

ASIAN DEVELOPMENT BANK

TAR: OTH 37621

TECHNICAL ASSISTANCE
(Financed by the Japan Special Fund)

TO THE

**KINGDOM OF CAMBODIA, LAO PEOPLE'S DEMOCRATIC REPUBLIC, AND
SOCIALIST REPUBLIC OF VIET NAM**

FOR PREPARING THE

**GREATER MEKONG SUBREGION REGIONAL COMMUNICABLE DISEASES
CONTROL PROJECT**

October 2004

ABBREVIATIONS

ADB	–	Asian Development Bank
AIDS	–	acquired immunodeficiency syndrome
ASEAN	–	Association of Southeast Asian Nations
CDC	–	communicable diseases control
GMS	–	Greater Mekong Subregion
HIV	–	human immunodeficiency virus
IHR	–	International Health Regulations
IDU	–	injecting drug user
LAO PDR	–	Lao People's Democratic Republic
MDG	–	Millennium Development Goals
MOH	–	Ministry of Health
PRC	–	People's Republic of China
RCU	–	regional coordination unit
SARS	–	severe acute respiratory syndrome
SEARO	–	South-East Asia Regional Office
STD	–	sexually transmitted diseases
TA	–	technical assistance
WHO	–	World Health Organization
WPRO	–	Western Pacific Regional Office

TA CLASSIFICATION

Poverty Classification	–	Poverty intervention
Sector	–	Health, nutrition, and social protection
Subsector	–	Health systems
Theme	–	Regional cooperation
Subtheme	–	Communicable diseases control

Following the Board approval of the R-Paper, *Review of ADB's Poverty Reduction Strategy*, staff instructions to replace the PI/CPI classification with a new tracking system are under preparation in line with paragraph 83 of the R-Paper.

NOTE

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

The report was prepared by V. de Wit (team leader) and E. Bloom.

I. INTRODUCTION

1. Since 1992, the Asian Development Bank (ADB) has been supporting the Greater Mekong Subregion (GMS) Economic Cooperation Program to enhance cooperation between Cambodia, Lao People's Democratic Republic (PDR), Myanmar, Thailand, Viet Nam, and People's Republic of China (PRC). During the fifth meeting of the GMS Human Resource Development working group on 16–17 June 2004 in Yangon, participants confirmed that communicable diseases control (CDC) is a top priority for regional collaboration in view of emerging diseases such as human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) and severe acute respiratory syndrome (SARS), along with endemic communicable diseases like diarrheal diseases, malaria, measles, and tuberculosis.

2. As a first phase, a project is proposed for regional CDC in Cambodia, Lao PDR, and Viet Nam, which will also facilitate collaboration with other GMS countries. Accordingly, ADB's GMS program includes a regional CDC project of \$30 million in grant or loan.¹ ADB and the World Health Organization/Western Pacific Regional Office² (WHO/WPRO) have been developing partnership in CDC through various small projects³ and want to strengthen this further.⁴ A joint ADB-WHO/WPRO project preparatory technical assistance (TA) Fact-Finding Mission carried out regional consultations and visited Cambodia, Lao PDR, and Viet Nam to develop the project concept with government representatives and external agencies.⁵ ADB, WHO/WPRO and the Governments of Cambodia, Lao PDR, and Viet Nam have agreed on the overall objectives, scope, cost estimates and financing plan, implementation arrangements, and consulting services, as documented in signed Memoranda of Understanding. The indicative project framework is in Appendix 1.

II. ISSUES

3. **Achieving Millennium Development Goals (MDGs).** At the Yangon meeting, the countries demonstrated their progress and commitment to achieving the MDGs by 2015. CDC directly relates to half the MDGs—reducing child and maternal mortality and malnutrition, and containing and beginning to reverse the trend of HIV/AIDS and other communicable diseases. Thus, achieving these MDGs in the Mekong will, to a large extent, depend on progress in CDC.

4. **Socioeconomic Transition.** The three countries, with a per capita income of less than \$450 per year and about one third of the population living in poverty, are undergoing rapid economic expansion. Road construction is improving regional and local connectivity, opening up new areas and creating employment. Settlements along these roads attract entrepreneurs and migrant laborers. Immigration and trade agreements stimulate the flow of people and goods between countries. Tourism promotion and increased wealth encourage regional travel and demand for services. These economic developments accelerate social change and are likely to have both positive and negative impacts on health. If unchecked, communicable diseases will

¹ The provisional distribution is \$9 million to Cambodia, \$6 million to the Lao PDR, and \$15 million to Viet Nam.

