suitable NGO identified</li> <li>• Contract signed and carried out</li> <li>• Peer education training, effective coaching and supervision carried out at all levels</li> <li>• At least 80% of trainees can correctly identify ways of preventing HIV transmission and reject major misconceptions</li> <li>• Increase in the proportion of trainees who can correctly identify ways of preventing HIV transmission and reject major misconceptions</li> </ul>

<sup>1</sup> “Sympathy houses” are residences used to offer refuge and support to Street Children. They are funded by different groups and supported by volunteers. These houses provide a way to access a highly marginalised population, even though not all Street Children live in these residences.

<sup>2</sup> “Sympathy classes” are increasingly being established through voluntary donations in most provinces to provide basic literacy and numeracy for children in difficult circumstances, e.g., Street Children, dropouts from poor families, orphans, invalids. Because these classes include children who are not Street Children, others will benefit – but they can also be considered vulnerable due to poverty, family circumstances, etc.

Outputs	Activities	Indicators
		<ul style="list-style-type: none"> <li>• Increase in the proportion of male trainees who report using condoms when having sex with sex workers and/or casual partners</li> <li>• Increase in the proportion of trainees who report confidence in responding assertively to potentially harmful situations</li> </ul>

**Sub-Component 3 - HIV/AIDS primary prevention programs implemented for mainstream youth, parents and community collaborators.**

Outputs	Activities	Indicators
3.3.1 NGOs specializing in parental skills, social welfare, family and advocacy selected	<ul style="list-style-type: none"> <li>• EA to advertise and call for bidding proposals.</li> <li>• EA to select suitable and qualified NGO(s) through bidding process (one NGO for 5 provinces)</li> <li>• EA to sign contract with suitably qualified NGO(s) to work in project provinces.</li> <li>• NGO(s) to carry out training of collaborators, effective coaching and supervision of training activities at various levels of project implementation</li> </ul>	<ul style="list-style-type: none"> <li>• Proposals selected and suitable NGO identified</li> <li>• Contract signed and carried out</li> <li>• Collaborator training, effective coaching and supervision carried out at all levels</li> </ul>
3.3.2 Parenting skills, social welfare skills and advocacy provided for parents/ collaborators at district and commune levels in project provinces	<ul style="list-style-type: none"> <li>• Provide IPC materials</li> <li>• Conduct training courses on parenting skills, care and support skills, gender awareness and use of IPC materials for district-level collaborators<sup>3</sup> (held at provincial level)</li> <li>• Conduct district-level training course on parenting skills and care ad support skills and use of IPC materials for commune-level collaborators and community-based organizations</li> <li>• Implement parenting classes<sup>4</sup> at commune level<sup>5</sup></li> <li>• Implement outreach parenting skills education / support program by collaborators and members of CBOs to individual families with vulnerable children</li> <li>• Provide condoms to community collaborators</li> </ul>	<ul style="list-style-type: none"> <li>• At least 80% of the trained collaborators organizing parenting skills education and regular home visits to individual families with vulnerable youth</li> <li>• At least 30% parents report conversations across generations about gender norms and sexuality</li> <li>• At least 20% of youth reporting they have sought advice from a trusted adult</li> <li>• At least 80% parents and 50% youth report increased openness of communication across generations</li> <li>• Reduction in the percent of parents who report difficulties in disciplining children (aged 15–24)</li> <li>• Increase in the percentage of adults who support education on condom use/needle-cleaning</li> </ul>

<p>3.3.3 Support HIV education and stigma reduction among youth in secondary schools and teaching colleges through use of Project IPC materials (e.g. teaching aids) by trained teachers</p>	<ul style="list-style-type: none"> <li>• Supply IPC materials (teaching aids, skills) for use in subjects that cover HIV/AIDS education (e.g., Biology, Civics and Extra-Curriculum)</li> <li>• MoET/DOET to hire health promotion trainers to provide training in the use of IPC materials</li> <li>• Train pre-service teacher and in-service teachers in HIV/AIDS education, BCC methods, stigma reduction, and use of IPC materials</li> <li>• Implement pre-service teacher training in selected teacher education colleges and secondary schools</li> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>• At least 80% of the trained teachers use IPC materials and HIV teaching aids to support their teaching of curriculum sessions.</li> <li>• Increase in the percentage of pre-service and in-service teachers who are in favor of young people being educated about the use of condoms and clean needles in order to prevent HIV/AIDS</li> <li>• Increase in the percentage of pre-service and in-service teachers who report confidence and willingness to teach about HIV/AIDS</li> <li>• Reduction in the percent of pre-service and in-service teachers expressing willing to discriminate against person living with HIV/AIDS.</li> </ul>
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## **Component 4 — Project management, monitoring and evaluation (M&E) and capacity building for implementing youth focused policy and programs.**

### **Objectives**

To establish and implement efficient and effective project management systems incorporating capacity building support for EA and implementing agencies.

To provide technical support for integrating the project M&E system with the national HIV/AIDS M&E framework as well as for a comprehensive capacity building program in the executing and implementing agencies.

### **Description**

This component is designed to support the implementation of the Project ensuring that efficient management, financial, and monitoring and evaluation systems are in place at national and provincial levels. The VCPFC, under the guidance of a Steering Committee, will establish a central Project Management Unit (PMU) to direct and coordinate the implementation of the Project, which will be managed as a SDP. (See section on Implementation Arrangements below for details.) This SDP approach means that the PMU will receive Project funding through an agreed schedule of large tranches from the ADB and they will be responsible for the management and administration of the funds according to agreed work plans. The PMU will develop sound monitoring and evaluation systems to ensure that Project activities are conducted according to plan and to agreed standards because the payment of subsequent tranches will be based on performance, submission of agreed milestones and the development of an Action Plan for the next phase. The benefit of this SDP approach is that it allows for flexibility and for the opportunity to respond to the changing nature of the HIV/AIDS epidemic over the life of the Project. Unlike a project where the activities are set for the Project's lifetime, a program approach permits adjustments to be made in each phase to respond to lessons learned, emerging needs and changing circumstances.

In order to implement the Project under the SDP approach, the PMU must establish strong planning, financial, monitoring and reporting systems to ensure that they are able to manage all the Project activities. The PMU will assign sufficient staff to work in the areas of project management and accounting, both at the national and at the provincial levels. To support the PMU to establish Project systems and set up central level activities, implementation of activities will occur in five provinces in the northern region in the first phase. Through the appointment of an Institutional Capacity Building (ICB) Adviser and a Monitoring and Evaluation Adviser in the first year of the Project, the PMU staff and PPMU staff will be supported in the development of management and monitoring systems through a capacity building program and mentoring by the advisers.

