August 2011

ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>ADB</td>
<td>Asian Development Bank</td>
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<tr>
<td>ASEAN</td>
<td>Association of South East Asian Nations</td>
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<td>CAREC</td>
<td>Central Asia Regional Economic Cooperation</td>
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<td>DMC</td>
<td>developing member country</td>
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<td>GMS</td>
<td>Greater Mekong Subregion</td>
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<td>MSM</td>
<td>men having sex with men</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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In this report, “$” refers to US$. 
The views expressed herein are those of the consultant and do not necessarily represent those of ADB’s members, Board of Directors, Management, or staff, and may be preliminary in nature.

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EXECUTIVE SUMMARY

Most Asian and Pacific countries have successfully stabilized the HIV epidemic. However, the level of success varies, and some countries still show rising HIV infection rates. Country and regional actions over the next 4 years will be critical in achieving—and sustaining—the Millennium Development Goals (MDGs), and in fully implementing the agreements laid out in the June 2011 United Nations High Level meeting on AIDS. The Asian Development Bank (ADB) remains committed to working with national, regional, and international partners to tackle HIV/AIDS. The Strategic Directions Paper outlines a framework for action to guide ADB’s work in HIV prevention.

ADB recognized the threat posed by HIV/AIDS in Asia and the Pacific at an early stage, and mobilized to respond. ADB’s first HIV/AIDS strategic framework in 2005 recognized that effective containment and reduction of the spread of the disease is vital to avoid human tragedy and negative economic impacts in Asia and the Pacific. Key features of the updated Strategic Directions Paper derive from previous ADB-supported HIV/AIDS initiatives, and take into account existing global and regional health commitments. ADB supports universal access to HIV prevention, treatment, care, and support by addressing the needs of key affected populations, including men and women who participate in unprotected paid sex, inject drugs, and/or share contaminated needles and syringes, as well as men who have unprotected sex with men. Other contributing factors such as gender inequality, poverty, stigma and discrimination, and misinformation will be carefully considered when designing and implementing new initiatives.

To be successful, ADB’s HIV/AIDS response must also focus on prevention and mitigation measures aimed at achieving the MDGs and ADB’s Strategy 2020, which sharpened the institution’s focus to achieve sustained poverty reduction.

To support the operationalization of Strategy 2020, ADB will intervene in areas where it can effectively and significantly add value. The new direction focuses on three priority areas:

(i) mitigating HIV and AIDS risks and vulnerabilities along economic corridors;
(ii) promoting regional cooperation to control and reverse the spread of HIV, specifically for those most at risk; and
(iii) supporting HIV/AIDS-related impact studies on economics, gender, and poverty in support of evidence-based policy dialogue

Key programs will include reducing the risks of transmission of HIV/AIDS as a result of ADB infrastructure projects; support for targeted assistance, including capacity development, to developing member countries that are frequently exposed to internal and/or cross-border migration of key affected populations; and continued policy dialogue and coordination with partners like UNAIDS, in preventing further spread of the virus. This approach complements the HIV/AIDS strategies of other major development partners, including UNAIDS. It also reinforces commitments laid out in ADB’s operational plans for health and transport, both of which recognize the need to give special attention to HIV/AIDS.
I. INTRODUCTION

1. In 2005, the Asian Development Bank (ADB) laid out its approach to addressing HIV/AIDS in a strategic directions paper: Development, Poverty, and HIV/AIDS: ADB’s Strategic Response to a Growing Epidemic. The overall objective of the 2005 direction was to support developing member countries (DMCs) to achieve the Millennium Development Goal (MDG) 6, Target 7: “to have halted and begun to reverse the spread of HIV/AIDS 2015.” The priorities for action were (i) leadership support (strengthening commitment of regional leaders to address HIV/AIDS); (ii) capacity building (increasing capacity at country and regional levels in Asia and the Pacific); and (iii) targeted programs (expanding HIV/AIDS interventions that mitigate risk among the poor, vulnerable, and high risk groups).

2. Since then, the epidemic has evolved with early epidemics becoming less severe in Cambodia and Thailand, but becoming more significant in countries like Lao People’s Democratic Republic and the Philippines. Program managers and scientists have amassed better understanding of the epidemics in the region. Effective evidence-based strategies have been presented in the Commission on AIDS in Asia Report, Redefining AIDS in Asia: Crafting an Effective Response, and a similar report commissioned for the Pacific, Turning the Tide, an OPEN Strategy for a Response to AIDS in the Pacific. Both reports were supported in part by the joint research of ADB and its key regional partner, the UNAIDS Regional Support Team based in Bangkok, Thailand.

3. Countries have gained significant experience in designing and implementing programs, and in monitoring their effectiveness. Many countries are engaging their second, third, and in some cases, fourth phase of the 5-year HIV/AIDS planning cycles. Countries are better informed of their epidemics and can develop capacities in line with national surveillance reports.

4. A number of new policy and strategy documents provide guidance to the portfolio of projects and the modes of work for ADB. For example, in 2006, ADB approved a regional integration and cooperation strategy, which describes ADB’s commitment to regional cooperation and integration. It outlines ADB’s role in supporting regional public goods, such as prevention of communicable diseases. In 2008, ADB launched Strategy 2020, laying out the vision and consolidated priorities of ADB for the next decade. ADB also introduced an updated results framework and streamlined process for monitoring and evaluating performance of ADB’s individual projects and operational efficiency. Following this launch, ADB developed an Operational Plan for Health to translate Strategy 2020’s vision into concrete action for improving

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health in the region and defining ADB’s health sector portfolio.\textsuperscript{6} In the second quarter of 2010, ADB launched the Sustainable Transport Initiative to enhance ADB’s contribution to environmental, social, and financial sustainability in the development of transport infrastructure in the region.\textsuperscript{7}

5. These new initiatives, together with the recommendations of the AIDS Commission’s reports and lessons learned from ADB’s experience in implementing the strategic directions paper, require an updated approach to deliver effective support to DMC efforts to prevent further spread of the virus. This updated strategic directions paper on HIV/AIDS (i) describes ADB’s re-focused approach to helping DMCs stem the HIV/AIDS epidemic using ADB’s comparative advantages; and (ii) defines ADB’s management strategy for ensuring effectiveness and efficiency in implementing its HIV/AIDS portfolio.

