

## PART III: ATTACHMENTS

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# Attachment 1: Checklists



Where you are at the project cycle: PREDESIGN PHASE

## Attachment 1.1: Checklist of Key HIV Issues<sup>1</sup>

<i>Types of Impacts (Social and Economic Risks)</i>				
<b>Potential for increasing HIV vulnerability</b>	<b>Not known</b>	<b>Yes</b>	<b>No</b>	<b>If yes, consider potential scope of HIV vulnerability</b>
Is the road construction project situated in an area with high HIV prevalence? Will it eventually connect to areas with high HIV prevalence?				
Will there be increased mobility of the general population to the project site (e.g., laborers, itinerant traders, mobile sex workers)? If yes, (i) Can (should) this be reduced? (ii) Can they be targeted with specific HIV-prevention messages?				
Will subgroups be increasingly mobile during or as a result of the project (e.g., construction workforce, truck drivers, and sex workers)? If yes, (i) Can (should) mobility be reduced or can the situation be managed to ensure they spend less time away from home, e.g., relocate their families to the project site? (ii) Can they be targeted with specific HIV-preventive and curative services (e.g., condom promotion, STI testing, and treatment)?				
Are construction workers likely to come from the local community or from neighboring communities/countries? If not from the local community, (i) Will there be a language barrier? (ii) Can the same strategies work for multicultural target groups or should they be customized according to key cultural groups?				

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<sup>1</sup> Framework adapted from the Initial Poverty and Social Assessment Checklist on Involuntary Resettlement. In Asian Development Bank (ADB). 2001. *Handbook on Poverty and Social Analysis*. Manila.

<i>Types of Impacts (Social and Economic Risks)</i>				
<b>Potential for increasing HIV vulnerability</b>	<b>Not known</b>	<b>Yes</b>	<b>No</b>	<b>If yes, consider potential scope of HIV vulnerability</b>
Will some groups be disadvantaged by the (e.g., people who need to resettle)? If yes, can this be prevented? If not, will there be processes to address the livelihood impact and will HIV vulnerability be considered?				
Will the project affect the access to health care in the local population? If it reduces access, can this be addressed? If it increases access, can this alter the current scope of services to enhance HIV-related measures?				
Will the project affect access to any type of education? If yes, (i) Will this be addressed by the project? (ii) Is there potential to enhance HIV-prevention measures in this process?				
Will the project affect ethnic minority groups? Will the road traverse through their land and communities? If yes, (i) Do they have cultural beliefs and traditions that make them extra vulnerable to HIV and other STI (e.g., premarital/courtship practices)? (ii) Do you need ethnic- and linguistic-specific information, education, and communication methods and materials? Are there any available or do they need to be developed?				

<i>Affected Persons</i>
Any estimate of construction workers and allied workers required for the project? No ( ) Yes ( ) If yes, approximately how many? ____ What is the gender ratio? ____
Any estimate of the number of those in the local communities to be affected by the project? No ( ) Yes ( ) If yes, approximately how many? ____ What is the gender ratio? ____
Are any of these people poor or vulnerable to poverty risks? No ( ) Yes ( ) If yes, how? ____ What is the gender ratio? ____

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<i>Institutional Constraints</i>				
Type	Not known	Yes	No	If yes, consider potential scale and scope of HIV activities
Are local health and HIV-related laws and regulations compatible with ADB policies (e.g., mandatory HIV testing for construction workforce)?				
Will coordination and collaboration among several government entities be required? What will be the role and responsibility of the National AIDS Authority?				
Is the executing agency willing to incorporate HIV considerations into their project?				
Are there adequately skilled staff members in the executing agency who are available for planning and monitoring an HIV-prevention component?				
Are training and capacity development interventions required prior to the implementation of the HIV intervention?				

<i>Summary of Actions Required During the Predesign Phase</i>			
Action Required	Not known	Yes	No
Is a full and separate HIV assessment required?			
Is an HIV/ AIDS specialist required to design the HIV component for the initial poverty and social assessment? For the feasibility study?			
What funding options are available?			
Is further work necessary during the design stage to answer these questions?			

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Table continued...

<i>Technical Design Status</i>			
<b>Action Required</b>	<b>Not known</b>	<b>Yes</b>	<b>No</b>
Is the HIV component design to be based on the feasibility study?			
Is a stand-alone TA on HIV prevention warranted and/or possible?			
Is the HIV component going to be blended into the loan?			
Will further technical design be needed after Board approval?			
Who will be the executing agency for the HIV component?			

HIV = human immune deficiency, STI = sexually transmitted infection, TA = technical assistance.



Where you are at the project cycle: PREDESIGN PHASE

## Attachment 1.2: Checklist on Gender-Responsive Design for HIV/AIDS Components in Transport Sector Projects

<i>I. Project Planning</i>	Yes	No
Does the PPTA team include a member with gender expertise?		
Are questions on gender relations and the socioeconomic situation of women included in the IPSA preliminary questionnaire?		
Is gender included in the team work plan for the fact-finding mission?		
Is gender included in the TOR for any consultant involved?		
Are women's and youth NGOs and government agencies included in the list of stakeholders consulted?		
Do the methods used for field consultations allow women, men, and youth to participate equally in culturally appropriate ways (e.g., separate consultations for men and women, and male and female youth, with same-sex facilitators)?		
Are men and women key informants interviewed?		
Are both men and women included in small sample surveys?		
Do the surveys cover the situation of women as well as men?		
Are sufficient data gathered on any local socioeconomic and cultural factors which discriminate against women and girls, or against men and boys?		
Are all data disaggregated by sex and by age group where relevant?		
Does the IPSA report fully cover gender issues and the factors affecting the vulnerability of men, women, male and female youth and children, including the risk of trafficking?		

<i>II. Project Design and Monitoring and Evaluation</i>	Yes	No
Is gender analysis used in deciding what approaches and activities to include in the HIV/AIDS component?		
Does the design include interventions to empower women?		
Are target groups sex-specific (e.g., men and women, male and female youth, male and female sex partners of male construction workers, female sex workers and their clients, MSM and their male and female sex partners, etc., instead of gender-blind groups such as "people," "workers," "communities")?		

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<i>II. Project Design and Monitoring and Evaluation</i>	Yes	No
Are the spouses/regular sex partners (both sexes) of people in high-risk groups included in the target groups identified?		
Are component objectives and targets sex-specific (e.g., to reach 50% of male and female construction workers with peer education in Year 1; to train 80% of male and female youth aged 14-20 years in local communities in male and female condom use)?		
Are there targets and quotas for the employment of women (especially female-headed households)? <sup>1</sup>		
Does the component address the risks of trafficking for women, men, girls, and boys?		
Is there a Gender Action Plan for the component?		
Does the design require sensitization on gender issues (e.g., to be included in HIV/AIDS-related trainings provided to project and component implementing agency staff and managers (senior as well as middle level) of both sexes, and to men, women, and youth in local communities)?		
Does the component track project effects on girls and boys, and male and female adolescents, in the area of influence (e.g., on school attendance)?		
Are strategic partnerships made with agencies assisting women and youth, sex workers, and MSM?		
Does the M&E framework use gender-sensitive indicators and sex disaggregated data to monitor and evaluate the different levels of involvement of women and men in the project and the impact on them of project activities?		
Are gender results analyzed routinely to identify lessons learned and modify project implementation accordingly?		
Does the budget provide specific allocations for activities needed to reach men and women separately, where necessary (e.g., separate consultations or trainings, different IEC materials, child care for village meetings, provision of female as well as male condoms, etc.)?		

<i>III. Project Implementation</i>	Yes	No
Are gender issues and women's needs integrated into the HIV/AIDS IEC materials used, and into the HIV/AIDS topics covered in meetings, inductions, workplace safety trainings, etc.?		
Are women effectively represented in project, component, and related workplace committees (less than 30% is usually not effective)?		