A Capacity building program for the EA, PPMUs and the implementing agencies will be designed by the ICB Adviser using the findings of a training needs analysis to be conducted in the first six months. The management capacity improvement program will be implemented first at the national level with the EA in the first year of the Project. In the second years the ICB adviser will work in the selected provinces and provide training and mentoring for the PPMUs and the contracted implementing agencies.

The M&E Adviser will develop the M&E framework and systems. This activity will draw on the work currently being done by the MoH to develop a national M&E framework for the national HIV/AIDS strategy, to ensure consistency across the national indicators.

The Management Structure underpinning national project implementation is as follows. A Project Steering Committee (PSC) will be established by the EA at the commencement of the Project. The PSC will be headed by the Minister of VCPFC and will include senior officials from the participating ministries and organizations, including Ministry of Planning and Investment, Ministry of Finance, the State Bank of Viet Nam, the VAAC, Youth Union, Women's Union and Farmer's Union. The PSC will provide the EA with overall direction and guidance for the Project.

A Project Management Unit at the national level will be established which will be headed by a designated project director from the EA. There will also be a Vice Director and a group of regular EA staff and contracted personnel who will constitute the National PMU. It will be responsible to pay for contracted staff as part of the GoV contribution. These positions may include Project support staff such as: Project Manager; Component Coordinators; Accountants; and Administrative staff. These individual staff will have experience in planning, accounting, disbursement, procurement and contract administration. The Component Coordinators will be responsible for co-ordination and monitoring of the component at the national level. An Organogram of the project management arrangements is shown in Appendix G.

The PMU will be responsible for the financial and organizational management of the Project. It will provide overall coordination and support to the Component Coordinators and to the Provincial Project Management Units (PPMUs). The Component Coordinators will be responsible for coordinating with the agencies that are sub-contracted to implement the Project activities.

### **Rationale**

By presenting Project management as a separate Component, activities required for effective Project management are budgeted for and monitored. This will include the conducting of baseline surveys and evaluations, consulting services and procurement. It also allows for a capacity building element to be included for the institutions involved in managing the Project. The Project M&E systems can be developed and adequate resources for implementation can be assured through allocation of personnel and equipment. It also allows for the development of a formative research phase in the first year to develop the baselines for the Project. This is important for measuring impact at the Project's conclusion.

### **Provincial Project Management**

At the provincial level, the Provincial Chairperson of the Commission of Population Family and Children will be the Director of the PPMU. There will be no provincial level Steering Committees. In the first phase of the Project there will be five provinces from the northern region selected to implement the project. They are Hanoi, Quang Ninh, Bac Ninh, Phu Tho and Ha Tay. The PPMU will be responsible to pay for contracted staff as part of the GoV contribution. These positions may include Project support staff such as: Project Manager, Chief Accountant, Book Keeper and Provincial Activity Coordinator for planning, monitoring, accounting, disbursement and procurement. Each position will have a written job descriptions prepared by the EA and Provincial CPFC offices to ensure their role and responsibilities are fully understood. The PPMU staff will be responsible for monitoring the implementation of the Project activities that have been sub-contracted to specific agencies. They will ensure that the sub-contracted agencies provide financial reports to the PPMU for processing and financial monitoring on a quarterly basis. The PPMUs will provide quarterly reports and financial acquittals for the provincial project activities to the PMU.

### **Outputs: National Level**

- i) Project management and financial systems functioning;
- ii) Provincial Sub-project proposal/contracts developed for each province;

- iii) Consulting services contracted and managed (individual consultants, NGOs agencies);
- iv) Baseline and formative research surveys and mid-term and final evaluations conducted;
- v) Management training needs analysis conducted in first six months
- vi) Capacity Improvement program for PMU staff conducted in Phase One
- vii) Effective M&E systems developed and implemented, including monitoring of the gender strategy; and
- viii) Procurement of equipment and supplies.

#### **Outputs: Provincial Level**

- i) Project management and financial systems functioning;
- ii) Consulting services contracted and managed in relation to Component 3: sub-component 3
- iii) Management training needs analysis conducted in first year
- iv) Capacity Improvement program for PPMU staff and implementing agencies conducted in Phase One
- v) Effective M&E systems implemented, including monitoring of the gender strategy.

#### **Methods : National Level**

In order to accomplish the outputs listed above the following steps will be carried out:

- i. PMU staff recruited, management and financial systems established;
- ii. Bank accounts opened;
- iii. Annual budgets for implementing agencies at national level and for PPMUs approved and funds transferred to accounts;
- iv. PMU and ADB manage the recruiting process to appoint the three international advisers;
- v. PMU manage the bidding and contracting process to recruit appropriate agencies to implement the different groups of sub-components across sets of five provinces;
- vi. Project Implementation plan and budget for each phase prepared and submitted to ADB three months prior to start of the next phase;
- vii. Project monitoring and evaluation framework developed in the first year;
- viii. PMU and PPMU staff develop and implement a monitoring plan to supervise the implementation of project activities at all levels;
- ix. Reporting system developed and implemented;
- x. Six month reports prepared by PMU and submitted to ADB;
- xi. Phase Completion reports prepared by PMU and submitted to ADB in the last quarter of each phase; and
- xii. PMU and M&E adviser to coordinate baseline surveys, mid term reports and final evaluations and submit reports to ADB.
- xiii. Conduct a management training needs analysis for PMU and PPMU staff;
- xiv. Develop and implement a Capacity Building Improvement program for PMU
- xv. Providing mentoring, coaching, training and skills transfer to PMU partners in health service management; and
- xvi. Assist PMU senior staff in the review of Phase one and in the preparation of the Phase One Completion Report.

#### **Methods : Provincial Level**

- a. Provincial PMUs established, staff recruited and management and financial systems established;
- b. Bank accounts opened;
- c. PPMU staff develop and implement a monitoring plan to supervise the implementation of project activities within the province

- d. Reporting system developed and implemented
- e. Develop and implement a Capacity Building Improvement program for PPMUs;
- f. Providing mentoring, coaching, training and skills transfer to implementing partners at provincial level in health service management

### Target Groups

- i) PMU staff, Provincial PMUs; and
- ii) Agencies contracted to implement Project activities at national and provincial levels.

### Potential Partners for Implementation

The VCPFC as the EA will be responsible for implementing the management and monitoring and evaluation systems according to ADB and GoV regulations and guidelines.

### Consulting Inputs

The following consulting inputs will be required for the implementation of activities under Component 4.