² WHO/WPRO, based in Manila, covers Cambodia, Lao PDR, Viet Nam, and People's Republic of China. WHO's South-East Asia Regional Office (WHO/SEARO), based in New Delhi, covers Myanmar and Thailand.

³ ADB. 2000. *Technical Assistance for Roll Back Malaria Initiative in the Greater Mekong Subregion*. Manila; ADB. 2003. *Technical Assistance for Emergency Regional Support to Address the Outbreak of Severe Acute Respiratory Syndrome*. Manila.

⁴ This TA paper was prepared in close collaboration with K. Palmer and C. Beaver of WHO/WPRO.

⁵ The TA first appeared in *ADB Business Opportunities* (Internet edition) on 14 April 2004.

constrict the regional economy and social development.⁶ On the other hand, effective CDC will not only help achieve the health-related MDGs, but also contribute toward economic productivity, better learning in school, and poverty reduction.

5. **Multiple Challenges.** The governments in the region have to address multiple challenges to CDC. They need to deal with a high burden of endemic diseases like diarrheal diseases and acute respiratory infections causing the highest child mortality, and expand coverage of vaccination and control of tuberculosis and malaria to remote populations not reached so far. They also need to provide a coordinated response to the HIV/AIDS epidemic to contain its spread among high-risk groups. Governments need to track and quickly respond to emerging epidemics like SARS and avian influenza. CDC will also require sound management. Participants at the Yangon conference identified harmonizing CDC programs, improving surveillance systems, CDC for remote populations, and HIV/AIDS prevention as regional priorities.

6. **Communicable Diseases Control Coordination.** Reducing the prevalence of communicable diseases across the region will require harmonization of CDC efforts and capacity building for health systems, by learning what works and doesn't work, developing common strategies and standards, staff development, and coordinated action. Regional networking and institutional collaboration will need to be intensified. One particular area of concern is the quality of medicines for CDC. Poor quality drugs and inappropriate use of drugs result in ineffective treatment and drug resistance.

7. **Emerging Epidemics.** SARS and avian influenza epidemics as seen during 2003–2004 can have a major economic impact on the region in terms of loss of tourism, export, and investment. The multiple surveillance systems currently operating are either limited in coverage or slow, and lack integration. The outbreaks clearly showed weaknesses in preparedness, surveillance, and response; and delays in intercountry coordination. Controlling these outbreaks will require strong coordination from community to global levels. ADB and WHO are currently reviewing surveillance systems in the region (footnote 3). The new WHO International Health Regulations (IHR), to become effective in 2006, will provide the global framework for surveillance, and will require considerable regional capacity building. Each country will need to make substantial efforts in upgrading and streamlining existing surveillance systems, including reporting and diagnostic capacity, and building a strong emergency response capacity.

8. **Endemic Diseases.** Poor people living in remote areas including mountains, jungles and border areas—many of whom are ethnic minorities—suffer most from common endemic infections that cause high levels of child mortality and malnutrition. Among these are diarrheal diseases, acute respiratory infections, malaria, measles, hepatitis, tuberculosis, and parasitic infections. Simple, highly cost-effective preventive and curative interventions are available for these conditions. However, public funding for primary care and child survival programs is inadequate, and local public health systems have limited capacity to reach remote populations. Reaching these populations to achieve MDGs will require innovative strategies such as multipurpose outreach workers and community-based programs that need to be explored.

9. **HIV/AIDS.** Within GMS, Cambodia, Myanmar, and Thailand have a generalized epidemic, defined as having HIV prevalence of more than 1% among pregnant women.

⁶ ADB/UNAIDS. 2004. *Asia Pacific's Opportunity: Investing to Avert an HIV Crisis*. Manila. Estimated economic loss due to HIV in Asia and Pacific totaled \$7.3 billion in 2001.