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<sup>1</sup> 30% female participation is a commonly accepted benchmark.

<i>III. Project Implementation</i>	Yes	No
Are women supported in taking leadership roles, both in the workplace and in local communities?		
Are efforts being made to involve men and women in work or activities not traditionally linked to their gender?		
Are women's needs being addressed in the workplace (e.g., provision of segregated and secure latrines and ablution facilities, lighting, safe accommodation and transport)?		
Is information provided to women in the workplace and in communities, on support services for victims of sexual or physical violence, especially where to get preventive treatment on STI, HIV, and pregnancy if they have been raped?		
Do the implementing agency and the construction company have policy, procedures, and awareness on sexual harassment in the workplace?		
Are the spouses of workers included in company health insurance covering HIV/AIDS?		
Are workplace HIV/AIDS education sessions arranged so that male and female employees can benefit from them equally?		
Do peer education and peer education programs reach women to the same extent as men?		
Are efforts being made to raise awareness with men, women, and youth in the workplace and in local communities about violence against women and children, and trafficking of women and children?		
Are local women's organizations involved, and links made with provincial and/or national level agencies and advocates?		
Are ADB standards for workplace equality being applied (e.g., equal pay for men and women doing similar work)?		
Are savings schemes for men/women available through the workplace?		

<i>Implementation: Capacity Development and Training</i>	Yes	No
Are gender issues included in the design of capacity development and training programs, and in the materials used?		
Are gender-equitable targets included in the objectives for capacity development and training outputs?		
Are safety issues for women considered in the logistics?		
Are the capacity development needs of women, and women's organizations, considered?		
Is there a code of conduct for trainers that require them to role-model respectful relations between men and women?		

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<i>Implementation: Capacity Development and Training</i>	Yes	No
Is there gender balance in training of trainers, and are man-woman training teams used whenever possible?		
Are trainers trained to facilitate women's equal participation in training activities?		

<i>Implementation: Behavior Change Communication</i>	Yes	No
Are sex-specific groups used for peer education and peer leadership?		
Are efforts made to reach the spouses/regular sex partners of people in high-risk groups?		
Do materials include gender issues (e.g., differences in vulnerability, VAW) and address different gender needs (e.g., different symptoms of STI for men and women)?		
Is violence-free sex included as a safer sex behavior ?		
Is information given to men and women about women's human rights, and the right to say "no" to sex?		
Are appropriate IEC materials and methods used for each sex (e.g., adjusted for different literacy levels, access to mass media, etc.)?		
Do materials avoid reinforcing negative gender stereotypes, or stigmatizing certain groups (e.g., female SW, MSM, or mothers who transmit the virus to their babies)?		
Is there regular monitoring of dialogue-based methods (e.g., peer education, community theater) to ensure that local prejudices or beliefs do not distort the intended messages?		
Does peer education with both sexes include demonstrating how to use a condom (male and female) and inform men and women how to get them?		

<i>Implementation: Condoms Provision and Promotion<sup>2</sup></i>	Yes	No
Are female condoms promoted to men and women, as well as male condoms?		
Are both sexes informed about how to use both types?		
Do IEC reduce stigma (e.g., by promoting condom use as the choice of "partners who care," inside marriage not just outside it)?		
Do distribution methods take account of the sexual double standard which makes it difficult for women to access condoms openly (e.g., not only placing condom distribution or vending machines in public areas such as hospital entrances, but also in more private areas accessed by women, or through woman-to-woman distribution)?		

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<sup>2</sup> Male and female condoms must not be used together.

<i>Implementation: Services for STI and HIV Testing</i>	Yes	No
Does the location of the service allow for privacy and confidentiality?		
Is staff trained to give confidential nonjudgmental service, including with marginalized groups such as sex workers, MSM, and young or unmarried people?		
Can clients be seen by a health worker/counselor of the same sex? <sup>3</sup>		
Are couples encouraged to be tested at the same time (especially in antenatal HIV testing) to minimize woman-blaming?		
Do staff demonstrate and provide male and female condoms to clients of both sexes, as part of prevention information?		
Do protocols require counselors to always ask clients, particularly women, about their risk of violence when they reveal a positive test result to their partner? <sup>4</sup>		
Are counselors trained to provide practical advice, support, and referrals to reduce the risk of violence when a client discloses a positive test result to partner?		
Are treatment kits for rape victims available (prevention of STI, of HIV through PEP, <sup>5</sup> and pregnancy prevention)?		
Does the service make efforts to reach mobile groups (e.g., sex workers moving with work camps)?		
Are cases recorded by sex and age group?		
<i>For STI Services Only</i>	Yes	No
Are staff trained to recognize the range of STI symptoms in women, and the oral and anal symptoms more common to sex workers and MSM?		
Are syndromic management and presumptive periodic treatment methods used?		
<i>For VCT Services Only</i>	Yes	No
Do staff explain to male and female clients about how HIV can be transmitted to babies through the mother if no preventive measures are taken, and refer pregnant women with an HIV+ test result to health services where they can access the necessary medications and support?		
<i>For Injecting Drug Users</i>	Yes	No
Are programs tailored to the needs of male and female users?		
Are male and female users educated on how to prevent sexual transmission of HIV, including for MSM?		

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<sup>3</sup> This is particularly important with STI services, which require a physical examination as well as a discussion of sexual behavior.

<sup>4</sup> Depending on the country, there may be a legal requirement for a person receiving an HIV+ test result to inform their sexual partners about the diagnosis. Because of women's dependent situation, revealing an HIV+ diagnosis can often have serious consequences.

<sup>5</sup> Postexposure prophylaxis.

<i>For Injecting Drug Users</i>	Yes	No
Does the component address safety issues for women/girls accessing harm-reduction facilities?		
Does rehabilitation training avoid gender stereotyping?		

AIDS = Acquired immune deficiency syndrome, HIV = Human immunodeficiency virus, IEC = information, education, and communication, IPSA = initial poverty and social assessment, M&E = monitoring and evaluation, MSM = men-who-have-sex-with-men, NGO = nongovernment organization, PPTA = project preparation technical assistance, STI = sexually transmitted infection, SW = sex worker, TOR = terms of reference, VAW = violence against women, VCT = voluntary counseling and testing.

Sources include:

- UNAIDS. 2002. *Gender Sensitivity Checklist*. Geneva. Available: [www.unaids.org/html/pub/topics/gender/genderchecklist\\_en\\_pdf.pdf](http://www.unaids.org/html/pub/topics/gender/genderchecklist_en_pdf.pdf)
- World Bank. 2004. *Integrating Gender Issues into HIV/AIDS Programmes: An Operational Guide*. Washington, DC. Available: <http://siteresources.worldbank.org/INTGENDER/Resources/GenderHIVAIDSGuideNov04.pdf>
- World Bank. 2006. *Mainstreaming Gender Considerations in the Multi-Country HIV/AIDS Program (MAP): A Portfolio Review of Selected Programs*. Draft prepared by the PREM Gender and Development Group, Washington, DC.
- ADB. 2006. *Operations Manual, Gender C2/OP*. Manila.

# Attachment 2: Sample Terms of Reference



Where you are at the project cycle: PREDESIGN PHASE

## Attachment 2.1: Sample TOR – HIV/AIDS Specialist during the Project Design Phase<sup>1</sup>

### 1. Introduction

The (*executing agency*) is entrusted to develop, operate, and maintain (*what types of roads or highways*) under (*implementing agency*) comprising of (*affected sections*). The Asian Development Bank (ADB) has provided a Technical Assistance (TA) to the (*executing agency*) for (*name of proposed loan project*). Under the TA, ADB appointed (*number of consultants*) consultants—(*identify if international and/or local*)—to prepare for resettlement management and social impact assessment for the sector project. The TA has provision for subcontracting special studies in resettlement, indigenous peoples, HIV and AIDS, and trafficking of women/children to facilitate project preparation activities.