Position	Person months	Outline ToR
Monitoring and Evaluation Adviser	20	<ul style="list-style-type: none"> <li>• Design and coordinate baseline survey, mid-term and final evaluations</li> <li>• Develop Monitor framework;</li> <li>• Develop performance indicators for Project evaluation linked to the national M&amp;E HIV/AIDS indicators of the National Strategy;</li> <li>• Provide overall co-ordination and monitoring of the gender strategy;</li> <li>• Conduct gender training for PMU, PPMUs, local government agencies, and contracted NGOs or civil society organizations on gender issues;</li> <li>• Mentor and coach the PMU and PPMU in project monitoring systems;</li> <li>• Mentor and coach provincial AIDS Divisions in the use of New national performance indicators for HIV/AIDS; and</li> <li>• Assist PMU in the preparation of the Phase Completion reports.</li> </ul>
Institutional Capacity Building Adviser	15	<ul style="list-style-type: none"> <li>• Conduct a management training needs analysis for PMU and PPMU staff;</li> <li>• Develop and implement a Capacity Building Improvement program for PMU and PPMUs;</li> <li>• Providing mentoring, coaching, training and skills transfer to PMU partners in health service management; and</li> <li>• Assist PMU senior staff in the review of Phase one and in the preparation of the Phase One Completion Report.</li> </ul>

## Implementation Schedule

Component 4 activities will be carried out as illustrated in the Implementation Schedule below.

### National Level

Activities	Year 1				Year 2				Year 3				Year 4				Year 5			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
PMU staff recruited, management and financial systems established																				
Provincial PMUs established, staff recruited, & systems established																				
Bank accounts opened																				
Approve annual budgets and transfer funds to agencies and PPMU accounts																				
Appoint 3 International Advisers – Youth Policy /HIV/AIDS Adviser, M&E Adviser & Institutional Capacity Building Adviser																				
Conduct management training needs analysis for PMU & PPMU staff																				
Implement Capacity Building Improvement program for PMU & PPMUs																				
Bid and contract agencies to implement different groups of sub-components in Phase one, two and three																				
Prepare Project Implementation Plan and budget for each Phase																				
Develop project monitoring and evaluation framework in first year																				
PMU and PPMU develop and implement a monitoring plan																				
Reporting system developed																				
Six month reports prepared by PMU for ADB																				
Phased completion reports prepared by PMU for ADB																				
Baseline Survey, Mid term and Final evaluation report submitted by PMU to ADB																				

### Provincial Level

Activities	Year 1				Year 2				Year 3				Year 4				Year 5			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Provincial PMUs established, staff recruited, & systems established																				
Bank accounts opened																				
Conduct management training needs analysis for PMU & PPMU staff																				
Implement Capacity Building Improvement program for PPMUs and IAs																				
Prepare Project Implementation Plan and budget for each Phase																				
PPMU develop and implement a monitoring plan																				
Reporting system developed																				
Quarterly reports prepared for PMU																				

## Component 4 — Project Management Logframe

**Objective —** *To establish and implement efficient and effective project management systems incorporating capacity building support for EA and implementing agencies and To provide technical support for integrating the project M&E system with the national HIV/AIDS M&E framework as well as for a comprehensive capacity building program in the executing and implementing agencies.*

Objectives/Outputs	Indicators	Means of Verification	Assumptions
4.1. Project management and financial systems functioning at national and provincial levels	<ul style="list-style-type: none"> <li>• Annual Action Plan are produced</li> <li>• Milestones of annual work plans are met in a timely manner</li> <li>• Satisfactory external Audit reports</li> </ul>	<ul style="list-style-type: none"> <li>• Annual action Plan from each province.</li> <li>• Milestone reports</li> <li>• Phased Completion report from PMU to ADB</li> <li>• Auditor reports</li> </ul>	<ul style="list-style-type: none"> <li>• PMU Director and PPMU Directors have the time to commit to the project activities to ensure management efficiency and effectiveness</li> </ul>
4.2. Consulting services contracted and managed	<ul style="list-style-type: none"> <li>• Qualified professionals hired to the three adviser position in the first three months of the project</li> <li>• Contract signed with a professional media production agency in the first three months of the Project</li> <li>• Contracts signed with agencies to implement sub-groups of activities by the end of the 3rd quarter of 1st year for Phase One activities</li> <li>• Financial and reporting systems between PMU and agencies functioning.</li> </ul>	<ul style="list-style-type: none"> <li>• Staff contracts</li> <li>• Contracts with agencies</li> <li>• Six month progress reports from agencies to PMU/PPMUs</li> <li>• Audit reports</li> </ul>	<ul style="list-style-type: none"> <li>• International and local technical agencies will want to be sub-contracted by PMU.</li> <li>• PMU and PPMUs will have management and financial systems that are flexible enough to allow the implementing agencies to work effectively</li> </ul>
4.3. Baseline and formative research surveys and mid-term and final evaluations conducted	<ul style="list-style-type: none"> <li>• Baseline survey conducted in 1st year</li> <li>• Conduct formative research surveys for each component</li> <li>• Set of targets for project performance agreed using results of baseline survey and formative research by end of 1st year</li> <li>• Mid term review conducted by 4th quarter of 3rd year and results used to prepare Action Plan for Phase 3</li> <li>• Final evaluation conducted in the last quarter of 5th</li> </ul>	<ul style="list-style-type: none"> <li>• Baseline survey report</li> <li>• Formative research reports</li> <li>• Mid term report</li> <li>• Final evaluation report</li> </ul>	<ul style="list-style-type: none"> <li>• National agencies available to conduct qualitative and quantitative research assessment independently</li> </ul>

Objectives/Outputs	Indicators	Means of Verification	Assumptions
	year		
4.4. Effective M&E systems developed and implemented	<ul style="list-style-type: none"> <li>• M&amp;E adviser develop monitoring tools and indicators for project monitoring</li> <li>• PPM and PPMU staff providing quarterly project progress reports using monitoring tools /indicators developed by the M&amp;E adviser</li> </ul>	<ul style="list-style-type: none"> <li>• M&amp;E framework</li> <li>• Quarterly Progress reports from PPMU</li> <li>• Reports from site visits</li> </ul>	<ul style="list-style-type: none"> <li>• PMU and PPMU staff will do regular monitor visit to project implementation site</li> </ul>
4.5. Procurement of equipment and supplies	<ul style="list-style-type: none"> <li>• All equipment and supplies purchased and delivered in a timely manner</li> </ul>	<ul style="list-style-type: none"> <li>• Purchase orders</li> <li>• Delivery notices</li> </ul>	<ul style="list-style-type: none"> <li>• PMU can organize the procurement systems to ensure timely delivery</li> </ul>