Cambodia and Thailand have managed to reduce HIV prevalence, but are still at risk of escalation. Viet Nam and PRC's southern provinces have concentrated epidemics (prevalence of more than 5% among drug users and sex workers). The Lao PDR still has low HIV prevalence, but is surrounded by countries with much higher HIV prevalence. The Mekong HIV/AIDS epidemic at this stage is largely driven by injecting drug users (IDUs) who pass it on to sex workers, their clients, partners, and children. Blood products and infected needles are other sources of HIV infections—and other pathogens like Hepatitis B virus. HIV/AIDS is spreading among migrant and mobile people, ethnic minorities living along new transport corridors, and youth due to high-risk behavior associated with wealth, poverty, and social changes. Despite major funding going into HIV/AIDS control, there is a paucity of funds for HIV/AIDS prevention, such as for promoting condom use among sex workers, reducing harm among IDUs, and preventing mother to child HIV transmission.⁷

10. **Regional Approach.** Regional coordination for CDC has a strong rationale. Cross-border migrant workers may not have access to CDC, are exposed to social pressure and urban environments, and face periodic unemployment without family support systems.⁸ New markets along roads and borders increase exposure of traditional communities to mobile people, but also expose settlers and those in transit to endemic diseases such as malaria. Ethnic minorities living across borders share similar languages and practices, requiring special strategies to reach them. CDC strategies need harmonization through regional networking. Exchanging experiences can also strengthen commitment and improve efforts for CDC at the national level. CDC will also benefit from standardizing products and services across borders, and improve quality control. Developing those areas will require institutional strengthening and technology transfer that would benefit from using regional policy analysis and research capacity. The need for strengthening regional surveillance, response capacity, and information exchange has become evident with the SARS and avian flu epidemics. Rather than relying on overseas assistance, the region needs to develop its own capacity to deal with epidemics.

11. **Opportunities.** The current setting is favorable for developing regional collaboration in CDC. Recent epidemics have created a political will to exchange information on CDC, impose quality standards, and learn from each other. In 2003, six ministers of health signed an agreement to share information on CDC surveillance. Progress in the Association of Southeast Asian Nations (ASEAN) and GMS have created strong regional frameworks for collaboration. The new IHR of WHO give a further boost to improving surveillance systems.

12. **Lessons Learned.** ADB's regional CDC projects (footnote 3) and national health projects⁹ have generally done well, driven by strong national commitments to improve the health of the poor. However, capacity constraints have caused initial delays in project implementation. Regional and national coordination has been satisfactory, but community-based activities proved more challenging.

⁷ Antiretroviral drugs can reduce mother to child HIV transmission from above 30% to below 5%.

⁸ For example, discontinuing the preferential trade agreement for Cambodia's garment industry would lead to thousands of young women in Phnom Penh becoming unemployed.

⁹ Ongoing projects are ADB. 2002. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the Kingdom of Cambodia for the Health Sector Support Project*. Manila; ADB. 2000. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to Lao People's Democratic Republic for the Primary Health Care Expansion Project*. Manila; and ADB. 2000. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the Socialist Republic of Viet Nam for the Rural Health Project*. Manila.

III. THE TECHNICAL ASSISTANCE

A. Purpose and Output

13. The TA will help (i) assess CDC efforts in Cambodia, Lao PDR, and Viet Nam in the context of the GMS; (ii) identify priorities for, and feasibility of strengthening CDC programs and coordination; and (iii) prepare a project proposal based on these priorities.

14. The Project will support MDGs of reducing child and maternal mortality, and containing and beginning to reverse the spread of HIV/AIDS and communicable diseases by reducing the burden of common communicable diseases in vulnerable populations, particularly among women and children; and reducing the economic cost of endemic diseases and emerging epidemics. The objectives would broadly be to (i) improve regional CDC coordination; (ii) ensure timely and appropriate control of epidemics that are likely to have a major impact on public health and the economy; (iii) reverse the spread of HIV/AIDS in high-risk populations; and (iv) reduce the burden of endemic infectious diseases of remote populations, including in border areas.

15. The scope of the Project will be determined during the TA. The indicative project components are (i) harmonizing and advocating CDC strategies, quality standards, and services through regional networking and institutional collaboration; (ii) strengthening surveillance systems and implementation of WHO IHR; (iii) preventing HIV/AIDS in high-risk populations; and (iv) developing district-wide integrated CDC systems for remote populations.