**Table 1: Project Packages**

Package	Section	NH	Km	Length	Area	Firm

### 2. Purpose/Objectives of the HIV and AIDS Study

It is now common knowledge that improved national/regional transportation networks have added to the rise of cross-border human trafficking, illegal drug, and sex trade, including the spread of HIV and sexually transmitted infections (STIs). Several studies indicate that the demand for commercial sex near construction sites and along major highway routes has facilitated the spread of HIV and other STIs. The essential purpose of the study is to assess the current situation, spatial/social dynamics of HIV and AIDS, and potential impact of highway development in transmitting HIV infection in the project influence areas.

#### 2.1. Scope of Works

The HIV/AIDS specialist will carry out rapid assessments at selected settings in project packages to:

<sup>1</sup> Adapted from: ADB. 2002. Technical Assistance to India for Preparing the National Highway Corridor (Sector) Project. Manila.

- (i) Analyze the HIV/AIDS and STI situation in the project influence areas and respective project states (e.g., HIV/AIDS/STI prevalence, main routes of transmission, policy environment, presence of HIV/AIDS/STI-implementing agencies, alternate funding options, available services for prevention, testing, treatment, care and support, etc.);
- (ii) Examine possibilities for collaboration among donors, UN agencies, government ministries, HIV-implementing organizations, private sector (construction and trucking companies), public/private health professionals, civil society, etc.
- (iii) Examine the local context for why, where, when, how, and among whom high-risk behaviors for HIV transmission occur (or can potentially occur) in the project area and respective project states. Emphasis should be placed on HIV vulnerability associated with construction activities (e.g., labor migration, increased mobility and connectivity, subculture in construction labor camps, etc.);
- (iv) Elaborate and model the intricate information and operational network (e.g., between truckers, sex workers, construction workers, construction supervisors, trafficking agents, etc.) in the project region that facilitates the spread of HIV; and
- (v) Assess the scope of highway projects, based on the findings of the study, to effectively address the HIV issues and, if so, what specific measures and activities are to be taken to mitigate such impacts.

## **2.2. *Structure and Length***

The report should be a total of 40–45 pages in length [or as otherwise determined], excluding tables and other field level data/maps, which should be placed in an appendix as much as possible. It should be analytical in nature and provide an assessment of the potential impact and dynamics of HIV transmission, and integrating the findings for a socially inclusive highway project. The report should be prepared in English with a 4–5-page [or as otherwise determined] “executive summary” highlighting the findings and recommendations.

## **2.3. *Methods and Timing***

It is expected that the preparation of the report will rely both on existing information/reports and primary data. Therefore,

field visits to the project sites are required. A list of potential problematic locations/areas in the project region is included for possible consideration. The specialist shall, however, adopt their own methodology and approach to identify critical locations and issues in the project influence area. Based on an initial field visit, a draft copy of the report should be presented to the TA consultant by (date). The ADB consultant will provide feedback by (date) and the final report should be submitted on or before (date).

### 3. Sample Outline of the Report

The following is a recommended outline. The consultant can use his/her own outline; however, the following issues must be covered by the report.

#### *Executive Summary*

- (i) Project description,
- (ii) Methodology,
- (iii) Situation analysis of HIV and AIDS in the project region,
- (iv) Vulnerability of communities to HIV infection caused by external influences/road development activities,
- (v) Information and operational network that facilitates the spread of HIV and AIDS,
- (vi) List of organizations/agencies/firms operating in the project areas,
- (vii) Project impact, and
- (viii) Measures and strategies to address and integrate the HIV issue in the highway projects.

The report should contain a series of recommendations for integrating HIV issues in the highway project, including project management, implementation and funding arrangements, and monitoring and evaluation frameworks.

### 4. Payments to Personnel/Consultants

The specialist will be paid [amount] for the assignment that includes the following:

(a) Travel (air and ground costs) <sup>2</sup> -	\$ ____
(b) Per diem for ____ days (\$__X __) <sup>3</sup>	\$ ____
(c) Research support	\$ ____
(d) Lump-sum fee for ____ days	\$ ____
Total	\$ ____

<sup>2</sup> Reimbursable at costs with supporting receipts/documents. Tickets required (including boarding passes).

<sup>3</sup> Fixed rates, no receipts required.

## **5. General Notes**

The study will become the property of ADB. The author does not retain ownership of the product. The author is responsible to the ADB TA team members in all matters related to this assignment.



Where you are at the project cycle: DESIGN PHASE

## Attachment 2.2: Sample TOR – HIV/AIDS Service Providers

1. The program implementation consultant will be responsible for the effective and efficient implementation of the following three components of the HIV, Illicit Drugs, and Human Trafficking Prevention Program (the program): (i) advocacy and capacity building; (ii) information, education, and behavior change campaign; and (iii) provision of medical packages. The project supervision consultant, who will be selected by the Vietnam Expressway Corporation (VEC) to supervise consulting services for the Greater Mekong Subregion: Kunming-Hai Phong Transport Corridor-Noi Bai-Lao Cai Highway Project (the project), will make a subcontract with the selected organization/consulting firm for the program implementation.

2. The selected program implementation consultant should have demonstrated competence and experience in implementing an HIV, drug, and human trafficking prevention programs in the infrastructure sector. The consultant team should consist of one international team leader (14 person-months), one national deputy team leader (40 person-months), and five national project officers (a total of 200 person-months). The team leader, the deputy team leader, and the project officer for Ha Noi should be based at the headquarters of the project management team (PMT) of VEC. The other project officers should be based in each of the four field offices of the PMT.

### A. Team Leader (14 person-months, international)

3. The team leader will have at least 15 years of public health experience, including at least 5 years in Asia, in prevention programs for HIV, illicit drugs, and human trafficking, and as team leader of projects. Some experience in Viet Nam along with HIV-prevention programs in non-health sectors would be beneficial. The team leader will be responsible for overall coordination, implementation, and report preparation for the program. In coordination with VEC's focal person for the program, the team leader will undertake the following tasks but will not be limited to them:

- (i) Report to the team leader of the project supervision consultant, VEC's focal person for the program, and the Asian Development Bank (ADB).
- (ii) Manage the administration and implementation of the program.
- (iii) Lead consultations on HIV, drug and human trafficking prevention in the project area.
- (iv) Guide the consultant team members, ensure that the program is implemented according to the TOR for the consultant and

- any subsequent instructions or guidance from VEC and ADB, and be responsible for the collective work of the consultant team.
- (v) Ensure regular liaison with VEC, the Viet Nam's Administration of HIV/AIDS Control (VAAC), provincial people's committees (PPCs) in the project area, other ministries, development partners, and civil society. Ensure collaboration with the resettlement and social development team of the project supervision consultant, and the project performance monitoring system (PPMS) consultant.
  - (vi) Take responsibility for preparing a detailed implementation and budget for the above three components of the program through a participatory planning process (including consultations, task forces, field visits, and workshops) with the PPCs and VAAC. The plan should comprise the five sets of plan of action, budget, and a performance monitoring system from each PPC. The plan must be approved by the PMT and ADB not later than 1.5 months after civil works commence.
  - (vii) Develop and ensure the overall implementation of an effective system for internal monitoring of the program implementation and outcomes, in collaboration with the PMT, PPCs, and the PPMS consultant. The scope of the internal monitoring system will include (a) maintaining baseline data for benefit evaluation purposes as developed by the PPMS team, and (b) tracking of resources, activities, and schedules related to the program.
  - (viii) Support the PPMS consultant in developing indicators and targets that are adequate for detailed planning, monitoring, and evaluation of the program using updated information on HIV/AIDS, sexually transmitted infections (STIs), illicit drug use, alcohol use, sex work, transport settings, commercial and entertainment settings, mobility and migration patterns, ethnic minority settings, health systems, among others.
  - (ix) Ensure that extensive consultation with the representatives of civil works contractors and subcontractors, transport companies, commercial and entertainment establishments, local communities, and PPCs about the program is conducted.
  - (x) Take responsibility for facilitating the steering committee and provincial steering committees, and ensuring that regular monitoring meetings are conducted with the PMT, construction and transport companies, and local community representatives. Provide guidance to the PPCs and the steering committees in the execution of their specific responsibilities.
  - (xi) Prepare memorandum of understanding/contracts required to implement the approved program design, and financial and reporting requirements and to ensure formal and documented approval of the program at provincial and district levels.