## Component 4 — Project Management Activities

**Objective —** *To establish and implement efficient and effective project management systems incorporating capacity building support for EA and implementing agencies and*

*To provide technical support for integrating the project M&E system with the national HIV/AIDS M&E framework as well as for a comprehensive capacity building program in the executing and implementing agencies.*

Outputs	Activities	Indicators
4.1. Project management and financial systems functioning at national and provincial levels.	<ul style="list-style-type: none"> <li>• Recruit PMU staff and establish management and financial systems</li> <li>• Establish Provincial PMUs, recruit staff and establish management and financial systems</li> <li>• Open Bank accounts at National and provincial levels</li> <li>• PMU to Approve Annual budgets for implementing agencies at national level and for PMUs and transfer funds to accounts.</li> <li>• PMU to prepare and submit to ADB project Implementation plan and budget for each phase</li> <li>• Six month reports prepared by PMU and submitted to ADB.</li> <li>• Phase Completion reports prepared by PMU and submitted to ADB in the last quarter of each phase.</li> </ul>	
4.2. Consulting services contracted and	<ul style="list-style-type: none"> <li>• PMU manage the recruiting process to appoint the two</li> </ul>	

Outputs	Activities	Indicators
managed.	international advisers <ul style="list-style-type: none"> <li>• PMU manage the bidding process to recruit appropriate agencies to implement the different groups of sub-components.</li> <li>• PMU to sign contracts with individual consultants and agencies hired.</li> <li>• PMU to transfer funds to agency accounts for implementation of activities</li> <li>• PMU to monitor sub-contracted agencies quarterly through site visits and progress reports</li> </ul>	
4.3. Baseline and formative research surveys and mid-term and final evaluations conducted.	<ul style="list-style-type: none"> <li>• PMU and M&amp;E adviser to co-ordinate the conducting of baseline surveys, mid term review and final evaluation and submit reports to ADB.</li> </ul>	
4.4. Effective M&E systems developed and implemented.	<ul style="list-style-type: none"> <li>• PMU and PPMU staff to develop and implement a monitoring plan to supervise the implementation of project activities at all levels.</li> <li>• Project monitoring and evaluation framework to be developed in the first year</li> <li>• Reporting system developed and implemented</li> </ul>	
4.5. Procurement of equipment and supplies.	<ul style="list-style-type: none"> <li>• Purchases on equipment and supplies in a timely manner according to the annual plans, using GoV and ADB guidelines and regulations.</li> </ul>	

## **Implementation Structure**

### **Implementation Period**

1. The Project will be implemented over a five year period, which is expected to commence by mid 2006. As a Sector Development Program the Project will be implemented at the national level and initially in five selected provinces in the northern region in the first two year phase. Following successful completion of Phase One the Project will be expanded to another five selected provinces in the 3<sup>rd</sup> year and a further five provinces in the 4<sup>th</sup> year. This will result in a total of 15 provinces by the 4<sup>th</sup> year. The expansion to provinces will be determined according to analysis of provincial progress and capacity and the recommendation of the SC and NPMU after review.

2. The project implementation schedule is presented in Appendix F.

### **Procurement**

3. All ADB procurement and consulting services will follow ADB guidelines. The PMU will be responsible for: (i) procurement that requires international competitive bidding (ICB) and international shopping (IS) procedures; and (ii) engagement of international consultants. The PPMUs will be given responsibility for: (i) procurement that follows local competitive bidding (LCB) or direct purchase (DP); (ii) engagement of local domestic consultants for each province; (iii) sub-contracting/engagement of agencies to implement peer education programs, VCT services, community collaborators training program; and (iv) other local procurement following the division of work and implementation regulations as established at the commencement of the project. Procedures for LCB procurement and the selection of organizations to implement activities will follow government procedures and other arrangements satisfactory to the ADB. (See Appendix K — Summary List of Procurement Items)

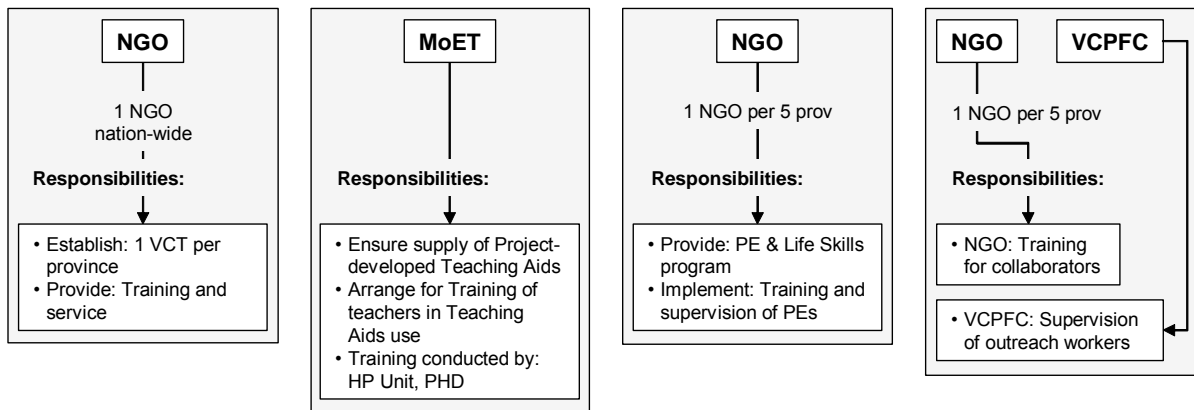
### **Consulting Services**

4. The Project will recruit the following three international consultants for the positions of Youth Policy and HIV/AIDS Adviser (24 months), Monitoring and Evaluation Adviser (20 months) and Institutional Capacity Building Adviser (15 months). The Youth Policy and HIV/AIDS Adviser will work within the Component One which focuses on Advocacy. The M&E Adviser and the Institutional Capacity Building Adviser will be assigned under Component Four which focuses on project management. The M&E Adviser will work across all components assisting with baseline surveys and formative research and the development of indicators for monitoring and evaluation. The Institutional Capacity Building Adviser will work with the PMU and PPMUs to build their capacity in project management.

5. The strategy for recruiting consulting services for the Mass Media and IPC component is to sub-contract the component by appointing an agency with the professional expertise in the specific area of mass media production and with experience in HIV/AIDS programs in developing countries. The appointed agency will develop a proposal to implement the component activities and this will be appraised and approved by the PMU. A contract will then be signed between the PMU and the agency for the life of the Project.