B. Methodology and Key Activities

16. The consulting team will conduct local, national, and regional consultations; and participatory planning with stakeholders and beneficiaries for the situation analysis and design of components. The team leader will coordinate with the agencies concerned, provide technical guidance, coordinate consultants and TA work, and prepare reports. A health policy expert will examine challenges and opportunities for strengthening and streamlining CDC in the region. A surveillance expert will review surveillance and health management information systems including those of vertical programs, their funding source and sustainability, capacity and performance, and potential for improvement. This will be followed by a regional discussion to identify priorities to strengthen surveillance systems, feasibility, and issues of various designs. A public health expert and a social development expert will review current CDC programs for vulnerable populations, their coverage and funding, and identify priorities based on cost-effectiveness and other criteria. The social development expert will prepare the poverty analysis (Appendix 2), the public health expert the environmental assessment, and the health economist the economic analysis, including the rationale for a regional project.

C. Cost and Financing

17. The total cost of the TA is estimated at \$800,000 equivalent. ADB will provide \$600,000 equivalent. The TA will be financed on a grant basis by the Japan Special Fund, funded by the Government of Japan. WHO will provide \$150,000 equivalent in kind. The three governments will provide \$50,000 equivalent in kind—\$25,000 from Viet Nam, \$15,000 from Cambodia, and \$10,000 from the Lao PDR—of the local currency cost. The cost estimates and financing plan are in Appendix 3. The Governments have been advised that approval of the TA does not commit ADB to finance any ensuing project.

D. Implementation Arrangements

18. ADB (Mekong Department Social Sectors Division) will be the Executing Agency for the TA. WHO will provide technical guidance. A regional steering committee will be established consisting of representatives of governments of the participating countries, ADB, and WHO. The committee will guide the TA through three regional meetings at inception, midterm, and completion of the draft final report. At the national level, a subcommittee chaired by a senior government representative with membership from the concerned departments, the ADB resident mission, and the WHO country office, will guide national planning activities.

19. ADB will establish and manage a regional coordination unit (RCU) in Hanoi for the purpose of implementing the TA. The international consultants will work from this base. The RCU will be responsible for regional coordination of the TA, including liaison with stakeholders; data collection and analysis; support of consultants; provision of logistic support; and organization of workshops. At the national level, each Ministry of Health (MOH) will identify a department as the focal point for coordinating TA work, and nominate a full-time government staff member, supplemented with one project research assistant, to help implement the TA. Each WHO country office will identify a resource person to assist MOH and RCU with TA implementation. A participatory planning process will be followed for analyzing and planning each subcomponent.

20. ADB will finance a total of 18 person-months (number of person-months enclosed in parentheses) of international consulting services, including a team leader-public health expert (6), a health economist (5), a social development-HIV/AIDS education expert (5), and a surveillance expert (2). WHO/WPRO will provide a CDC policy expert (2) on part-time basis, and three domestic public health experts (18 total) for this TA. ADB consultants will be engaged as individual consultants by ADB in accordance with its *Guidelines on the Use of Consultants* and other arrangements satisfactory to ADB for engaging domestic consultants. The indicative terms of reference for consultants are in Appendix 4. Any equipment and supplies financed by ADB will be procured under the TA in accordance with ADB's *Guidelines for Procurement*. On completion of the TA, acquired equipment will be transferred to the project office.

21. Within 6 weeks of the start of the TA, the RCU will submit an inception report discussing the findings of the first consultants, outputs, methodology, and work schedule. The sector analysis will be submitted at midterm, the draft final report 2 weeks before completion of the TA, and the final report within 2 weeks after completion of the TA, for approval of the steering committee. The TA will start in October 2004 and will be completed by April 2005.

IV. THE PRESIDENT'S DECISION

22. The President, acting under the authority delegated by the Board, has approved the provision of technical assistance not exceeding the equivalent of \$600,000 on a grant basis to the Governments of Cambodia, Lao PDR, and Viet Nam for preparing the Greater Mekong Subregion Regional Communicable Diseases Control Project, and hereby reports this action to the Board.