6. Although ADB is not a major financier in the fight against HIV/AIDS, it has become a lead agency on HIV/AIDS and infrastructure mitigation and on regional public goods that enhance the understanding of the epidemics in the region. Many countries in Asia and the Pacific are on their way to stabilizing their epidemics, but success will require a strategic vision and well coordinated division of work between countries and development partners. Implementation of these strategic directions will directly result in reduced HIV incidence in high-risk populations in targeted economic and transport corridors, reducing the risk of a generalized epidemic in these areas. Such implementation will indirectly reduce HIV by improving national governments’ capacities to plan, implement, and measure programs that reduce cross-border transmission of the virus. By responding to those most at risk, these measures provide critical support to the countries of Asia and the Pacific in meeting the MDG target for HIV/AIDS, and averting a potential economic and social crisis. ADB’s programs must emphasize the leadership of the DMCs so that sustainable and long-term effects can be achieved.

7. The Political Declaration adopted during the June 2011 UN High Level Meeting on AIDS promotes a continued political commitment and engagement of leaders in a comprehensive response among all key stakeholders to halt and reverse the HIV epidemic and mitigate its impact.\textsuperscript{8} The declaration reaffirms earlier commitments to scale up efforts to achieve the MDGs, in particular, Goal 6. The declaration highlights prevention as the cornerstone of the national and regional HIV and AIDS response. It strongly recommends that financial resources for prevention be targeted to evidence-based measures that reflect the specific nature of each country’s epidemic. This means resources should focus on geographic locations, social networks and populations vulnerable to HIV infection. The declaration stresses the need to support enabling frameworks addressing legal, social, and policy barriers to reduce stigma and discrimination against people living with HIV. It also reinforces that implementation must be inclusive, country-led and multisectoral to accelerate efforts to achieve the MDGs by 2015.

II. HIV/AIDS EPIDEMIC IN ASIA AND THE PACIFIC

A. The Current State of the HIV/AIDS Epidemic in Asia and the Pacific

8. To contextualize ADB’s contribution to the response, this paper summarizes the current understanding of the HIV/AIDS epidemic in the region and the responses by DMCs. Most experts agree that the Asian and Pacific region will not imitate the generalized epidemics seen in sub-Saharan Africa. A heterosexually driven epidemic among the general population is not likely to be observed in Asia and the Pacific. General population prevalence is expected to remain below 5% in almost all parts of the region. However, due to large population centers in many Asian megacities with highly vulnerable groups, extremely mobile migrant populations, and the presence of very active sex trade and illicit drug production centers, countries in Asia and the Pacific will still face numerous challenges. Concentrated epidemics in these settings could lead to large absolute numbers of HIV-infected people, presenting a serious burden to the health system and threatening the economic stability of affected households.

9. With urban populations expanding rapidly over the last 50 years, many Asian cities face deteriorating urban infrastructure and services on water supply, sanitation, waste management, and transport; and worsening environmental conditions. There are concerns that cities are not sufficiently responding to key affected populations, such as men who have sex with men (MSM) and transgender populations. Not addressing the needs of these urban populations at high risk may lead to reversal of national progress on HIV. Effective prevention programs at the city level will require close collaboration with members of local governments, health departments, work places, and civil society.

10. A United Nations Development Program (UNDP) and United States Agency for International Development (USAID) regional multicity MSM and HIV study of city-level responses in Bangkok, Chengdu, Ho Chi Minh City, Jakarta, Manila, and Yangon confirmed that prevention and outreach progress continues to be hampered by the existence of punitive laws and policies, selective enforcement practices and the lack of coordination between local health and law enforcement officials. ADB recognizes that managing cities and urbanization requires HIV prevention programs that are integrated with other programs and that foster the involvement of the private sector and civil society in targeting people most at risk.

11. The 2008 AIDS Commission report for Asia on Redefining AIDS in ASIA—Crafting an Effective Response uses data from countries in the region to model and characterize the key factors influencing the rate of the spread of HIV. Data and models suggest that groups that engage in high-risk behaviors, such as sex work, injecting drug use, and unprotected sex between men, are most at risk for acquiring and transmitting HIV infection.

12. The frequency or intensity of risk exposure and the size of the groups engaging in this behavior comprise the key determinants for the rate and extent of the spread of the virus. Epidemic models suggest that in a sex work-driven epidemic, the HIV prevalence among the general population will be 3 to 4 times higher if the proportion of the male population that buys sex increases from 10% to 20% of the general population, and the number of clients per night

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9 Examples of Municipal HIV Programming for Men who have Sex with Men and Transgender People in Six Asian Cities
10 Special emphasis is placed on prevention for the sub-set of men who have sex with men who are of high risk, i.e., have large numbers of male sex partners
per sex worker increases from one to two per night.\textsuperscript{11} A growing body of evidence suggests that insufficient attention to prevention for MSM has led to increased levels of HIV prevalence in this group. This can be seen in countries including India, Indonesia, Myanmar, Nepal, Philippines, Thailand, and Viet Nam. Per contact transmission probabilities for men who have unprotected sex with men are comparable to the sharing of injection equipment, leading to concerns that MSM communities are bearing the brunt of the next large wave of infections observed in Asia.\textsuperscript{12} Large internal and external migration, facilitated by substantial and rapid infrastructure development, is also associated with greater risk behavior among migrant workers, increasing the risks for themselves and for surrounding communities.

13. In most countries, the size of the populations practicing high-risk behaviors is relatively small, compared to the overall adult population. However, in the case of clients of sex workers or MSM, the size of at-risk population can be substantial, especially when including the large number of “intimate partners” (i.e., wives and girlfriends) who may acquire HIV after repeated exposure to an infected partner. Regional estimates suggest that several million otherwise “low risk” women could become infected through a spouse or a regular sex partner who belongs to a high-risk group.\textsuperscript{13} Although the most effective prevention intervention for intimate partners remain programs that focus on upstream infections (i.e., prevention among sex workers and clients, injecting drug users, and MSM), globally there is still a need to develop effective and cost-effective secondary prevention measures for intimate partners of most at-risk populations.\textsuperscript{14}

14. The 2010 estimate of persons living with HIV/AIDS in the Asia region (excluding Central Asia and Pacific) is more than 4.7 million and the number of new infections in 2009 was more than 350,000.\textsuperscript{15} These infections represent tremendous diversity in epidemics across the countries of the region. Countries with large population size, such as the People’s Republic of China, India, and Indonesia, comprise almost three-quarters of all estimated infections in the region.\textsuperscript{16} Each of these countries has multiple subnational epidemics with different trajectories that require tailored and prioritized responses. Mature concentrated epidemics driven by both sex work and injecting drug use are found in the Greater Mekong Subregion (GMS), which includes Guangxi and Yunnan provinces in the People’s Republic of China, Cambodia, the Lao People’s Democratic Republic, Myanmar, Thailand, and Viet Nam.