- (xii) Ensure complete and on-time submission of formal written reports, including the inception report, implementation report, annual reports, and completion report.

**B. Deputy Team Leader (40 person-months, national)**

4. The deputy team leader will have relevant postgraduate qualification and at least 10 years of HIV-prevention experience, including 5 years in project planning and management. The deputy team leader will undertake the following tasks but will not be limited to them:

- (i) Report to the team leader, and support the team leader in managing the consultant team and other consultants and making all arrangements for the smooth implementation and administration of the consultant's work.
- (ii) Arrange and support the establishment of close working relationships with the VEC, VAAC, PPCs, civil works contractors, as well as with nongovernment/community groups and other donors. Support and coordinate with the resettlement and social development team of the project supervision consultant and the PPMS consultant.
- (iii) Work with the team leader to prepare a detailed implementation and budget for the above three components of the program through a participative approach.
- (iv) Ensure that systems and procedures including reporting for overall management and implementation of the components are conducted smoothly. Conduct quality internal monitoring of the program implementation and outcomes, in collaboration with the PPCs and the program officers of the consultant team.
- (v) Ensure and maintain close working relationships with the PPCs through the program officers. Provide guidance and support to the provincial steering committees.
- (vi) Ensure that each PPC undertakes appropriate consultations at provincial, district, and village levels to obtain consensus on the program and to ensure that agencies/organizations involved understand, endorse, and are able to comply with the objectives, principles, and procedures for the implementation of the program.
- (vii) Support the PPMS consultant in establishing and maintaining the PPMS.
- (viii) Organize regular monitoring meetings with the representatives of civil works contractors and subcontractors, transport companies, commercial and entertainment establishments, local communities, PPCs, and others related to the project.

- (ix) Draft memorandum of understanding/contracts required to implement the program, including designs, and financial and reporting requirements. Facilitate in getting formal and documented approval of the program at provincial and district levels.
- (x) Liaise with the PMT to ensure proper and timely disbursement of the TA funds to the PPCs.
- (xi) Provide the team leader with quarterly progress reports, including detailing achievements, implementation issues, and recommendations for remedial measures.
- (xii) Assist the team leader in preparing formal written reports, including the inception report, implementation report, annual reports, and completion report.
- (xiii) Provide support and TA to the PPCs for the preparation of a detailed action plan, and financial and monitoring requirements. Ensure that these are congruent with ADB policies, protocols, and regulations.

### **C. Program Officers (200 person-months, national)**

5. The program officers will have a bachelor's degree in public health, social service, or related field and at least 5 years of work experience in project implementation and/or coordination. Experience in HIV prevention, drug and/or human trafficking prevention in Viet Nam is highly desirable. The program officers will undertake the following tasks but will not be limited to them:

- (i) Report to the deputy team leader and work as a member of the team.
- (ii) Perform liaison work with, and ensure close working relationships among, the PMT field offices, PPCs, civil works contractors, and nongovernment/community groups in the project area.
- (iii) Provide support and technical assistance to the PPCs for preparing a detailed action plan, and financial and monitoring requirements.
- (iv) Assist in ensuring that the PPCs undertake appropriate consultations at provincial, district, and village levels to obtain consensus on the program and to ensure that agencies/organizations involved understand, endorse, and are able to comply with the objectives, principles, and procedures for program implementation.
- (v) Take responsibility for the smooth implementation and monitoring of the provincial plans of action and financial and reporting mechanisms.

- (vi) Liaise between the PPCs, the PMT field offices, and civil work contractors.
- (vii) Provide the deputy team leader with monthly progress reports based on the implementation plan and budget of the program and the PPCs, including detailing achievements, implementation issues, and recommendations for remedial measures.
- (viii) Provide coordination and secretariat work to the provincial steering committees.
- (ix) Conduct regular monitoring meetings with the PPCs, civil works contractors and subcontractors, transport companies, commercial and entertainment establishments, local communities, nongovernment/civic organizations in each designated project area.
- (x) Assist the PPMS consultant in arranging meetings and logistics to conduct the PPMS surveys and other tasks when required.



Where you are at the project cycle:  
MONITORING AND EVALUATION PHASE

### Attachment 2.3: Sample TOR – Monitoring and Evaluation Consultant

1. The objectives of the consulting services are to develop and implement a program performance monitoring system (PPMS) to (i) assess the progress of the HIV, Illicit Drugs, and Human Trafficking Prevention Program (the program) associated with the Greater Mekong Subregion: Kunming-Hai Phong Transport Corridor-Noi Bai-Lao Cai Highway Project (the project) in a timely fashion, (ii) enable appropriate adjustment of the program activities during the highway construction through monitoring performance indicators, and (iii) evaluate the impacts of the program. The PPMS is aimed at improving the knowledge of the HIV issue and its dynamics in relation with the implementation of large infrastructure projects to help fine-tune prevention programs associated with such projects in the future.
2. The PPMS consultant team will consist of one international and two national specialists. The international specialist will be required for a total input of 7 person-months, while the two national specialists will be required for a total of 20 person-months. The consulting firm/organization will be highly qualified in PPMS, with recognized experience in monitoring and evaluating HIV/AIDS, drug and human trafficking prevention programs in Viet Nam. The consulting services will be intermittently conducted over a period of about 4 years from the third quarter of 2008 until 2 months after civil works finishes (estimated to be the second quarter of 2012).
3. The PPMS consultant will undertake the following tasks but will not necessarily be limited to them:
  - (i) Develop a PPMS including establishment of data sources and a set of performance indicators based on the targets and anticipated outputs of the program, and the detailed prevention program prepared by the program implementation consultant; in addition to the program performance indicators, the PPMS will report on a set of data including (a) HIV prevalence in the project areas disaggregated by gender and group, e.g., construction workers, sex workers, and local communities; (b) incidence of STI among the same vulnerable groups and accessibility of quality STI testing and treatment services; (c) behavior change; and (d) availability of condoms in project areas.
  - (ii) Prepare appropriate procedures and mechanisms for the participation of key stakeholders and periodic collection and processing of data.

- (iii) Design a baseline survey that considers the high turnover of employees in the construction companies and among migrant and mobile workers for the follow-up surveys. Complete the baseline survey 1 month after the start of civil works.
- (iv) Review and assess the current HIV-prevention measures, and HIV and STI testing and treatment protocols, and costs including clinic monitoring and record system.
- (v) Undertake annual evaluations/surveys, analyze the outcomes, compare them with those anticipated, and recommend corrective measures; in evaluating the program's impacts, the PPMS should focus on those benefiting the vulnerable populations (construction workforce, local communities affected by the construction of the highway and subsequent feeder roads, and sex workers); these impacts will be further analyzed upon completion of the program to evaluate the cost-effectiveness of each behavior change communication method adopted, health systems intervention and condom social marketing.
- (vi) Provide inputs to the meetings and seminars organized by the program implementation consultant.
- (vii) Train VEC staff in PPMS to evaluate and monitor the spread of HIV, STI, and drug and human trafficking in the project area.
- (viii) Prepare a PPMS manual for use by relevant government agencies for HIV, drug and human trafficking prevention in similar road construction projects.