INDICATIVE PROJECT FRAMEWORK

Design Summary	Indicators and Targets	Monitoring Instruments	Risks/Assumptions
<p>Goals</p> <p>(i) Contain the spread of HIV/AIDS and epidemics.</p> <p>(ii) Reduce the burden of endemic communicable diseases, and child and maternal mortality among the poor, and minorities in border areas.</p>	<p>Prevalence of HIV in target populations</p> <p>Child mortality rate in targeted communities</p>	<p>UNAIDS survey</p> <p>Local survey</p>	
<p>Purpose</p> <p>(i) Improve coordination of CDC in the region.</p> <p>(ii) Ensure timely and appropriate control of epidemics likely to have major impact on public health and the economy.</p> <p>(iii) Reverse the spread of HIV/AIDS, tuberculosis and sexually transmitted diseases in high-risk populations.</p> <p>(iv) Reduce the burden of endemic infectious diseases in border areas.</p>	<p>Progress in regional harmonization of CDC</p> <p>Proportion of cases reported through the surveillance system</p> <p>Proportion of condom users</p> <p>Proportion of children treated for common infections in an appropriate manner</p>	<p>Government documentation</p> <p>Analysis of disease outbreak</p> <p>Survey of target groups</p> <p>Local survey</p>	<p>Assumptions:</p> <p>Policies are effectively implemented.</p> <p>Governments are committed to sustaining standards.</p> <p>Surveillance system is capable of identifying diseases in time.</p> <p>Behavioral change is effective in reducing HIV.</p> <p>System is sustainable.</p>
<p>Outputs</p> <p>(i) Harmonized CDC strategies, and standards of products and services</p> <p>(ii) Strengthened surveillance systems and implementation of WHO International Health Regulations</p> <p>(iii) HIV/AIDS prevention in high-risk populations</p> <p>(iv) District-wide integrated CDC in remote populations</p>	<p>Progress in development of strategies and standards for CDC</p> <p>Surveillance systems design and operation</p> <p>Proportion of target population reached</p> <p>Proportion of target population reached</p>	<p>Project report</p> <p>Special study</p> <p>Survey of target groups</p> <p>Local survey</p>	<p>Assumptions:</p> <p>There is institutional capacity for long-term collaboration.</p> <p>Stakeholders agree to simplify systems and maintain alert/response capacity.</p> <p>Work can be carried out in border areas.</p> <p>Support for extension of successful demonstration districts will be forthcoming.</p>

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INDICATIVE PROJECT FRAMEWORK—Continued

Design Summary	Indicators and Targets	Monitoring Instruments	Risks/Assumptions
<p>Activities</p> <p>(i) Conduct regional coordination activities, policy analysis, and studies for CDC.</p> <p>(ii) Bring together surveillance providers to strengthen viable surveillance systems based on IHR, and strengthen response capacity, including dengue and blood safety.</p> <p>(iii) Analyze HIV/AIDS trends, identify target groups and funding requirements, prepare behavioral change plans, and implement the plans.</p> <p>(iv) Identify needs of isolated communities, plan basic packages and strategies, and implement in selective districts.</p>	<p>Number of issues addressed, resolved and implemented</p> <p>Plan for strengthening surveillance, response training, and number of laboratories providing HIV test</p> <p>Number of target groups assessed, participatory planning, and training activities</p> <p>Number of persons trained to provide community-based services</p>	<p>Component report by MOH</p> <p>Component report by implementation unit</p> <p>Component report by implementation unit</p> <p>Component report by MOH</p>	<p>Assumptions:</p> <p>Stakeholders agree to work together on improving surveillance systems.</p> <p>Behavioral change programs are acceptable to MOH and target populations.</p> <p>Communities collaborate with the Project.</p> <p>Risk:</p> <p>Capacity is limited and staff turnover is high.</p>
<p>Inputs</p> <p>(i) Equipment for laboratories, communication, BCC</p> <p>(ii) Vehicles for promotion campaigns, supervision, mobile clinics</p> <p>(iii) Training and fellowships</p> <p>(iv) Supplies for CDC surveillance and response</p> <p>(v) Consulting services for policy harmonization, standard setting, surveillance systems, HIV/AIDS BCC, and community-based CDC</p> <p>(vi) ADB funding: \$30 million WHO: to be decided Viet Nam: \$3 million Cambodia: \$1.8 million Lao PDR: \$1.2 million</p>			

ADB = Asian Development Bank, BCC = behavioral change communication, CDC = communicable diseases control, HIV/AIDS = human immunodeficiency virus/acquired immunodeficiency syndrome, MOH = Ministry of Health, UNAIDS = Joint United Nations Programme on HIV/AIDS, WHO = World Health Organization.