6. Within Component Three it will be necessary to sub-contract a number of different consulting agencies to implement the different sub-components at the provincial level as illustrated in the diagram below.

### **Figure 4 — Recommended Sub-Contracting Arrangements**



7. The Voluntary Counseling and Testing (VCT) services will be sub-contracted by PMU through a bidding process to one consulting agency to pilot the implementation of VCT services in all five provinces in Phase One.

8. For the Peer Education and Life Skills training programs which is for the number of different target groups (IDUs, service industry workers, factory workers, vocational training center trainees etc) it is proposed that each PPMU will use a bidding process to sub-contract one consulting agency or one consortium of agencies to provide the PE/Life Skills program in each province.

9. The same process will be applied in each province to sub-contract consulting services to provide training programs for community based collaborators from CPFC and other mass organizations (e.g. Women's Union). As there are a number of topics to be cover in the training, including HIV/AIDS, care and support for PLWHA, it is recommended that the EA engage external trainers. After training the outreach activities of the sub-component will be managed by CPFC managers at the provincial, district and commune levels. (See Appendix I, Consulting Services.)

## k. Summary List of Procurement Items

Procurement list	Base Costs (US\$)					
	Y1	Y2	Y3	Y4	Y5	Total
<b>EQUIPMENT</b>						
<b>Mass media production:</b>						
<b>Research Centre and operation costs</b>						
Computer/printer	2,456	0	0	0	0	2,456
Photocopier	10,000	0	0	0	0	10,000
LCD projector	3,300	0	0	0	0	3,300
TV monitor	2,500	0	0	0	0	2,500
VCR	300	0	0	0	0	300
<b>Media agency management</b>						
Office Furniture	10,000	0	0	0	0	10,000
Computer/printer	12,500	0	5,000	0	0	17,500
Photocopier	10,000	0	0	0	0	10,000
<b>HIV/AIDS prevention:</b>						
Provision of condoms	0	11,111	22,222	33,333	33,333	100,000
Provision of clean needles	0	15,556	31,111	46,667	46,667	140,000
TV & VCD sets	0	200,000	200,000	200,000	0	600,000
Cassette players	0	1,000	1,000	1,000	0	3,000
<b>National and provincial PMUs</b>						
Accounting software	10,400	0	0	0	0	10,400
Computer and printer	5,000	0	5,000	5,000	0	15,000
Office furniture	5,000	0	5,000	5,000	0	15,000
Project car	40,000	0	0	0	0	40,000
Photocopier upgrade	6,000	0	0	0	0	6,000
Computers and printers	5,000	0	0	0	0	5,000
Office furniture and fittings	5,000	0	0	0	0	5,000
<b>CONSULTING SERVICES</b>						
<b>Media agency technical assistance:</b>						
Media agency technical assistance	404,925	765,741	601,641	315,483	134,328	2,222,118
<b>HIV/AIDS prevention</b>						
Contract NGOs for one VCTC per province per year	0	36,000	60,000	126,000	186,000	408,000
<b>Consulting services</b>						
Capacity Building Advisor	129,300	40,200	0	0	0	169,500
M&E Advisor	117,600	27,300	27,300	14,400	40,200	226,800
Youth Advisor	129,300	40,200	40,200	40,200	40,200	290,100

## I. Map



Provinces selected for activities during the first phase of the Project include:

1. Hanoi
2. Quang Ninh
3. Bac Ninh
4. Phu Tho
5. Ha Tay

During phase two and three an additional ten provinces may be selected from the following list:

1. Dien Bien
2. Hai Phong
3. Hai Duong
4. Da Nang
5. Binh Duong
6. HCMC
7. Ba Ria-Vung Tau
8. Long An
9. Dong Thap
10. Can Tho

## m. TA Consultations

TA consultations from 18th August–15th Sept  
(note: TA Final Interim Report has consultation list from 17th May–17th August 2005)

18 August  Consultation on Draft FS with International Organization and NGOs at ADB office	Mr. Larry Holzman, Director	DKT
	Ms. Nguyen Thi Bich Hang, Country Representative	Marie Stopes International
	Ms. Hoang Thi Huyen, AIDS program Ms. Ha Ngoc Lan	SCUK
	Ms. Barbara Bale, program Coordinator	Care International
	Ms. Ngo Thanh Thuy, AIDS Program	PATH/ US
	Mr. David Trees, Advisor	IOM
	Ms. Nancy Fee, Coordinator Mr. Jodi Charles	UNAIDS
	Ms. Nguyen Kieu Trinh	Burnet Institute
	Mr. Chris Jones	PSI
	Ms. Lauren Siegmann	
	Mr. Nguyen Duy Tung Mr. Steve Mill	FHI
	Ms. Nina Rehn Ms. Narumi Yamada	UNODC
	Ms. Lisa Studdert, Health Specialist Ms. Nguyen Nhat Tuyen, Social Development and Gender Officer	ADB
	Eileen Darby, Ken Swann, Martha Morrow, Hoang Thuy Lan, Vu Pham Nguyen Thanh, Pham Thi Mai Chi, Dao Huy Dap	ADB–TA 4542–VIE
31 August, 2005  Consultation with Groups of PLWHA at Gia Lam, Ha Noi	Dinh Tuan Anh Bui My Hanh	Bright Futures (BF) Ha Long Town Van Don District Quang Ninh
	Vu Ngoc Hoang Trinh Anh Tuan Do Dang Dong Pham Quoc Hung Pham Thuy Linh Nguyen Thi Tuyet Lan Nguyen Thu Hang	BF, Ha Noi
	Tran Thi Hang	BF, Hai Duong
	Quach Thi Mai	BF, Hai Phong
	Nguyen Hai Yen	BF Thai Nguyen
	Tran Danh Mat	BF Thanh Hoa
	Dang Thi Lan Nguyen Thi Hai	Sunflower group Ha Noi
	Chu Thi Tam Tran van Chien Hoang Bich Ngoc Nguyen Vu Thu	Lotus Group, Ha Noi
	Ngo Tien Phat	
	Hoang Bich Ngoc Nguyen Van Thuc	Kind Arms Group, Tu Liem, Ha Noi
	Vu Pham Nguyen Thanh, Pham Thi Mai Chi, Dao Huy Dap	ADB–TA 4542–VIE