## Attachment 3: Bidding Documents



Where you are at the project cycle: IMPLEMENTATION PHASE

### Attachment 3.1: Draft HIV Clause for Inclusion in Construction Contracts

#### 1. For the Purpose of this Clause:

“Service Provider” means a person or entity approved to provide the HIV-Awareness and Prevention Program;

“the Contractor’s Employees” means, without prejudice to any other definition contained in the Contract, any workers who are under the Contractor’s control and on the Site in connection with the Contract, including any workers who are under the control of any person or entity to whom the Contractor has subcontracted any its obligations under the Contract other than those responsibilities set out in this Clause);

“the HIV Prevention Program” means an HIV-prevention program that will use the Tool Kits for HIV/AIDS prevention among construction workers developed by ADB/UNDP in 2002 ;

#### 1.2. It shall be a Condition of the Contract that the Contractor:

- 1.2.1 subcontracts with a Service Provider to implement an HIV-prevention program among the Contractor’s Employees for the duration of the Contractor’s contract and commencing as soon as practicable after the Contractor’s Employees arrive at the Site/s Contractor’s Employees arrive at the Site/s;
- 1.2.2 gives any representative of the Service Provider, and the Employer all reasonable access to the Site in connection with the HIV-prevention program;
- 1.2.3 instructs the Contractor’s Employees to participate in the HIV -Prevention Program in the course of their employment and during their normal working hours or any period of overtime provided for in the relevant employment contracts and uses all reasonable endeavors to ensure this instruction is followed;
- 1.2.4 does nothing to dissuade the Contractor’s Employees from participating in the HIV-Awareness and Prevention Program.

- 1.3 The Contractor shall be entitled to be reimbursed by the Employer for any payments made under a subcontract made for the purpose of Clause 1.2.1 in accordance with the relevant provisions in the Contract.
- 1.4 Where the Contract does not provide for reimbursement of named costs, the amount paid by the Contractor to the Service Provider shall be added to any lump sum to be paid by the Employer to the Contractor under the Contract and, before such lump sum is paid, the Contractor shall provide to the Employer evidence of:
  - 1.4.1 payment of the amount claimed to the Service Provider; and
  - 1.4.2 provision of the HIV-Prevention Program (e.g., a certificate issued by the Service Provider).
- 1.5 Where a clinic is provided on behalf of the Contractor on Site, the Contractor shall ensure that such clinic provides to the Contractor's Employees, on request and without charge:
  - 1.5.1 confidential counseling and advice on HIV/AIDS and
  - 1.5.2 condoms that comply with the WHO/UNAIDS Specification and for Condoms 1998 or any more recent equivalent publication to a maximum of [number] per member of the Contractor's Employees per year.
- 1.6 Where the Contractor subcontracts any of its obligations under the Contract, it shall require any subcontractor to comply with sub clauses [1.2.2-1.2.6] of the Contract as if it were the Contractor.



Where you are at the project cycle: IMPLEMENTATION PHASE

### **Attachment 3.2: Draft Explanatory Note (for Inclusion in Bidding Documents)**

Clause [ ] requires the Contractor to arrange for its employees, its subcontractor's employees, and others to attend an HIV-prevention program provided in accordance with the National HIV/AIDS Authority strategy.

The program will be provided at the Employer's cost, though the Contractor will make the initial payment to the program provider before claiming reimbursement from the Employer in the usual way. The program will take place during its employees' normal working hours. In pricing his bid, the Contractor should therefore take into account the "down time" during which employees attend the program.

Further information on the HIV-Prevention Program using the ADB/UNDP tool kit for construction workers; please refer to [www.hivmekong.net/](http://www.hivmekong.net/) or [www.hiv-development.org](http://www.hiv-development.org) (a UNDP website).

# Attachment 4: Examples from ADB Projects



Where you are at the project cycle: DESIGN PHASE

## Attachment 4.1: Comparative Analysis of HIV/AIDS Components in ADB Transport Projects

	Project Title	Country	Loan Status/No.	Sector	Total ADB Financing (\$'000,000)	Type of Loan	Cost of HIV/AIDS Comp. (\$'000)	Type of Financing	Executing Agency	Implementing Arrangement	Approved
1	Southern Transport Corridor Road Rehabilitation	KGZ	2106	T&C	32.80	ADF	500	TA	Ministry of Healthcare	Ministry of Healthcare	23 Nov 2004
2	Road Network Improvement and Maintenance Project II	BAN	2021	T&C	126.00	ADF	250	Loan	Ministry of Women's and Children's Affairs	Local NGOs	20 Nov 2003
3	GMS: Cambodia Road Improvement	CAM	1945	T&C	50.00	ADF	100	Loan	Ministry of Public Works & Transport	NGO/Agency	26 Nov 2002
4	Chhattisgarh State Roads Development Sector	IND	2050	T&C	180.00	OCR			Chhattisgarh State AIDS Control Society	Chhattisgarh State AIDS Control Society	15 Dec 2003
5	National Highway Corridor Sector I	IND	2029	T&C	400.00	OCR	400	Gov't.	National Highways Authority of India	Locally based NGOs	4 Dec 2003
6	National Highway Corridor Sector II	IND	2154	T&C	400.00	OCR	600		National Highways Authority of India	National Highways Authority of India	21 Dec 2003

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Table continued...

	Project Title	Country	Loan Status/No.	Sector	Total ADB Financing (\$'000,000)	Type of Loan	Cost of HIV/AIDS Comp. (\$'000)	Type of Financing	Executing Agency	Implementing Arrangement	Approved
7	East-West Corridor	IND	1944	T&C	320.00	OCR	4,300	Loan	National Highways Authority of India	NGOs	26 Nov 2002
8	West Bengal Corridor Development	IND	1870	T&C	210.00	OCR	13,350	Gov't.	Public Works Road Department	NGOs	11 Dec 2001
9	Roads for Rural Development	LAO	2085	T&C	15.00	ADF	1,200	Loan	National and Provincial Committees for Control of AIDS	National and Provincial Committees for Control of AIDS	28 Jun 2004
10	GMS: East-West Corridor	LAO	1727	T&C	32.00	ADF			Ministry of Communications, Transport, Post & Construction	Local NGO	20 Dec 1999
11	GMS: Northern Economic Corridor	LAO	1989	T&C	30.00	ADF	250	Loan	National and Provincial Committees for Control of AIDS	International NGO	20 Dec 2002
12	Regional Road Development	MON	2087	T&C	37.13	ADF	350	TA	Ministry of Health	Local Health Departments	22 Jul 2004
13	Subregional Transport Facilitation	NEP	2097	T&C	20.00	ADF	30	Loan	Department of Roads	Local NGOs and local staff	4 Nov 2004
14	Guangxi Roads Development II	PRC	2094	T&C	200.00	OCR	NA	NA	Australian Agency for International Development	Acil Australia	21 Oct 2004
15	Western Yunnan Roads Development	PRC	2014	T&C	250.00	OCR	1,000	TA	Yunnan Provincial Leading Group for HIV/AIDS Control	Yunnan Provincial Leading Group for HIV/AIDS Control	28 Oct 2003
16	GMS: East-West Corridor	VIE	1727	T&C	25.00	ADF			Ministry of Transport	Local NGO	20 Dec 1999

ADF = Asian Development Fund, AIDS = acquired immune deficiency syndrome, BAN = Bangladesh, CAM = Cambodia, GMS = Greater Mekong Subregion, HIV = human immunodeficiency syndrome, IND = India, KGZ = Kyrgyz Republic, LAO = Lao People's Democratic Republic, MON = Mongolia, NEP = Nepal, NGO = nongovernment organization, OCR = ordinary capital resource, PRC = People's Republic of China, TA = technical assistance, T&C = transport and communications, US = United States, VIE = Viet Nam, \$ = US dollar.

Source: ADB Database.