15. In contrast, Central Asia is still considered to have low-level epidemics, but infrastructure development, trade, and growing population mobility increase the potential for injecting drug use- and sex work-driven epidemics. According to UNAIDS, Eastern Europe and Central Asia is the only region where HIV prevalence remains on the rise.\textsuperscript{17} The number of people living with HIV has almost tripled since 2000 and has reached an estimated total of 1.4 million in 2009, mainly due a rapid rise in HIV infections among people who inject drugs. Although relatively small in population, both Papua New Guinea and the West Papua province in Indonesia face epidemics unlike any other in the region, mixing elements of a sex work-driven epidemic, fueled further by high levels of casual sex and sexual violence in some segments of the general

\textsuperscript{11} UNAIDS. 2008. \textit{Report of the Commission on AIDS in Asia}. p. 32
\textsuperscript{13} UNAIDS. 2008. \textit{Report of the Commission on AIDS in Asia}. p. 51
\textsuperscript{15} UNAIDS group data for Central Asia with Eastern Europe.
\textsuperscript{17} UNAIDS. 2010. \textit{UNAIDS Report on the Global AIDS Epidemic 2010}. 
population. According to UNAIDS, the number of people living with HIV in the Pacific nearly
doubled between 2001 and 2009, from 28,000 to 57,000.\textsuperscript{18}

16. While prevention is the highest priority for all national strategies in the region, countries also need to have comprehensive treatment and care programs. Deploying resources effectively requires a commitment to evidence-based allocation of resources for better population group and geographic targeting. The AIDS Commission for Asia recommends a focus on realistic, evidence-based interventions, especially high impact and low cost interventions that address both prevention and impact mitigation—an approach that ADB strongly endorses. The Pacific Commission highlights the importance of a strategy that is rooted in—and reinforces—existing family, church, and community relationships. Both commissions mention the importance of supporting HIV/AIDS programs that strengthen health systems, rather than creating parallel programs.

B. An Evolving Response to HIV/AIDS in Asia

17. This updated strategic direction on HIV/AIDS is guided by lessons from past operations. Several countries with some of the most severe early epidemics in Asia (such as Cambodia and Thailand) responded quickly and managed to reverse the tide of increasing rates of infection through large, focused prevention programs. Their experiences demonstrate that when DMCs adopt known cost-effective interventions, progress in prevention is attainable.

18. Critical to any successful prevention program is the need for engaging civil society partners for better outreach services to people most at risk.\textsuperscript{19} Simultaneously, better surveillance systems and an increasing orientation toward outcomes have allowed for improved estimates of the current burden of disease. Many countries have begun investing more systematically in identifying and measuring the size of populations most at risk. More robust estimates and improvements in surveillance methods allow countries to develop more realistic and focused strategies for allocating resources.

19. The experience in Asia provides good examples on how policy makers can take charge in leading prevention programs with high impact. For example, the 100\% Total Condom Program was designed to promote 100\% condom use at every commercial sex establishment, and has been implemented with local government support in Thailand and now adopted in People’s Republic of China, the Lao People’s Democratic Republic, Mongolia, Myanmar, the Philippines and Viet Nam.\textsuperscript{20} Some countries have also begun harm reduction programs, including the revision of narcotics control laws to facilitate implementation of these programs.\textsuperscript{21}

20. Stigma and discrimination, including in law and policy, are two areas where many DMCs face the greatest challenge to an effective response. The association of HIV with sex, drug use, and death stigmatizes those who are affected, and incomplete and inaccurate information breeds fear. A majority of countries in the region have laws that criminalize sex work, sex between men, and opioid drug use. An effective response requires a legal and policy

\textsuperscript{21} Harm reduction programs for injecting drug users are based on oral substitution therapy (methadone and/or bupenorphine) to support de-addiction and reduce injection frequency.
environment that enforces freedom from stigma and discrimination, and supports prevention and treatment services for people living with HIV/AIDS and those most at risk.

21. Often, the hostile environment discourages populations most at risk from trusting service providers and accessing needed services. In some cases, local authorities frequently interfere with peer educators’ abilities to conduct outreach services and distribute condoms or needles and syringes by detainment or harassment. Regional efforts to combat stigma and discrimination suggest that effective programs require substantial time and investment in engaging authorities and other stakeholders. Moreover, programs need to be complemented with multiple strategies (e.g. infotainment, media relations, training, policy change, etc.).

22. The impact of HIV/AIDS differs markedly along gender lines, reflecting men’s and women’s differing roles and responsibilities in household and market activities, and critical gender differences in access to, and control of, resources. Women—even when infected with HIV—are nearly always the caretakers of males who are sick, in addition to housekeeping, childcare, and eldercare roles. In terms of impact mitigation, the Commission on AIDS in Asia report cites the importance of amending the legal rights of women heads of households affected by HIV/AIDS to ensure their property or means of supporting their families cannot be taken away due to stigma and discrimination in their communities.

23. Global initiatives to prevent violence against women—a recognized contributor to sexual risk and vulnerability of HIV among women—have developed accountability scorecards on national programs’ responses to gender and HIV/AIDS. Male gender roles also need attention, to disassociate perceptions of masculinity with risk-taking behaviors, and to cultivate a positive and proactive role of men in preventing sexual transmission of HIV in both commercial sex and sex with regular intimate partners. Trafficking of women and girls for the sex trade is another priority area for intervention. Regional efforts to combat trafficking include the Coordinated Mekong Ministerial Initiative Against Trafficking, supported by ADB’s Social Development Subgroup under the GMS Working Group on Human Resources Development.

24. Men who buy sex constitute the largest infected population group in Asia and the Pacific. Most of these men either are married or will get married. This puts a significant number of women, often perceived as “low-risk” because they only have sex with their husbands, at great risk of acquiring HIV. Evidence also indicates that there is a strong link between gender-based violence and the spread of HIV. Eliminating gender inequalities and increasing the capacity of women and girls to protect them from the risk of HIV infection must become a higher priority.