INITIAL POVERTY AND SOCIAL ANALYSIS

A. Linkages to the Country Poverty Analysis

Is the sector identified as a national priority in country poverty analysis?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Is the sector identified as a national priority in country poverty partnership agreement?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<p>Contribution of the sector or subsector to reduce poverty in Cambodia, Lao People's Democratic Republic, and Viet Nam: Communicable diseases pose major human and economic burdens on families living in isolated areas, many of them ethnic minorities lacking access to public or private health systems. Medical expenses constitute a major share of household expenditures, particularly for the poor. As a result of frequent and serious illnesses, many households end up in poverty, have to sell their assets, and send family members, often young persons, out as migrant laborers, exposing them to new health risks with little preparation. The roads that are being constructed in the region have opened up remote areas in these countries, drawing in local people and enabling the spread of human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) and sexually transmitted diseases (STDs) among them. The sector will need to make major efforts to reach these poor people and help them protect themselves from endemic and emerging communicable diseases.</p>			

B. Poverty Analysis

Proposed Poverty Classification: Poverty intervention¹

<p>What type of poverty analysis is needed? The Project will target remote living communities, many of them ethnic minorities and high-risk populations for HIV/AIDS. The analysis will include an assessment of health status, priorities, services and issues for the poor, including major ethnic minorities, compared with other populations. The analysis will also look at distributional impact and the effects of the high cost of health care on the poor. To reach remote populations, the Project will analyze alternative strategies that will make services affordable and acceptable, of adequate quality, and locally sustainable within the scope of government and community resources. Similarly, for the high-risk populations, including sex workers and drug users, special strategies will need to be developed to reach them, secure their trust and participation, and engage them through behavioral change programs and targeted services. The poverty analysis will also need to assess the potential benefits, issues and constraints of the Project, and ensure that the investments are benefiting the poor and disadvantaged groups most.</p>

C. Participation Process

Is there a stakeholder analysis?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	
Is there a participation strategy?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	
<p>The Project will analyze alternative strategies to reach remote populations, making services affordable and acceptable, of adequate quality, and locally sustainable within the scope of government and community resources. Similarly, for the high-risk populations, including sex workers and drug users, special strategies will be developed to reach them, secure their trust and participation, and engage them through behavioral change programs and targeted services.</p>			

D. Gender Development

<p>Strategy to maximize impacts on women: The technical assistance (TA) will develop a gender strategy to ensure the equal inclusion of the needs of women in the Project. The strategy will incorporate the views of vulnerable women including women from ethnic minorities, teens, pregnant women, sex workers, and migrant women. The project design will especially seek to protect women from endemic and emerging communicable diseases, including exploitation and violence against women, and promote women's role and opportunities in society.</p>			
Has an output been prepared?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	

¹ Following the Board approval of the R-Paper, *Review of ADB's Poverty Reduction Strategy*, staff instructions to replace the PI/CPI classification with a new tracking system are under preparation in line with paragraph 83 of the R-Paper.

E. Social Safeguards and other Social Risks

Item	Significant/ Not Significant/ None	Strategy to Address Issues	Plan Required
Resettlement	<input type="checkbox"/> Significant <input type="checkbox"/> Not significant <input checked="" type="checkbox"/> None	The Project will use existing health facilities and no civil works are expected.	<input type="checkbox"/> Full <input type="checkbox"/> Short <input checked="" type="checkbox"/> None
Affordability	<input type="checkbox"/> Significant <input type="checkbox"/> Not significant <input checked="" type="checkbox"/> None	The Project will increase access to primary health for the poor, and will support the delivery of free services to vulnerable groups.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Labor	<input type="checkbox"/> Significant <input type="checkbox"/> Not significant <input checked="" type="checkbox"/> None	The Project will use the existing health workforce.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Indigenous Peoples	<input checked="" type="checkbox"/> Significant <input type="checkbox"/> Not significant <input type="checkbox"/> None	Ethnic minorities are one of the Project's focal groups and the Project will develop an ethnic minority development plan (EMDP). The EMDP will ensure that ethnic minority groups fully benefit from the project activities and that there is no discrimination against them in project implementation.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Other Risks and/or Vulnerabilities	<input type="checkbox"/> Significant <input type="checkbox"/> Not significant <input checked="" type="checkbox"/> None		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