## n. References

- ADB JFPR Project draft report. 2005. Evaluation of Effectiveness of Project “Community Action for Preventing HIV/AIDS”. ADB JFPR: REG–9006. Hanoi, March 2005.
- ADB/UNAIDS. 2004. The Impact of HIV/AIDS on Poverty in Cambodia, India, Thailand, and Viet Nam. ADB/UNAIDS Study Series: Paper IV. (unpublished).
- AVERT. 2005. South Africa HIV/AIDS Statistics. <http://www.avert.org/safricastats.htm> (accessed 16 August 2005).
- Blum RWM. 1998. Healthy youth development as a model for youth health promotion. *Journal of Adolescent Health*;22:368–375.
- Bond L, Patton G, Glover S, Carlin JB, Butler H, Thomas L & Bowes G. 2004 The Gatehouse Project: can a multi–level school intervention affect emotional wellbeing and health risk behaviors? *Journal of Epidemiology and Community Health*, 58: 997–1000.
- Bondurant A, Henderson S and Nguyen Cuong Quoc. 2003. Addressing the Reproductive and Health Needs of Young People since ICPD: The Contribution of UNFPA and IPPF. Viet Nam Country Evaluation Report.
- CCRD and ILSSA. 2003. Bao cao thuc trang he thong to chuc phong chong AIDS tai Viet nam. (Study on situation of organizational system about AIDS program in Vietnam). UNDP Study, VIE/98/006.
- CDC—Center for Disease Control STD Prevention website. 2004. Community and individual behavior change interventions. <http://www.cdc.gov/std/program/community/6-PGcommunity.htm#individual> accessed 31 July 2005.
- Collins RL, Elliott MN, Berry SH, Kanouse DE and Hunter SB. 2004. Entertainment Television as a Healthy Sex Educator: The Impact of Condom–Efficacy Information in an Episode of Friends. *Pediatrics*, 112(5):1115–1121.
- Comprehensive Poverty Reduction and Growth Strategy, May 2002. P126.
- Coulson Nancy, 2004. Developments in the use of mass media at the national level for HIV/AIDS prevention in South Africa.
- Courtenay WH. 2000. Constructions of masculinity and their influence on men’s well–being: a theory of gender and health. *Social Science & Medicine*;50:1385–1401.
- Dang Nguyen Anh. 2005. Internal Migration: Opportunities and challenges for renovations and development in Viet Nam. Nha Xuat Ban The Gioi, Hanoi. (in Vietnamese and English).
- Do Thi Ngoc Nga and Morrow M. 1999. Nutrition in pregnancy in rural Vietnam: poverty, self–sacrifice and fear of obstructed labor. In Berer M and Ravindran TKS (eds), *Safe Motherhood Initiatives: Critical Issues. Reproductive Health Matters Special Edition*, Oxford: Blackwell Science:137–146.
- Dolan KA and Niven H. 2005. A review of HIV prevention among young injecting drug users: A guide for researchers. *Harm Reduction Journal*, 2:5.
- EU/UNFPA. 2005. Final Report: Baseline Survey for RHIYA Vietnam. Reproductive Health Initiative For Youth In Asia (RHIYA) Vietnam. EU/UNFPA, Hanoi.

- FHI. 2004. HIV/AIDS Prevention and Care in Viet Nam; Lessons Learned from the FHI/IMPACT Project.
- FHI. 2001. Effective Prevention Strategies in Low HIV Prevalence Countries. UNAIDS Best Practice Key Materials. Prepared through FHI International.
- GoV—Government of Viet Nam. 2004. National Strategy on HIV/AIDS Prevention and Control in Viet Nam till 2010 with a Vision to 2020. 17 March 2004, Decision of the Prime Minister, Hanoi.
- GSO—General Statistical Office. 2003. Preliminary Data from the Viet Nam Households Living Standards Survey (VHLSS) 2002, Hanoi.
- International Harm Reduction Association. 2005. <http://www.ihra.net/> Accessed 31 July 2005.
- Jamieson, N. 1993. Understanding Vietnam. Berkeley: University of California Press.
- Kanaef N and Higgs P. 2003. A Study Tour on HIV/AIDS Awareness and Policy Advocacy hosted by the Centre for Harm Reduction, Burnet Institute. Trainer and Facilitator Report. Melbourne.
- MAP (Monitoring the AIDS Pandemic). 2004. AIDS in Asia: Face the facts. A comprehensive analysis of the AIDS epidemics in Asia. MAP.
- Mensch B, Clark WH and Dang Nguyen Anh. .2003. Adolescents in Vietnam: Looking Beyond Reproductive Health. Studies in Family Planning, 34(4):249–262.
- MoH—Ministry of Health, NIHE, FHI, USAID. No date. What can we do to control the HIV epidemic in Viet Nam? What high-risk groups have to tell us.
- MoH—Ministry of Health. 2005a. HIV/AIDS Estimates and Projections 2005–2010. MoH, General Department of Preventive Medicine, and HIV/AIDS Control UNAIDS, Hanoi.
- MoH—Ministry of Health. 2005b. Survey Assessment of Vietnamese Youth (SAVY) (with GSO, UNICEF Viet Nam, WHO Viet Nam) Hanoi.
- MoLISA, Department for Social Evils Prevention. 2003. The National System for Disease Treatment for IDUs and SWs. MoLISA, Hanoi.
- MoLISA. 2004a. Documentation and Data on the Results of Detoxification and Rehabilitation 2004 (unpublished report). Policy Section. Department for Social Evils Prevention, MoLISA, Hanoi.
- MoLISA. 2004b. Strategic Orientations of the National Target Programme on Poverty Alleviation: 2006–2010. Social Labor Publishing House: Hanoi.
- MoLISA and UNICEF/Viet Nam. 2005a. The Situation of Families and Children Affected by HIV/AIDS in Viet Nam. MoLISA and UNICEF/Viet Nam, Hanoi. (report of 2003)
- MoLISA and UNICEF/Viet Nam. 2005b. Children Affected by HIV/AIDS in Viet Nam: A Legal Review. MoLISA and UNICEF/Viet Nam, Hanoi.

Morrow M, Do Hong Ngoc, Truong Trong Hoang & Tran Hue Trinh. 2002. Smoking and young women in Vietnam: The influence of normative gender roles. *Social Science & Medicine* 55(4):681–690.

NCFAW 2002, Statistics on Women and Men in Vietnam, NCFAW–UNDP Netherlands Project.

Prochaska J O, & DiClemente C C. 1982. Transtheoretical therapy toward a more integrative model of change. *Psychotherapy: Theory, Research and Practice*, 19(3), 276–287.

RCH—Royal Children’s Hospital, Melbourne. 2004. Gatehouse Project. [http://www.rch.org.au/gatehouseproject/project/theresearch/index.cfm?doc\\_id=399](http://www.rch.org.au/gatehouseproject/project/theresearch/index.cfm?doc_id=399) (accessed 15 August 2005).