25. The Commission on AIDS in Asia estimates that $3 billion is required to adequately respond to the epidemic. The Commission also estimates that, by committing between $0.50 to $1.00 per capita to the response, Asia and the Pacific could reverse the epidemic, avert up to 40% of AIDS-related deaths, and provide 80% of affected women and orphans with adequate livelihood support in the region. The Asian and Pacific region includes several middle income countries that are becoming less dependent on foreign donor funding for AIDS control.

programs. These countries need models for introducing higher levels of national funds into program budgets.

26. Greater investment in HIV prevention programs requires stronger political commitment and more sustainable approaches to programming. Large investments by many countries into a single disease program may not be feasible, given the other challenges facing the health system. For this reason, more efforts are needed to identify strategies by which HIV programming can strengthen the health system, rather than create an additional burden. Natural points of integration exist in the arenas of sexual and reproductive health, maternal and child health, integration of HIV testing in existing laboratories, development of more useful health information systems, and adoption of universal precautions in health care settings. Integration opportunities extend beyond the public sector, and a need exists to explore effective partnership with the private sector and private health care providers.

27. Integration of HIV into the broader health system, including clinical management and training for health care providers, has been explored extensively in Africa, due to the high disease burden of HIV in many sub-Saharan countries. However, the health care infrastructure and relative burden of disease in Asia and the Pacific will have different implications for the most cost-efficient mechanism for integration, as well as approaches to system strengthening. Operational research on approaches suitable for this region and cost effectiveness studies of larger implementation are needed to guide the response to HIV/AIDS in Asia and the Pacific.

28. In the 2010–2011 biennium, 16 national programs are developing new national strategic plans on HIV/AIDS for the next 5-year phase of activities. These strategies are critical to sustainable and effective prevention interventions at scale. They lay out the blueprint for the effective use of development aid. Lessons learned over the last 5 years suggest that scaled up HIV prevention programs require (i) strong national guidelines describing service quality standards; (ii) feasible and sustainable intervention models appropriate for local contexts; and (iii) concrete coverage targets that are tied to budgeted action plans. Development partners and technical agencies play an active role in supporting evidence-based, cost-effective, and prioritized national strategic planning processes. Nationally identified priorities and national programs linked to appropriate budgeting are more likely to succeed. This has been documented in the ADB-supported project on evidence-based action.

29. Aid effectiveness is critical in HIV/AIDS programming. In 2004, UNAIDS launched the Three Ones initiative, requesting partners’ commitment to support national leadership, clear ownership at the country level for overseeing the national response to HIV/AIDS, and assurance of their efforts to avoid duplication and align activities with DMCs’ national strategy. To reinforce coordination within its own structure, the UN identified clear divisions of labor, based on each agency’s comparative advantages.

28 Three Ones refers to: One agreed national AIDS Action Framework that provides the basis for coordinating the work of all partners; one national AIDS coordinating authority with a broad-based multi-sector mandate; and one agreed country-level monitoring and evaluation system.
30. The Three Ones approach is in line with the Paris Declaration for Aid Effectiveness in 2005 and subsequent Accra Agenda for Action in 2008. Through the Paris Declaration, international partners recognized the importance of country ownership of poverty reduction strategies and the need for development partners to coordinate and align with country-defined needs and priorities.

III. ASIAN DEVELOPMENT BANK’S RESPONSE TO HIV/AIDS IN ASIA AND THE PACIFIC

A. Establishment of the Link of HIV/AIDS to Poverty Reduction and Development

31. As a regional development bank, ADB is concerned with the threat the HIV epidemic poses to the region’s progress in reducing poverty and its social and economic development. According to studies commissioned by ADB, among others, HIV infection reduces the income-earning capacity of affected households and significantly increases their spending on health care. And while all chronic diseases take their toll on human productivity, HIV is markedly worse because it affects people in their prime productive years (15–49 years of age). Many studies have documented the impact on families and communities, particularly due to the loss of income (from the infected persons and those who care for them), spending on health care, and loss of future earnings and investment as children drop out of school to earn money or help caretakers. Women are particularly affected.

32. Studies in 2008 by ADB and UNAIDS assessed the impact of HIV/AIDS on households in four countries (Cambodia, India, Thailand, and Viet Nam). In India, the financial burden on households affected by HIV (with at least one member living with the virus) averaged 49% of household income, ranging from 82% among the poorest quintile to just over 20% among the richest quintile. The study found that, at current estimates of the epidemic’s growth, annual poverty reduction estimates and trends may be reduced by as much as 60% in Cambodia and 23% in India. It also found that, in every year from 2003 to 2015, an average of 5.6 million people in the four countries will become poor or fall deeper into poverty because of HIV/AIDS. The link between poverty and HIV/AIDS becomes even stronger, since the poor are also more likely to get entangled in sex work or human trafficking for economic survival. Poor women in particular are less likely to be able to negotiate or protect themselves against sexual harassment or coercion.

B. HIV/AIDS Project Portfolio and Funding Mechanisms

33. Over the last two decades, ADB’s portfolio has evolved from a series of economic analyses, support for regional conferences, and information-sharing activities to selective prevention programs, most notably in the transport sector.

34. HIV prevention programming within the transport sector remains a central component of ADB’s portfolio of activities addressing HIV/AIDS. ADB began to incorporate HIV prevention in transport projects in 1999 (in the GMS). A systematic assessment of HIV risk and vulnerability is now part of all ADB-financed infrastructure projects. This approach has been implemented with support from ADB’s Transport Community of Practice and infrastructure mission leaders.

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number of ADB-supported infrastructure loans included HIV-risk mitigations, through the application of loan covenant agreements. The assessment is being replicated in 2011.

35. The HIV prevention component of ADB-financed infrastructure projects has been commonly funded through one of two mechanisms: by allocating a portion of the actual project budgets (requiring investment from DMC governments); or by using grant funds. Interventions funded through project budgets tend to be fairly basic, focusing on health education for workers during the construction phase of an infrastructure project. When more extensive interventions have been proposed (e.g., implementing demonstration projects, executing efforts to effect broader transport sector policy change in a country, conducting more rigorous evaluation efforts, or engaging in cross-border coordination and knowledge sharing activities), projects have used special technical assistance financed by designated trust funds and administered by ADB.