Where you are at the project cycle: DESIGN PHASE

**Attachment 4.3: Example – Design and Monitoring Framework**

Design Summary	Performance Targets/ Indicators	Data Sources/ Reporting Mechanisms	Assumptions and Risks
<p><b>Impact</b> Preventing the spread of HIV and halting drug and human trafficking in Viet Nam.</p>	<p>On completion of the project, Viet Nam will have already reached the 2015 MDG targets for halting and beginning to reversing the spread of HIV, achieved its goals in the National Drug Control Master Plan (2001–2010), and halted human trafficking.</p>	<p>Viet Nam HIV sentinel surveillance survey</p> <p>Report on the Viet Nam National Drug Control Master Plan</p> <p>UNODC report</p>	<p><b>Assumptions</b></p> <ul style="list-style-type: none"> <li>• Data are available</li> </ul> <p><b>Risks</b></p> <ul style="list-style-type: none"> <li>• Weak political commitment to sector</li> </ul>
<p><b>Outcome</b> Mitigated the spread of HIV and drug and human trafficking associated along the Lao Cai–Hai Phong Transport Corridor.</p>	<p>30% increase in HIV and STI testing at provincial level.</p> <p>60% increase in positive behavior change among construction workforce and local communities affected by the road project.</p> <p>10% decrease in cases of illegal drug use and human trafficking at provincial level.</p>	<p>Provincial HIV and STI sentinel surveillance survey</p> <p>TA final report</p> <p>Reports from the provincial people’s committees</p>	<p><b>Assumptions</b></p> <ul style="list-style-type: none"> <li>• Data are available.</li> <li>• Efficient implementation of the HIV, drug and human trafficking prevention program.</li> <li>• Commitment of the national and provincial governments.</li> </ul> <p><b>Risks</b></p> <ul style="list-style-type: none"> <li>• Quality HIV and STI diagnostic and treatment services are not available.</li> <li>• Change in government policies and goals for drug and human trafficking.</li> </ul>

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Table continued...

Design Summary	Performance Targets/ Indicators	Data Sources/ Reporting Mechanisms	Assumptions and Risks
<p><b>Outputs</b></p> <p>1. Increased awareness about, and capacity to address, HIV, drug and human trafficking issues among key partners in the infrastructure sector.</p> <p>2. Increased awareness and positive behavior change among construction workforce, local communities, and sex workers affected by the road project.</p> <p>3. Increased access to quality HIV, STI, and other health services.</p>	<p>Development of HIV and AIDS policies in VEC and construction companies.</p> <p>Workshops and on-the-job training have improved capacity of MOT and VEC to design and monitor HIV, drug and human trafficking prevention programs.</p> <p>100% coverage of construction workforce and local communities affected by the road project.</p> <p>60% increase in positive behavior change among construction workforce and local communities affected by the road project.</p> <p>50% increase in condom availability outside the government's family planning program.</p>	<p>TA midterm report</p> <p>PPMS report</p> <p>TA progress reports</p> <p>PPMS report</p> <p>PPMS report</p>	<p><b>Assumptions</b></p> <ul style="list-style-type: none"> <li>• MOT counterparts participate in workshops.</li> <li>• VEC and counterparts participate in on-the-job training.</li> <li>• Condom social marketing in the project areas is feasible and sustainable.</li> <li>• HIV testing is only available at provincial center and STI testing and treatment is allowed at district level.</li> </ul> <p><b>Risks</b></p> <ul style="list-style-type: none"> <li>• Quality HIV and STI diagnostic and treatment services are not available.</li> <li>• Change in current pattern for drug and human trafficking in the project area.</li> <li>• Change in government policy on the commercial retail of condoms.</li> </ul>

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Design Summary	Performance Targets/ Indicators	Data Sources/ Reporting Mechanisms	Assumptions and Risks
	<p>50% increase in reported capacity among provincial and district health workers to diagnose and treat STI and to conduct HIV counseling and testing.</p> <p>50% increase in district health centers providing STI testing and treatment services.</p> <p>Updated protocols on HIV and STI voluntary counseling and testing, treatment, care, and support in the provinces.</p>	<p>PPMS report</p> <p>PPMS report</p> <p>PPMS report</p>	<ul style="list-style-type: none"> <li>High turnover of construction workforce and mobile sex workers to capture in PPMS surveys</li> </ul>
<p><b>Activities with Milestones</b></p> <ol style="list-style-type: none"> <li>1. Consultant selection <ol style="list-style-type: none"> <li>1.1 Program implementation consultant is selected by June 2008.</li> <li>1.2 PPMS consultant is selected by July 2008.</li> </ol> </li> <li>2. Advocacy and Capacity Building <ol style="list-style-type: none"> <li>2.1 Advocacy workshops are completed by May 2009.</li> <li>2.2 HIV and AIDS policy in the construction workplace is completed by May 2011.</li> <li>2.3 Mid- and end-of-project dissemination workshops are completed by May 2010 and May 2012, respectively.</li> </ol> </li> <li>3. Information, Education, and Behavior Changes Campaign <ol style="list-style-type: none"> <li>3.1 Inclusion of HIV prevention in contractors' occupation health and safety program is completed by July 2009.</li> <li>3.2 Production of customized IEC and BCC materials completed by May 2009.</li> <li>3.3 Weekly education and training sessions in construction camps/sites are conducted until project completion.</li> </ol> </li> </ol>			<p><b>Inputs</b></p> <ul style="list-style-type: none"> <li>ADB: \$1,000,000</li> </ul>

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Design Summary	Performance Targets/ Indicators	Data Sources/ Reporting Mechanisms	Assumptions and Risks
<p>3.4 Mechanism for sustained condom delivery is established by May 2012.</p> <p>3.5 Confidential HIV referral and counseling system is established by December 2009.</p> <p>4. Provision of Medical Packages</p> <p>4.1 Updated protocols on HIV and STI services for migrant and mobile populations completed for each province by December 2011.</p> <p>4.2 Training of health implementers is completed by December 2009.</p> <p>5. Monitoring and Evaluation</p> <p>5.1 Baseline survey report is completed by October 2008.</p> <p>5.2 PPMS is completed by November 2008.</p> <p>5.3 Annual survey report is completed by May 2009, 2010, and 2011.</p> <p>5.4 Final report is completed by May 2012.</p>			

ADB = Asian Development Bank, AIDS = acquired immune deficiency syndrome, BCC = behavior change modification, HIV = human immunodeficiency virus, IEC = information, education, and communication, MDG = Millennium Development Goal, MOT = Ministry of Transport, PPMS = project performance monitoring system, STI = sexually transmitted infection, TA = technical assistance, UNODC = United Nations Office on Drugs and Crime, US = United States, VEC = Vietnam Expressway Corporation, \$ = US dollar.

Source: ADB. 2007. Report and Recommendation of the President to the Board of Directors on a Proposed Loan to Viet Nam for the GMS: Kunming-Hai Phong Transport Corridor-Noi Bai-Lao Cai Highway Project. Manila. [Project Number 33307]



Where you are at the project cycle: DESIGN PHASE

**Attachment 4.4: Example – Cost Estimates for the Program**

Item	Cost (\$'000)
<b>A. Asian Development Bank Financing<sup>1</sup></b>	
1. Consultants for Program Implementation	470.0
a. Remuneration and Per Diem	
i. International Consultants	140.0
ii. National Consultants	300.0
b. International and Local Travel	30.0
2. Consultants for Program Performance Monitoring System	105.0
a. Remuneration and Per Diem	
i. International Consultants	50.0
ii. National Consultants	40.0
b. International and Local Travel	15.0
3. IEC Materials, Medical Supplies, and Office Equipment	265.0
a. Print and audiovisual materials and equipment	80.0
b. Condoms	140.0
c. STI treatment kits	30.0
d. Office equipment	15.0
4. Training, Seminars, and Conferences	30.0
5. Surveys	30.0
6. Contingencies	100.0
<b>Total</b>	<b>1,000.0</b>

IEC = information, education, and communication; STI = sexually transmitted infection; TA = technical assistance.