Reerink A, Hoang Thuy Lan and Eskola T. 2003. Promoting More and Better Jobs for Young Women in Vietnam: Final Evaluation Report. INT/00/M57/NET. Dec. 2003, Hanoi.

Rugkasa J, Knox B, Sittlington J, et al. 2001. Anxious adults vs. cool children: children’s views on smoking and addiction. *Social Science & Medicine*;53:593–602.

Tran Thinh, Bain D, Mai Doan Anh Thi, Le Truong Giang, Mandel J and Linden D. 2002. Vietnam’s First and Only Anonymous Test Site. Poster Presentation, XIV International AIDS Conference, Barcelona, July 2002. <http://ari.ucsf.edu/pdf/Posters/barcelona/thinh.pdf> (accessed 1 August 2005).

UNAIDS Country Level Progress Report, n.d. Viet Nam. Country Situation Analysis.

UNAIDS. 2004. 2004 Report on the Global AIDS Pandemic. Joint United Nations Programme on HIV/AIDS: Geneva.

UN—United Nations Country Team. 2004. United Nations Common Country Assessment for Viet Nam. Hanoi.

UNDP—United Nations Development Programme, Viet Nam. 2003. Socio–economic Impact of HIV/AIDS in Viet Nam. A preliminary note. <http://www.undp.org.vn/undp/docs/2003/seimpact/seimpacte.pdf> (accessed 1 August 2005)

UNODC—United National Office on Drugs and Crime. 2003. Ethnic Minorities, Drug Use and Crime in the Highlands of Northern Vietnam: A contextual analysis of six communes in Son La, Lai Chau and Lao Cai. UNODC.

UN Message on International Youth Day. Press release, 12 August 2003. <http://www.un.org.vn/mr/2003/engl/1208youth.htm> Accessed 29 July 2005

UNICEF. 2002. Measures and Indicators for Evaluating Life Skills-Based Education Programmes. Draft - UNICEF, New York.

UNICEF. 2003. The Situation of Families and Children Affected by HIV/AIDS in Viet Nam: a national overview. Final Report, August 2003. UNICEF Viet Nam.

UNICEF. 2005. At a Glance: Viet Nam Statistics. [http://www.unicef.org/infobycountry/vietnam\\_statistics.html](http://www.unicef.org/infobycountry/vietnam_statistics.html) accessed 30 July 2005.

Viet Nam News. 7 June 2005. 'Viet Nam to codify rights and duties of its youths'. Viet Nam News. 07/06/05.

Viet Nam News. 28 July 2005. 'MoLISA submits plan to develop, socialize vocational training schools. Viet Nam News, 28/07/05.

Webb D and Elliot L. 2002 Learning to Live: Monitoring and evaluating HIV/AIDS programmes for young people (abbreviated version). Save the Children UK. With support from UNAIDS and DFID.

WHO — World Health Organization. 1999. Programming for adolescent health and development. Report of a WHO/UNFPA/UNICEF Study Group on Programming for Adolescent Health, WHO Technical Report Series 886, Geneva: World Health Organization.

WHO. 2004. Evidence for Action: a Review of Community-based Outreach in Preventing HIV/AIDS among Injecting Drug Users. WHO: Geneva.

WHO 2004. National AIDS Programmes: A guide to indicators for monitoring and evaluating national HIV/AIDS prevention programmes for young people. WHO, Department of HIV/AIDS : Geneva.

WHO. 2005. Effectiveness of Drug Dependence Treatment in Preventing HIV among Injecting Drug Users. Evidence for Action Technical Papers, final draft, March 2005. WHO: Geneva.

World Bank. 2003. HIV/AIDS and Youth "at a glance" series.  
<http://wbi018.worldbank.org/HDNet/hddocs.nsf/0/62beb610bb2fc69085256df800582d70?OpenDocument> (accessed 16 August 2005).

World Bank. 2004. Vietnam: HIV/AIDS Prevention Project, Aide Memoire for Pre-appraisal Mission, Sep—Oct 2004.

## o. HIV/AIDS Projects in Viet Nam

#	Organization	Project Areas	Target Groups	Time/Status	BCC						Harm Reduc-tion		Care & Support	M&E Surveillance		Treatment		STI Man-agement			Capacity Building/ International Cooperation
					Mass Me-dia/ IEC	Counseling	PE	Outreach	Support Groups	Training/ Workshop/ Advocacy	Needle Exchange	Alternative Drugs		Access to Drugs	Treatment	PMCT	HIV Testing	Condon Availability	Safe Blood		
1	ActionAid	Quang Ninh, Ha Giang, Lai Chau, Son La, Ha Tinh, HCMC	Integrated youth, women, CSW				X	X	X	X			X				X				
2	AED	Baria-Vung Tau, Dong Nai, HCMC, Hai Phong, Thai Binh, Quang Nam	Workers, managers, trade union officials, provincial government		X		X	X		X							X	X	X		
3	ANRS	HCMC	High risk behavior groups	2003-2006		X	X		X	X		X	X	X	X	X	X	X			
4	Asia Foundation	An Giang, Quang Ninh	Women's Union, National Legal Aid Agency	2005-2006			X	X		X											
5	ADB		Youth and adolescents	To be designed 2005, implemented 2006-09	X	X	X	X		X				X	X				X		
6	AusAID	Central level								X								X			
7	ARHP	Central level	Policy makers – MoH, MoP, MoLISA	2005-6	X					X											
8	Australian Red Cross	Hanoi, HCMC	Youth					X				X									
9	CECI																				
10	Care	Hanoi, HCM, Quang Ninh, An Giang, Can Tho, Soc Trang	Youth, mobile populations, SW, IDU	Proposal	X	X				X		X									
11	CDC	40 provinces-highest HIV prevalence	High risk behavior groups		X	X	X			X					X	X	X	X			
12	Center of Action for Development	Hanoi	PWHA, CSW, IDU, youth	2004	X			X		X		X		X							
13	CIDA	HCMC, Can Tho, Kien Giang, An Giang	CSW, mobile populations, youth at risk			X						X	X					X			
14	CIDSE	Thai Nguyen, Hue, Cho Moi, Bac Kan	General population		X	X	X	X		X		X			X				X		
15	CRS																				
16	DFID	Lang Son, Quang Ninh, Hanoi, Hatay, Hai Phong, Nam Dinh, Thanh Hoa, Ha Tinh, Hue, Khan Hoa, Binh Thuan, HCMC, Tay Ninh, Dong Nai, Ba Ria-Vung Tau, Dong Thap, An Giang, Can Tho, Soc Trang, Keng Giang				X				X						X			X		
17	DKT	32 provinces	CSW, IDU, youth	Continuing	X			X		X									X		
18	ESTHER	HCMC, Hanoi, Hai Phong	High risk behavior groups	2003-2006		X	X	X	X	X		X	X	X	X	X	X	X	X	X	
19	FHI	Can Tho, Hai Phong, Quang Ninh, HCMC, Hanoi, An Giang	SW, IDU, MSM, male clients, PLWHA	2004		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
20	Ford Foundation	Central level	IDU, CSW				X	X		X	X							X	X		X
21	Global Fund	Cao Bang, Lang Son, Quang Ninh, Thai Nguyen, Phu Tho, Hanoi, Hai Duong, Hai Phong, Nam Dinh, Thanh Hoa, Ha Tinh, Hue, Khanh Hoa, Binh Thuan, HCMC, Tay Ninh, Dac Lac, An Giang, Can Tho, Soc Trang, Kien Giang, Camau			X	X	X			X							X	X	X		
22	GTZ	Lao Cai, Hanoi, Quang Ninh, Nin Binh, Binh Dinh	IDU, CSW	2004			X			X											
23	ILO	Thanh Hoa, Quang Ninh, Ho Chi Minh, Tay Ninh, Can Tho, Nationwide	Policy makers	2005-2007	X			X		X											
24	IOM	Hanoi, Quang Ninh, HCMC, Yen Bai, Thai Binh, Hai Duong, Soc Trang, Kien Giang	Trafficked persons, internal migrants	2003-2005	X	X	X	X		X									X	X	
25	KfW	Lao Cai, Quang Ninh, Hanoi, Ha Tay, Thai Binh, Ha Nam, Nam Dinh, Ninh Binh, Nghe An, Ha Tinh, Quang Binh, Quang Ngai, Khanh Hoa, Dac Lac, Binh Thuan				X	X				X								X	X	
26	MCNV	Hanoi	Mothers, children		X	X	X	X	X	X		X		X	X	X	X	X			
27	Medicins du Monde – Canada	HCMC				X															
28	Medicins du Monde –France	HCMC	Homeless, high risk groups, migrants	2001-2007		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
29	MSI	Hanoi, HCMC, Nghe An, Ha Tinh	Youth, CSW	2003-2005		X		X										X	X		