COST ESTIMATES AND FINANCING PLAN

(\$'000)

Item	Cost
A. Japan Special Fund Financing^a	
1. International Consultants	
a. Remuneration and Per Diem	337.5
b. International and Local Travel	67.2
c. Reports and Communications	4.2
2. Equipment and Furniture ^b	16.7
3. Workshops ^c	71.0
4. Surveys and Studies	24.9
5. Miscellaneous Administration and Support Costs	18.0
6. Contingencies	60.5
Subtotal (A)	600.0
B. World Health Organization Financing	
1. Experts	
a. Remuneration and Per Diem	
i. International Experts	50.0
ii. Domestic Experts	40.0
b. International and Local Travel	8.0
c. Reports and Communications	2.0
2. Office Facilities and Services	50.0
Subtotal (B)	150.0
C. Government Financing	
1. Remuneration and Per Diem of Counterpart Staff	34.7
2. Office Facilities, Services and Transport	13.0
3. Others	2.3
Subtotal (C)	50.0
Total	800.0

^aFunded by the Government of Japan.^bComputers, printer, facsimile machine, photocopier, software, mobile phones.^cNational and subregional workshops.

Source: Asian Development Bank estimates.

OUTLINE TERMS OF REFERENCE FOR CONSULTANTS

A. Asian Development Bank-supported

1. Team Leader-Public Health Expert (international, 6 person-months)

1. The team leader will have substantial experience in Southeast Asia and in managing public health programs, including system design, standard setting, quality control, and evaluation. The team leader will be responsible for overall project planning, including consultation of stakeholders, the project framework, and preparing the reports. The team leader should have strong leadership and organizational capabilities.

2. As team leader, the expert will have the following tasks:

- (i) Serve as liaison between the Asian Development Bank (ADB) and the governments participating in the Project, including the respective ministries of health, other relevant ministries, and World Health Organization (WHO).
- (ii) Organize the project office, steering committee, and work program for the technical assistance (TA).
- (iii) Guide the project preparation team and be responsible for the collective work of the team.
- (iv) Plan and coordinate a participatory planning process including stakeholder consultations and workshops to obtain the necessary inputs for project design and ensure government ownership of the Project.
- (v) Develop the project scope and implementation arrangements, and prepare the project framework in consultation with the stakeholders.
- (vi) Ensure on-time submission of formal written reports, including the inception report after 6 weeks, the sector analysis at midterm, the draft final report 2 weeks before completion, and the final report and project implementation manual within 2 weeks after completion.
- (vii) Ensure that the TA is implemented according to the terms of reference of the consultants and any subsequent instructions or guidance from the executing agency and ADB.

3. The technical tasks of the team leader-public health expert are as follows:

- (i) Examine in detail the problem of communicable diseases in isolated communities, among the poor and vulnerable, ethnic minorities, and people living in border areas; analyze alternative interventions; and prepare an innovative component to reach these communities with a basic package of interventions using existing public and private services and programs, where possible.
- (ii) Propose a component, and prepare an implementation plan for sustainable regional cooperation for health systems development, initially with a focus on communicable diseases control (CDC) control, including arrangements for sector

analysis, sharing and learning, and incorporation of findings in national policies and strategies.

- (iii) Examine institutional capabilities and networking for standards setting and quality control for CDC programs, propose a component to strengthen regional coordination for standards setting and quality control for such programs, and prepare a component proposal and implementation plan.
- (iv) Following the ADB format, develop a draft initial environmental examination, identifying the possible negative environmental impact of the Project and a cost-efficient and technological appropriate mitigation strategy for the safe disposal of laboratory and medical waste.