<sup>1</sup> ADB. 2007. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to Viet Nam for the GMS: Kunming-Hai Phong Transport Corridor–Noi Bai-Lao Cai Highway Project*. Manila. [Project Number 33307]



Where you are at the project cycle: DESIGN PHASE

## Attachment 4.2: Example – Technical Assistance for HIV, Illicit Drugs, and Human Trafficking Prevention Program

### I. INTRODUCTION

1. The Greater Mekong Subregion: Kunming-Hai Phong Transport Corridor—Noi Bai-Lao Cai Highway Project (the project) has potential social risks for the increase of HIV infection, and the trafficking of drugs and humans. After discussions with Asian Development Bank (ADB), the Government of Viet Nam requested additional technical assistance (TA) to implement a prevention program against HIV, and the trafficking of drugs and humans in the project area to help mitigate the potential social risks. The need for such a program was identified during ADB's Review Mission that visited the project area in March 2007. Further discussions on the program objectives, scope, cost, and implementation arrangements were held with key stakeholders in June 2007. A major change in the scope of the ongoing regional TA for Fighting HIV/AIDS in Asia and the Pacific<sup>4</sup> with additional grant fund of \$1 million is proposed to undertake the proposed HIV, Illicit Drugs, and Human Trafficking Prevention Program (the program) associated with the project.

### II. ISSUES

2. The linkages between migration, mobility, and the spread of HIV are well documented. Increases in HIV prevalence have been observed along major transport routes, cross-border areas, and in regions experiencing high seasonal and long-term population mobility. In many developing countries, large infrastructure projects offer economic opportunities that attract migrant workers, commercial retailers, and entertainment industries to previously remote and isolated communities. The interaction among the construction workforce, local communities, and sex workers can create a potentially high-risk environment for the spread of HIV and other sexually transmitted infections (STIs) through unprotected sex and/or injecting drug use (IDU). Mobile and migrant

<sup>1</sup> ADB. 2006. TA 6231-REG: *Technical Assistance for Fighting HIV/AIDS in Asia and the Pacific* (Financed by the Cooperation Fund for Fighting HIV/AIDS in Asia and the Pacific). Manila. The Fund was established in 2005 with an initial grant of \$14.3 million from the Government of Sweden.

workers, including construction workers, are highly vulnerable since their prolonged separation from family and communities, access to disposable income, and lack of alternative sources for rest and recreation can lead them to adopt high-risk behaviors. Other vulnerable groups include truck drivers and their helpers, commercial retailers, and border police.

3. ADB has been incorporating HIV-prevention programs targeting construction workers and the local communities they interact with into the design of its transport projects for some years. In August 2006, ADB signed a joint initiative together with five other donor agencies to commit to reducing HIV vulnerabilities associated with infrastructure projects through targeted interventions and supporting the HIV and AIDS response of partner countries. The proposed program is consistent with the recommendations of the joint initiative as well as lessons learned from ADB's experience with similar activities.

4. **Situation in Viet Nam.** The HIV epidemic in Viet Nam continues to rise and HIV has been detected in all 64 provinces and cities. The number of people living with HIV has doubled since 2000, with an estimated 260,000 cases by the end of 2005. Around 40,000 Vietnamese are believed to be infected with HIV each year, mostly through the sharing of contaminated needles during the use of illicit drugs and unsafe sex between a female sex worker and her client. IDUs are the most affected, accounting for 53% of the total reported HIV cases in the country. While female sex workers are the second most vulnerable group with a prevalence of 6.5% among those tested in 2004.

5. Trafficking of women and children in Viet Nam is reported to be on the rise. It is thought that thousands of Vietnamese women are trafficked through the Viet Nam–People's Republic of China (PRC) border by illegal organizers who take them to Cambodia and other neighboring countries for sexual exploitation. Reports also indicate that women are trafficked to Europe and Macau for prostitution and arranged marriages.

6. **Situation in the Project Area.** The Noi Bai-Lao Cai Highway will connect Kunming in Yunnan province in the PRC to the Hai Phong and Cai Lan ports in Viet Nam via the major city of Ha Noi. These cities and provinces have some of the worst HIV epidemics in their respective countries and the region. More than 1% of the adult population in Yunnan is HIV positive, mainly transmitted through IDU. In 2005, HIV prevalence among IDUs in Yunnan was estimated to have exceeded 50%. The epidemic has also affected truck routes and border towns, particularly near the Myanmar border. Likewise, Ha Noi and Hai Phong have some of Viet Nam's worst HIV epidemics. More than 1% of the

adult population in Hai Phong is HIV positive, while it is estimated to be 0.9% in Ha Noi. Viet Nam's epidemic has mostly been driven by IDU and its association with sex work.

7. The proposed highway cuts across the northern plateau of Viet Nam through Ha Noi, Vinh Phuc, Pho Tho, Yen Bai, and Lao Cai provinces. In 2005, this region (excluding Ha Noi) was estimated to have a total of 6,000 HIV cases. Lao Cai, the international border town with Yunnan Province, has the worst HIV situation among the cluster with 181 reported cases in 2003, of which 75% were associated with IDU. Lao Cai has 1,000–1,500 travelers passing through its international border gate daily; among them are traders, long-distance truckers, construction/transportation workers, and porters.

8. IDU, commercial sex, and trafficking of women and children are rapidly increasing in Lao Cai. With improved transportation and infrastructure, enabling 1-day travel time between Kunming and Hai Phong, the existing risks and vulnerabilities for HIV transmission, drug use, and human trafficking along the Noi Bai-Lao Cai Highway will significantly increase if targeted risk mitigation initiatives are not implemented.

### III. THE TECHNICAL ASSISTANCE

#### A. Impact and Outcome

9. The overall objective of the additional scope of the TA is to prevent the spread of HIV along the Noi Bai-Lao Cai Highway during and after the construction stage and to mitigate the increased risk of illicit drug use and human trafficking that may result from the project. The specific objective is to raise public awareness, address the risks, and highlight multi-sectoral roles and responsibilities for the project management staff, consultants and workers, IDUs, local residents, transport service providers, local police and border officials, commercial and entertainment establishments, and other groups affected by the project. Key outputs will include (i) increased awareness about HIV, AIDS, and STI, drug and human trafficking among local communities, road contractors and workers, and local authorities; (ii) behavior change among construction workforce, local communities, and sex workers and their clients; (iii) improved access to affordable, high-quality condoms, and HIV/STI-related and other health services and products in project area; (iv) increased collaboration among key players for drug and trafficking prevention; and (v) an improved monitoring and evaluation system. The design and monitoring framework for the program is shown in Attachment 4.3.

## B. Methodology and Key Activities

10. The additional scope of the TA will comprise four components:

- (i) **Advocacy and Capacity Building.** To ensure commitment and cooperation across a wide range of stakeholders, awareness will be raised to prevent HIV and drug and human trafficking in a sustainable way through: (a) workshops targeting the construction workforce (management, consultants, contractors, subcontractors, and workers), provincial and district government authorities, border police, local communities, health providers (private and public clinics and pharmacies), commercial and entertainment establishment owners and staff, and other groups located in the project area; (b) development of HIV/AIDS policies in the construction workplace including preemployment screening, confidentiality of medical status and worker's rights to ongoing employment if found positive for HIV and other STIs; (c) strengthening cross-border cooperation for prevention of HIV, drug and human trafficking between the Lao Cai and Yunnan provincial authorities; and (d) mid- and end-of-project workshops among key stakeholders to discuss lessons learned and recommendations for midterm remedial measures and improving strategies for future prevention programs in the infrastructure sector.
- (ii) **Information, Education, and Behavior Change Campaign.** Awareness on HIV, drug use, and human trafficking will be raised and positive behavior changes will be created through: (a) integrating HIV and drug prevention activities into the occupation health and safety program of consultants, contractors, and subcontractors; (b) developing and using customized information, IEC materials, and behavior change communication (BCC) methods for construction sites and camps, commercial and entertainment settings, transport corridors and hubs including border area, local communities affected by the road project including from the construction of access roads, and health service delivery; (c) ensuring that education and training sessions in the construction sites/camps are conducted; (d) considering the difference in women's issues, duties, and work schedules; (e) using IEC and BCC materials and methods for ethnic minority groups that are culturally and linguistically appropriate, participative and consider low literacy and education levels; (f) providing condoms throughout the project duration and ensuring the availability of condoms after project ends (e.g., through condom social marketing); (g) supporting, strengthening, and/or partnering with agencies/organizations working on drug and human trafficking in the

project areas; (h) supporting, coordinating, and collaborating with the resettlement and social development team of the project supervision consultant for the project in implementing HIV, drug and human trafficking prevention activities; and (i) ensuring that a confidential referral system is in place for construction workers who want to be tested and treated for HIV.