36. The primary source of ADB intervention funds is a $19.3 million Cooperation Fund for HIV/AIDS established in 2005. The multi-donor fund is open to any development partner or private sector funder willing to support ADB’s HIV/AIDS response. The Australian Agency for International Development and the Swedish International Development Cooperation Agency are the major development partners currently supporting ADB’s HIV/AIDS portfolio.

37. ADB also stands strongly committed to gender mainstreaming in its operations and policy dialogue. Addressing gender inequality in the context of HIV/AIDS is a priority. Any new intervention supported by ADB will undertake a proper gender analysis with possible implications for design, implementation arrangements, and expected impact. An analysis of how gender issues have been addressed in ADB-financed, HIV-related infrastructure projects was completed in 2008. The recommendations from this report provide concrete examples of gender mainstreaming at different stages of project implementation, including fostering collaboration between the infrastructure sector with law enforcement, civil society, and women’s groups (including sex worker representatives) to (i) design the intervention jointly; (ii) monitor employment practices to prevent discrimination, sexual harassment, coercion, and violence against women; (iii) enable families to live together on site; and (iv) support women’s economic empowerment through vocational training and business management education.

C. Partnerships at National and Regional Level

38. Both Strategy 2020 and the Operational Plan for Health emphasize the need for strategic partnerships at national and regional levels. At the national level, the primary partners for HIV/AIDS programming are the designated national AIDS control authorities. This ensures that any ADB-supported intervention is contextualized in the national AIDS strategic plan. In addition, ministries of finance and transport, civil society organizations, private sector operators, and development partners are partners and stakeholders in ADB activities.

39. Regional and subregional partnerships complement national partnerships. Regional and subregional approaches in addressing communicable diseases can strengthen national responses and take advantage of synergies and economies of scale through joint production and provision of public goods. Examples include (i) cost-sharing to tackle common challenges, such as joint knowledge generation projects, training and capacity building, or development of cheaper pharmaceuticals; (ii) promoting regional standards or harmonization to guide country programming; (iii) disseminating and sharing knowledge and lessons learned in implementation.

among countries; and (iv) leveraging wider policy change at the government level through regional organizations such as Association of Southeast Asian Nations (ASEAN) and Central Asia Regional Economic Cooperation (CAREC).

40. Regional and subregional partners have been mobilized around a number of priority thematic areas. Working groups and joint initiatives are in place to (i) provide services for MSM populations, injecting drug users, and female and male sex workers; (ii) address the needs of mobile populations and, in particular, the vulnerability of migrant populations; and (iii) promote structural interventions in the infrastructure sector. The latter is an area where ADB plays a regional leadership role, particularly in the GMS. A successful collaboration between ADB and the UNAIDS regional support team in generating knowledge resulted in the Commission on AIDS in Asia report, which is considered a key resource document for planning and advocating for effective responses to HIV in the region.

41. Working in partnership is critical for ADB to maximize its comparative advantage in infrastructure investment and policy dialogue with DMCs. Delivering aid effectively and transparently with improved results frameworks will remain a key priority. ADB will work closely with UNAIDS (Joint United Nations Programme on HIV/AIDS) and its co-sponsors, and the Global Fund for AIDS, Tuberculoses, and Malaria. Such partnerships leverage each organization’s comparative advantage and facilitate collaboration at the country level. ADB also has existing partnerships with the majority of UNAIDS co-sponsors, with which joint undertakings have been planned or are being considered.

42. Closer collaboration with the private sector and philanthropic organizations, and the use of market-based instruments, will be scaled up and explored. The private sector is engaged in many aspects of HIV response. In addition, businesses are at particular risk from the potential impacts of HIV/AIDS. Numerous companies around the world remain committed to educating and protecting their workers from HIV infection.

43. The public sector can benefit from private sector experience in HIV/AIDS prevention and service delivery, including marketing and financial management. The private sector also plays a critical role in research, leading efforts to develop AIDS drugs and vaccines, HIV test kits, and prevention programs. The private sector contributes financially to HIV/AIDS prevention programs in collaboration with governments, civil society, and development partners. For example, national business coalitions against AIDS have been established in Cambodia, Fiji, Indonesia, Myanmar, Papua New Guinea, Philippines, Singapore, Sri Lanka, and Thailand, to reduce the burden of AIDS in communities where businesses are based, and as part of their corporate social responsibility efforts. The Global Business Coalition on HIV/AIDS, Tuberculosis, and Malaria is another example of how the private sector mobilizes resources, commitment, and support for HIV prevention. There is also (RED), a program that engages the private sector to commit a portion of its profits to help finance the fight against HIV/AIDS, in collaboration with The Global Fund.33 Innovative partnerships with the private sector on HIV/AIDS will be explored in close collaboration with ADB’s private sector operations department.

44. The role of community and civil society organizations and people living with HIV, in partnership with governments, development agencies, and other partners, is essential. Developing systems for service coordination at the local level that are led by local health

33 (RED) has teamed up with the world’s most popular brands to produce branded products for mobilizing resources for the fight against AIDS in Africa.
authorities and local government officials, involving representatives of affected populations and local service providers, is critical for an effective local HIV response. A correlated key action is to work in partnership with, and strengthen, regional research institutes to carry out this work. Numerous economic research institutions in the region are primed to develop more specific expertise for HIV/AIDS-related topics. Increasing the research opportunities in the region and expanding the available pool of regional technical experts provides a more sustainable approach to generating knowledge products. Ultimately, these resources will support the culture and orientation of DMCs to adopt evidence-based decision making.

45. Regional partners such as UNAIDS, World Health Organization, ASEAN, and the Pacific Leaders Forum have recently launched, or are in the process of updating, their strategies against HIV/AIDS. As many of the core approaches identified in these documents (e.g., health system strengthening, evidence based responses, and support for DMC-level strategic planning) coincide with ADB’s strategic directions, opportunities exist to work collaboratively. As ADB moves toward a more focused agenda in its contributions to HIV/AIDS in the region, it will continue to further shape its regional partnerships to reflect these priorities and ADB’s comparative advantages.