2. Health Economist (international, 5 person-months)

4. The health economist will be the deputy team leader and have substantial experience in Southeast Asia, including in CDC services and programs. The expert will assist in overall project planning, including examination of regional priorities, economic analysis, and cost estimates. The expert's tasks are as follows:

- (i) As the co-team leader, assist ADB and the team leader in TA management, including the establishment of a project office in Hanoi, and communications with Government officials and development partners.
- (ii) Develop a communicable disease profile for the Greater Mekong Subregion (GMS) that clearly identifies and prioritizes the regional needs for CDC based on needs, cost-effectiveness of interventions, funding requirements, and feasibility of intervention.
- (iii) Prepare a comprehensive report on health sector financing with a focus on CDC, including resources available from development partners and from national and local budgets.
- (iv) Explore the potential for cofinancing and for involving nongovernment organizations in project activities.
- (v) Assess the capacity of the governments to meet counterpart financing requirements; and prepare an analysis of the financial sustainability of the Project, including recurrent costs associated with the Project, and the ability of the economy and the health sector to channel sufficient resources to support the investments introduced by the Project.
- (vi) Prepare cost estimates for the project components using standard tools, prepare the final project budget, with the cost tables disaggregated into investment and recurrent costs and local and foreign currency costs.
- (vii) Using ADB's *Guidelines for the Economic Analysis of Projects*, analyze the project components to identify the economic justification of alternate interventions and to estimate the overall rate of return of the Project.

- (viii) Develop a poverty profile that quantifies the poverty impact of the Project, and the contribution of the Project in reducing the vulnerability of the poor and the near-poor to health-related shocks.

3. Social Development-HIV/AIDS Education Expert (international, 5 person-months)

5. The consultant will have a strong background in sociology or applied medical anthropology, and have experience with preparing ethnic minority development plans, and with behavioral change programs for control of human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) in Southeast Asia. The expert will have the following tasks:

- (i) Make a comprehensive review of health practices and health-seeking behavior in relation to communicable diseases among selected high-risk communities, vulnerable groups, and marginalized communities in the region; include a review of social norms and gender differences in responding to different health concerns.
- (ii) Prepare a component for behavioral change in high-risk communities (migrant workers, people in new markets, people in institutions, etc).
- (iii) Work with the team leader and public health expert to identify culturally appropriate integrated CDC packages for ethnic minorities and other marginalized communities in the region.
- (iv) Prepare an ethnic minority development plan, gender development plan, and community participation action plan to ensure the full participation of ethnic minorities, women, and communities in the project's processes and benefits.

4. Surveillance Expert (international, 2 person-months)

6. The surveillance expert will have a technical background in developing sustainable health surveillance systems focusing on monitoring communicable diseases, and be fully familiar with international health regulations for communicable diseases. The expert will do the following tasks:

- (i) In partnership with the ADB-WHO Severe Acute Respiratory Syndrome (SARS) team, review existing surveillance systems in the region and appraise their objectives, performance, and potential for improvement in terms of costs and benefits.
- (ii) Propose a component for building capacity; improve viable surveillance systems based on international health regulations, and integrate and digitalize these where possible so as to reduce the monitoring burden on health staff; and prepare the implementation plan.

B. World Health Organization-supported

1. Communicable Disease Control Policy Expert (international, 2 person-months on part-time basis)

7. The expert will have a background in developing public health initiatives in a regional context, particularly in Southeast Asia. The expert will have a strong background in institutional building and experience in leading an international group of professionals. The expert will have the following tasks:

- (i) Provide overall policy advice to the team leader and guidance to participating governments, the steering committee, and workshop participants.
- (ii) Advise the surveillance expert on strengthening and rationalizing national surveillance systems and implementing international health regulations.
- (iii) Identify and develop policy recommendations to be implemented in conjunction with the Project.
- (iv) Carefully assess the assumptions underlying the Project, identify risks that may hamper its implementation, and suggest measures that will mitigate such risks.

2. Public Health Experts (domestic, 18 person-months)

8. The consultants, who will be financed by WHO/Western Pacific Regional Office (WPRO), will have the following tasks:

- (i) Provide in-country coordination and facilitation for the TA in coordination with the WHO Country Office focal point and team leader.
- (ii) Prepare the CDC profile of the country, describing and analyzing CDC priorities and trends, structure, policy, targets, capacity, funding, and other relevant information for identifying project priorities.
- (iii) Assist the project team as necessary.