- (iii) **Provision of Medical Packages.** In collaboration with the Department of Health in each province, it will be ensured that the construction workforce, transport workers, local communities, and entertainment workers have access to quality HIV, STI, and other health services through: (a) preparing and/or updating protocols on HIV and STI voluntary counseling and testing, treatment, and care and support, especially for migrant and mobile clients; (b) designing and implementing training sessions for health workers at the construction work sites and health centers and pharmacies serving the local communities in the project area; (c) ensuring the availability of STI diagnostic tools and drugs at project-affected districts; and (d) establishing a system to ensure that those diagnosed with HIV are provided with or referred to counseling and support services, information about clinical support services and treatment options, and information about rights to employment and protection from discrimination.
- (iv) **Monitoring and Evaluation.** In close collaboration with the Vietnam's Administration of HIV/AIDS Control (VAAC), independent program monitoring will be undertaken to: (a) develop a PPMS to be applied throughout the project duration (baseline, mid-term, and end-term) that is streamlined with the National Monitoring and Evaluation Framework for HIV Prevention and Control programs of VAAC; and (b) undertake program monitoring at regular intervals and report to the executing agency, ADB, HIV and drug and human trafficking steering committees, and local AIDS authorities.

### C. Cost and Financing

11. The total cost of the additional scope of the TA is estimated at \$1,000,000. The cost estimates are shown in Attachment 4.4. The cost will be financed through the Cooperation Fund for Fighting HIV/AIDS in Asia and the Pacific.

### D. Implementation Arrangements

12. The Vietnam Expressway Corporation (VEC) will be the executing agency for the Program and will be responsible for overall coordination with the steering committee (to be established) and other partners. In

the project management team (PMT) of VEC, a focal person responsible for overseeing the implementation of the program will be nominated. This focal person will convene a steering committee that will provide technical advice in the design and evaluation of the TA activities, chaired by VEC and VAAC. The co-chairs will include representatives from the project supervision consultant and provincial steering committees (to be established).

## **E. Consulting Services**

### **1. Program Implementation Consultant**

13. ADB will select a program implementation consultant following the quality- and cost-based selection and simplified technical proposal according to ADB's *Guideline on Use of Consultants* (2007, as amended from time to time). Quality-cost ratio is 80:20. The program implementation services are expected to start in the second quarter of 2008 and to be completed when civil works are completed (estimated to be in the second quarter of 2012). The office equipment and supplies required for the program implementation will be procured by the consultants in accordance with ADB's *Procurement Guidelines* (2007, as amended from time to time).

14. The program implementation consultant will be responsible for the effective and efficient implementation of the program. The consultant should have demonstrated competence and experience in implementing HIV and drug and human trafficking prevention programs in the infrastructure sector. The consultant team should consist of one international team leader (14 person-months), one national deputy team leader (40 person-months), and five national project officers (a total of 200 person months). The team leader, the deputy team leader, and the program officer for Ha Noi should be based at the PMT headquarters of VEC. The other program officers should be based in each of the four field offices of the PMT. This is detailed in the terms of reference (TOR) of the project supervision consultant (Appendix 7 of the RRP). The indicative TOR for the program implementation consultant is found as Attachment 2.2. Civil works contractors for the project need to be involved in the program. In ADB's experiences on other road projects, civil works contractors do not collaboratively work with consultants for the similar program engaged by ADB, as there is no direct contract between the contractors and the consultants. Therefore, the program implementation consultant should work with the construction supervision consultant, which has the power to supervise the contractors. Work with the program implementation consultant is included in the TOR for the project supervision consultant.

15. The consultant team will establish a partnership with the provincial people's committees (PPCs) of Ha Noi, Vinh Phuc, Pho Tho, Yen Bai,

and Lao Cai to design and implement the prevention activities in their respective provinces. Each PPC will convene a provincial steering committee consisting of representatives from the Department of Health, the Department of Labor Invalids and Social Affairs, the Department of Education, Women's Union, Public Security, Ethnic Minority and Religion Committee, and Youth Union. The team leader will be responsible for facilitating the provincial steering committees, which will meet at least twice a year. A specific action plan, budget, and monitoring scheme should be developed for each province. The consultant team will be allowed to subcontract other specialized institutions and/or government agencies for condom social marketing and activities specifically targeted to prevent drug use and human trafficking.

## **2. PPMS Consultant**

16. ADB will recruit another consulting firm to develop and implement the PPMS according to ADB's *Guidelines on the Use of Consultants*. The quality- and cost-based selection and biodata technical proposal will be used. Quality-cost ratio is 80:20. The inputs required for the PPMS consulting services will be one international consultant (7 person-months) and two national consultants (20 person-months total). The PPMS consulting services are expected to start in the third quarter of 2008 and to be completed 2 months after civil works are completed (estimated in the second quarter of 2012), intermittently. The indicative TOR is found as Attachment 2.3.

## **F. Reporting**

17. The program implementation consultant will prepare the following reports: (i) an inception report, 4 weeks after commencement of the services; (ii) baseline study report, 1 month after civil works commence; (iii) an implementation report detailing activities and annual budgets, 1 month after completing the baseline study; (iv) quarterly progress reports highlighting the component achievements over the period under review, the issues, and proposed remedial actions at the end of each quarter; (v) four annual reports detailing achievements, implementation issues, and remedial measures, at the end of each year; and (vi) a completion report, 3 months after completion of the project. Two copies of these reports in the English language will be submitted to VEC, VAAC, and ADB. Also, two copies of these reports in the Vietnamese language will be submitted to VEC and the program partners.

18. The PPMS consultant will prepare (i) a PPMS report detailing indicators, targets, source of data, and PPMS methodology, 4 months prior to the start of the civil works; (ii) a baseline report, 1 month after commencement of the services; (iii) annual reports including results of the annual survey, analysis of the same, and recommended correctives measures if required, 1 month after completion of the annual survey; and (iv) a final report providing a detailed analysis of the program

impacts, lessons learned, and recommendations for improving future similar programs associated with infrastructure projects. Two copies of these reports in the English language will be submitted to VEC, VAAC, and ADB. Also, two copies of these reports in the Vietnamese language will be submitted to VEC and the program partners.

Source: ADB. 2007. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to Viet Nam for the GMS: Kunming-Hai Phong Transport Corridor-Noi Bai-Lao Cai Highway Project*. Manila [Project Number 33307]

## Attachment 5: Case Studies

### **Attachment 5.1: Case Study Review of HIV Prevention in Four ADB Transport Projects in the Greater Mekong Subregion**

(ADB. 2007. *HIV and Infrastructure: ADB Experience*. Manila.)

[www.adb.org/Documents/Reports/GMS-Case-Studies-HIV/default.asp](http://www.adb.org/Documents/Reports/GMS-Case-Studies-HIV/default.asp)