IV. STRATEGIC PRIORITIES FOR HIV/AIDS PREVENTION

46. The Operational Plans for Health and Transport provide guidance in applying the principles and priorities of Strategy 2020 by measuring the health-related impacts of infrastructure projects, supporting DMCs in planning and designing cost-effective risk mitigation interventions, and contributing to regional public goods, such as communicable disease control, which can benefit from ADB’s areas of comparative advantage. The Operational Plan for Transport stresses the need for developing more effective approaches to the social dimensions of transport, including more participatory approaches to project planning and project strategies to protect against transport-related HIV/AIDS risks.

47. ADB’s HIV/AIDS portfolio is aligned with the broader focus of its investments in core sectors, primarily related to infrastructure. Projects focused on urban development may also be particularly relevant to HIV/AIDS risk and vulnerability. In most countries in the region, urban areas are often epicenters of sex work and drug trafficking, and where higher concentrations of the most at risk populations are found. Mitigating the increased risk for HIV transmission associated with migrant labor and increased mobility from urbanization, and urban HIV prevention programming are consistent with the type and level of funding that is available through ADB, and its interest in promoting cost-effective and sustainable interventions.

48. ADB is optimizing its comparative advantages to scale up its response to stop new infections by

(i) utilizing its role as a major investor in the region to engage leaders in key economic sectors, including finance, planning, and infrastructure ministries, to address DMCs’ national HIV/AIDS strategic policy agenda;

(ii) working as an “honest broker” with other partners to establish and facilitate a platform where effective collaboration can take place among key players involved in HIV prevention; and

(iii) generating and disseminating knowledge products, especially those that address issues of economic sustainability and cost effectiveness, to provide evidence for widespread adoption of prevention interventions; leverage additional funding; and support the effectiveness of regional aid spending.
49. In addition, ADB will explore how it can bring its financial and technical expertise to collaborative projects with other regional institutions. Criteria applied in considering non-infrastructure projects include (i) the results of epidemiologic situation analyses, (ii) the strength of partners’ joint commitment, and (iii) the specificity of ADB’s added value to the success of the project.

A. Mitigation of HIV Risks and Vulnerabilities Linked to Economic Corridors

50. Mitigating the HIV risks in economic corridors will remain the key approach to ADB’s HIV prevention programs. An integrated approach that identifies a project’s HIV risks and vulnerability at the planning stage will be the modus operandi. This type of systematic approach will help mitigate increased vulnerability to HIV among workers and affected communities of major infrastructure projects across the region, as well as provide an opportunity to contribute to existing national and regional HIV/AIDS outcomes.

51. The second action taken is strategic selectivity in HIV prevention programming, such as policy dialogue, facilitation of collaboration between partners, support for cost-effective interventions, development of tools and knowledge products, and/or direct service implementation. ADB’s role in mitigating harm in the infrastructure sector varies depending on the severity of the assessed potential impact, as well as the existing capacity and commitment of other partners to address those impacts. Ideally, ADB will support policy discussion and action in government ministries, to encourage ownership over mitigation efforts. In countries with identified epidemic need, ADB can work with regional partners, such as UNAIDS and the signatories of the Joint Initiative by Development Agencies for the Infrastructure Sectors to mitigate the spread of HIV/AIDS to advocate for national AIDS control programs to incorporate prevention activities associated with infrastructure development into national strategic plans.34

52. As countries and the private sector gain capacity for new leadership roles, ADB should continue to support the development of tools and methodologies for designing appropriate and cost-effective programs. Development of these tools and knowledge products multiply the benefits of investments made in implementing transport-related HIV/AIDS projects. This can be accomplished by connecting partners in different countries to share good practices and lessons learned. Resources should be mobilized to conduct operational research and share lessons learned to make implementation more effective. Through the generation of these types of knowledge products, ADB should focus attention on its core principles and values, such as reducing gender-based violence and discrimination, fueling inclusive growth through social protection, and maintaining cultural sensitivity to ethnic minorities and indigenous people, within the context of HIV/AIDS intervention.

53. On a more selective basis, ADB will support direct implementation of prevention interventions. Developing objective criteria for selecting which projects should receive ADB funding will help ensure adherence to ADB’s identified priorities, and maximize the potential impact on the local epidemic it addresses. Such criteria and protocol will serve two purposes: (i) to illustrate transparent and strategic decision-making for both internal and external stakeholders, and (ii) reinforce the priorities ADB has identified for its clients and project officers, when identifying and designing project proposals.

34 Signed by African Development Bank; United Kingdom Department for International Development; Japan International Cooperation Agency; Kreditanstalt für Wiederaufbau (KfW), Germany; and the World Bank.
54. National AIDS control authorities in DMCs will lead and coordinate the implementation of these types of prevention interventions, and ministry counterparts in the health and infrastructure sector will support implementation. The interventions will engage private sector operators and nongovernment or community-based organizations. Civil society partnership has been shown to be particularly effective in working with most at-risk populations in countries where the legal and policy environment categorized these groups to be engaging in illegal activities and where governments are not able to participate fully in providing the package of prevention services. Collaborative efforts require greater investment in coordination and joint-decision making, but ultimately result in more effective programming, bringing to bear the strengths of different partners, such as the civil society.

55. Experiences from current ADB projects in the HIV/AIDS portfolio illustrate the effectiveness of these approaches. For example, HIV prevention activities that focused on workers and communities associated with major road projects in the GMS mitigated the potential for increased sex work along these transport corridors. In addition to implementation of prevention interventions, the GMS countries provided leadership in responding to HIV/AIDS in a multisectoral manner. As a result of this support, ministries of transport in Cambodia, Lao People’s Democratic Republic, and Viet Nam developed budgeted action plans to implement a sector-wide approach to HIV prevention. At the same time, these projects illustrate the importance of cross-border coordination in the GMS, and include annual workshops for sharing experiences in the field and facilitating the extension of the lessons learned to future projects in the region. These good practices have been translated into specific knowledge products, such as *Practice Guidelines for Harmonizing HIV Prevention Initiatives in the Infrastructure Sector (2010)* and *ADB, Roads, and HIV/AIDS: A Resource Book for the Transport Sector (2008)*, for use by internal and external stakeholders.

B. Support for HIV Prevention through Regional and Subregional Cooperation

56. Supporting increased connectivity and regional and subregional integration and cooperation via major infrastructure investments requires understanding the social and economic dimensions of migration and HIV risks. ADB has an obligation to mitigate risks and vulnerabilities associated with large infrastructure projects and an opportunity to support regional organizations and private sector operators to develop and implement operational regional and subregional strategies on HIV/AIDS. ADB has developed significant experience in addressing HIV risks in the design and implementation of HIV initiatives in large infrastructure projects in cross-border areas.