#	Organization	Project Areas	Target Groups	Time/Status	BCC						Harm Reduction		Care & Support	M&E Surveillance	Treatment		STI Management			Capacity Building/ International Cooperation	
					Mass Media/ IEC	Counseling	PE	Outreach	Support Groups	Training/ Workshops/ Advocacy	Needle Exchange	Alternative Drugs			Access to Drugs	Treatment	PMCT	HIV Testing	Condom Availability		Safe Blood
30	NAV	Hai Phong, Quang Tri, Hue	Migrant workers, prisoners, PLWHA	2004–2008	X	X	X	X	X				X		X						
31	NMAV	Hanoi, HCMC	School students	2003–2007	X					X								X			
32	PATH	Lang Son, Lao Cai	Local NGOs, Local government partners, mobile population	2004																X	
33	PATH C	Hanoi	Children	2004–2005	X		X	X													
34	Pathfinder	An Giang	Public health service providers	2004–2006	X	X				X						X					
35	PDI	Nghia Dan, Nghe An	PLWHA, students	2004		X			X			X									
36	Plan in Viet Nam	Nam Dinh, Ha Nam, Thai Nguyen, Bac Giang, Phu Tho, Hanoi, Quang Binh, Quang Tri, Quang Ngai	Migrant workers		X	X	X	X	X	X		X									
37	POLICY Project	HCMC, Ha Noi, Quang Ninh, Thai Nguyen, Ba Ria-Vung Tau, Kien Giang	Policy makers	2003–2006			X	X	X	X		X	X	X	X						
38	PSI	Hanoi, Hai Phong	Local NGOs, IDU, CSW, clients	Oct 2004 – Sept 2005	X	X	X	X		X											
39	SC US	Lao Cai, Hai Phong, Hanoi, Da Nang, HCMC	Youth	2004–2005	X	X	X	X		X		X									
40	SCF UK	Hai Phong, HCMC	Youth	2004–2006	X	X	X	X	X	X		X									
41	SHAPC	Hanoi, Thai Nguyen, Quang Ninh, Nghe An	MSM, PLWHA, IDU, CSW, youth	2004–2006	X	X	X	X		X	X	X			X			X		X	X
42	PSBI				X																
43	UNDP	Hai Duong, Lang Son; Da Nang, Son La Ha Tinh, Can Tho, Hau Giang, Tay Ninh	Policy makers	2001–2005	X		X	X	X	X											
44	UNESCO	Quangninh, Haiphong	Youth, PLWHA, MSM	2003–2005	X	X	X	X		X	X	X						X			
45	UNICEF	Hanoi, HCM, Hai Phong, Danang, Dong Thap, Quangninh, Lang Son, An Giang (border regions)	Youth, pregnant women, PLWHA		X	X	X	X	X	X		X	X	X	X	X	X	X			
46	VCHAP	Hanoi, HCMC, Hai Phong, Quang Ninh	Physicians & nurses									X	X	X							
47	World Vision	Hanoi, Danang, Hai Phong, Quang Nam, Thanh Hoa, HCMC, Quang Tri, Thua Thien Hue, HungYen	IDU, CSW, youth, migrant workers, PLWHA	Short-term projects and area development programs	X	X	X	X	X		X	X	X	X	X	X	X	X	X		

**p. Key Players of VCT in Viet Nam**

Organization	# of provinces	# of VCT	Target group						Setting		Clients				Note
			IDU	CSW	Sex partner (of IDC & CSW)	MSM	Family member	Others	Health	Non-health	Counseled	Tested	Returned	HIV +	
CDC—Center for Disease Control (Life Gap project)	40 provinces and 10 institutes	53	X	X	X				53	0	125,092	93.90%	91.60%	17.20%	data by 5/05
FHI—Family Health International	7 provinces	6	X	X	X	X			1	5	2,500	90%	95%	20–25%	Data of the first 6 months, 2005
Medecin du Monde— (MDM Canada) mobile clinic (STI, VCT, home care for AIDS patient)	HCMC	1	X	X			X (home care support for AIDS patient)	General population		1	93	25	70%	30%	MDM has just only implemented VCT since beginning of August, 2005
MSI—Marie Stopes International	8 provinces			X				Women, youth	4	4	2,636	2,257	85.60%	1%	Data by 2005