57. An area where regional partners must make a concerted collaborative effort is in addressing HIV risks related to the large migration, internally and internationally, which is increasingly common in many countries in Asia. Existing data in the region indicates that migrants are not a homogeneous group with equal risk of acquiring HIV. Better tracking of these patterns of movement and the conditions of risk in destinations can help prioritize where interventions may be most needed or most efficient at preventing HIV transmission. The effort requires a more sustained, long-term commitment and partnership between countries to provide prevention interventions at key destinations of population movement and then to develop strategies that are culturally and linguistically appropriate for migrant workers. Investment by host countries (i.e., destination countries) in prevention for migrant populations is critical to reducing transmission among its native population. Countries of origin of at-risk migrant populations should invest in prevention interventions in foreign destinations as it offsets the future cost of care and treatment for returning infected migrants as well as prevention efforts.
among affected families. ADB should use its existing regional and subregional platforms to enhance the work on mobility and HIV/AIDS.

58. To the extent that migrant populations that are at risk may be employed by private sector operators, ADB could facilitate private–public partnership that encourages corporate social responsibility to reach out with services for their workers and affected communities. Mitigating the harm associated with large migration intersects with the need to effect policy change to protect the rights of marginalized populations, such as sex workers, injecting drug users, and men having sex with men. Emerging and existing economic corridors that facilitate tourism may also exacerbate the risk of HIV transmission, particularly cross-border areas. ADB and its partners should play a role in reinforcing this agenda during interactions with relevant ministerial counterparts as opportunities arise during negotiations of project financing, as well as through assessing social protection and issues in the planning and design phase of supported projects.

59. ADB’s Operational Plan for Health specifically highlights the importance of supporting health outcomes through regional public goods. Support for regional projects and programs that focus on pandemic control and are consistent with existing regional and subregional strategies remains a priority. To help build and institutionalize capacity in the region, it is also recommended that ADB support emerging networks that analyze policies and cost-effectiveness of HIV/AIDS interventions, and develop tools and good practices. ADB will also liaise with regional economic and political organizations such as the ASEAN, the Secretariat for the Pacific Community (SPC), and CAREC and provide support for capacity building and implementation of regional projects.

60. The joint ADB and UNAIDS project, Evidence-based Advocacy for Action, includes training and planning workshops and technical support to help DMCs develop costed national HIV/AIDS strategic plans and an online data hub35 that serves as a data warehouse where original reports of key studies conducted in different countries are available for downloading. Access to this information supports the use of evidence for action, as well as allows for analysis in epidemic patterns that transcend national borders and multi-country phenomena.

C. Knowledge Solutions and Policy Dialogue

61. ADB will apply an integrated approach using evidence-based information for its programming. The Regional AIDS Data Hub will play a significant role in building regional capacity on the use of evidence for action and for the analysis of the epidemic for effective programming. Moreover, it will provide tools and methodologies for cost-effective national strategic planning and measuring progress toward the Millennium Development Goals and Universal Access.

62. Adequate investment in dissemination of knowledge products is equally important. Different means of dissemination will reach different audiences and have different impacts on how findings and tools will be used. For example, peer reviewed publications are read by academic or technical experts but can also be cited in proposals and advocacy documents. Initiatives in the form of case studies, toolkits, or practical guidelines are important resources for implementers or technical experts. Fact sheets provide evidence to back up key messages aimed toward policy makers or decision makers. Slide presentations provide examples or information that can be shared through partnership forums, training, or workshops designed for dissemination, consensus building, and endorsement of results. The research protocol or

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35 www.aidsdatahub.org
analysis plan for commissioned knowledge products can include a dissemination plan that outlines intended audiences, product formats, and media opportunities to share learning. Knowledge products should have both specific DMC or subregional applications as well as broader geographic or sector related uses.

63. ADB must align its knowledge generation activities with the regional operational research agenda, and ADB’s own areas of comparative advantage. This includes working with partners to develop cohesive regional research priorities. Epidemiologic and programmatic data available through the regional AIDS data hub allow for an up-to-date assessment of key gaps, from which ADB and other organizations can identify priority issues for commissioned research and studies or secondary data analyses and synthesis.

V. IMPLEMENTATION OF STRATEGIC DIRECTIONS

64. This paper has described the characteristics of the HIV/AIDS epidemics in Asia and the Pacific, and the areas of comparative advantage of ADB. To ensure effectiveness and impact, it is essential to define the optimal modes for working in these selected areas. In general, direct implementation of service delivery activities is only expected when programs meet certain criteria of epidemiologic needs, partner commitments and capacities, and broader regional benefits. ADB’s future investments will be primarily in the form of generating and disseminating knowledge in support of advocacy and policy dialogue for cost-effective interventions targeting vulnerable groups, while respecting their rights. These investments will be focused on interventions in infrastructure sectors, support for cost-effective interventions, and sustainable, region-appropriate financing mechanisms.

65. Ensuring progress toward more effective and sustainable responses to HIV/AIDS at the country and regional levels will require a robust and feasible design and monitoring framework. ADB has recognized interest in stronger monitoring and evaluation systems. Monitoring the progress ADB makes toward HIV/AIDS related goals poses several challenges. First, the contributions of ADB’s interventions are focused and strategic but ultimately a small component of a larger national or regional strategy, which makes it difficult to assess impact-level effects. Second, one of the key criteria for HIV/AIDS interventions financed and/or cofinanced by ADB is that they are integrated into a larger project. This type of integration constrains the extent to which data for key indicators can be collected, as larger project performance measures may take precedence. Third, interventions for most at-risk populations are difficult to measure due to the mobile and hidden nature of many groups, which poses even greater challenges for characterizing and sampling these populations for robust, representative surveys.

66. Increasingly, ADB will rely on project officers developing infrastructure projects to effectively and efficiently assess the need for HIV-related mitigation activities as part of overall business processes. Regional departments must ensure DMC ownership over more intensive prevention interventions, in close partnership with national partners that effectively liaise with national AIDS control programs. Strengthening capacities and skills within ADB to effectively design and implement HIV/AIDS programs in line with the priorities outlined in the strategic direction will take place in close coordination with UNAIDS and its co-sponsors. If ADB intends to play a central role in regional coordination, it must ensure strong coordination and information sharing internally. Regional departments must be aware of each others’ HIV/AIDS-related activities, staff who have experience with these issues, and lessons learned from previous projects that took on similar scopes of work. As ADB’s HIV/AIDS portfolio becomes more focused and strategic, this will support efficient and valuable internal coordination, and the honing of tools and skills among staff.
67. The Health Community of Practice will, in particular, continue to work closely with the transport; gender equity; social development and poverty; urban; and other communities of practice to exercise its comparative advantage in addressing adverse impacts of HIV/AIDS, and to assist sector-specific mitigation strategies on HIV prevention.

### DESIGN AND MONITORING FRAMEWORK

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<tr>
<th>Design Summary</th>
<th>Performance Targets/Indicators</th>
<th>Data Sources/ Reporting Mechanisms</th>
<th>Assumptions and Risks</th>
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<tbody>
<tr>
<td><strong>Impact</strong></td>
<td>The 2015 sex disaggregated data indicate that the prevalence of HIV infections among men and women 15–49 years old in Asia and the Pacific, in percentage of the male/female population, has not been increasing for the last 2 years. The 2015 sex-disaggregated data indicate that the prevalence of HIV infections among men and women 15–49 years old, in percentage of the population, has started to decrease in at least one-third of DMCs.</td>
<td>UNGASS reports UNAIDS reports</td>
<td>Assumptions: Continued long-term commitment and ownership for the HIV epidemics in region. Risks: Complacency and lack of financial and human resources available to control the virus.</td>
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<tr>
<td><strong>Outcome</strong></td>
<td><strong>Effectiveness</strong> Two-thirds of DMCs developed and implemented national HIV programs supported by evidence from appropriate epidemiologic data by 2015.</td>
<td>UNAIDS reports Country reports National budgets National Health Accounts Country UNAIDS report</td>
<td>Assumptions: The supported interventions, reflecting the best up-to-date knowledge about the HIV/AIDS epidemics, are assumed to be effective. Increasing resources (domestic and from donors) available to fight the HIV/AIDS epidemics. Risks: If new more effective interventions are identified (e.g., vaccine), resources should be shifted towards these interventions.</td>
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*Although behavioral surveillance data assessing the impact of specific interventions focusing on behavioral changes may be a more sensitive indicator of program effectiveness and impact, zero-prevalence data are more regularly collected and available.*
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<td>25% of DMCs have provisions in their national HIV program for protection, respect, and defense of the rights of the vulnerable groups</td>
<td>Laws, regulations, by-laws of chambers of commerce or private sector associations</td>
<td>Resources diverted either to other regions or to other major health issues</td>
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<tr>
<td>Outputs 1. Adverse HIV risks and vulnerabilities in ADB-supported infrastructure projects are mitigated</td>
<td>70% of all ADB infrastructure projects address HIV/AIDS mitigation at design stage in IPSA and SPRSS 70% of all ADB-financed infrastructure projects include HIV/AIDS mitigation measures in the contractors contracts and include such provisions in the loan covenant</td>
<td>ADB project and program progress reports UNGASS and regional task force reports (mobility and migration) Contractors reports Organization and regulations of the ministries of transport</td>
<td>Assumption An effective response to HIV/AIDS requires domestic financial resources. Leaders’ commitments and instructions to actively address the epidemic are essential to raise awareness and keep HIV/AIDS among the priorities.</td>
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<tr>
<td>2. Regional and subregional cooperation to control the spread of HIV is strengthened</td>
<td>By 2015, 75% of DMCs are sharing data and information for data usage through the regional HIV/AIDS data hub At least 2 sub-regional HIV/AIDS mitigation and prevention programs are funded by ADB’s HIF trust fund, and implemented by 2015</td>
<td>Regional HIV/AIDS data hub web site UNAIDS and Global Fund reports Web sites and reports of regional organizations (ASEAN, GMS, CAREC and the Pacific Community)</td>
<td>Assumption Successful interventions that prevent the spread of HIV/AIDS among key vulnerable populations will have the biggest impact on the epidemic and society</td>
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<td>(v) poverty and social protection and inclusiveness relevant to HIV/AIDS</td>
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<td>(vi) public–private partnerships for effective service delivery on HIV/AIDS prevention/mitigation</td>
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### Activities with Milestones

1.1 Provide capacity building for key stakeholders and ADB staff in addressing HIV risks in the designing, implementation and monitoring processes of infrastructure projects

1.2 Support mitigation programs that address adverse HIV/AIDS impacts of infrastructure projects with 70% of the infrastructure projects considering the HIV/AIDS risk and incorporating mitigation measures as appropriate.

1.3 Develop tools for monitoring the implementation of contractual obligations on HIV prevention by construction contractors

1.4 Strengthen knowledge sharing about ADB good practices on HIV prevention in the infrastructure sectors

2.1 Support regional programs to raise awareness and commitment on the key dynamics of the HIV epidemics in the region through innovative and new partnerships

2.2 Support implementation for regional public goods that enhance the response to the epidemic together with UNAIDS and its co-sponsors

2.3 Support regional economic and political organizations and nongovernment organizations in implementing cost-effective responses to HIV/AIDS

2.4 Support exchange of visits for learning and good practice implementation and explore South-South collaboration

2.5 Explore new regional partnerships with lead institutions to leverage ADB programs on HIV/AIDS infrastructure, mobile and migrant populations, and health system strengthening

2.6 Support policy dialogue with at least 25% of DMC to develop laws which protect, respect, and defend the rights of the vulnerable population groups

3.1 Support joint research and analyses in line with AIDS Commission reports and new emerging areas relevant to the epidemics in the region and in line with ADB’s mandate

3.2 Support regional seminars, workshops, and training opportunities that discuss strategies for cost-effective responses to the HIV epidemics in the region

3.3 Produce thematic papers, capsules, interactive presentations, policy papers related to cost-effective prevention strategies addressing those most at risk

3.4 Develop e-learning courses, web-based information, and innovative information and communications technology programs that engage both the public and private sectors in HIV prevention

3.5 Develop new partnerships with research and think-tank institutions to support cutting-edge knowledge products

### Inputs

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<th>c. Loan Operations</th>
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