

Practice Guidelines for Harmonizing HIV Prevention Initiatives in the Infrastructure Sector

GREATER MEKONG SUBREGION

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Asian Development Bank
6 ADB Avenue, Mandaluyong City
1550 Metro Manila, Philippines
Tel +63 2 632 4444
Fax +63 2 636 2444
www.adb.org

For orders, please contact:
Department of External Relations
Fax +63 2 636 2648
adbpub@adb.org

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The overall writing, editing, and coordination process was led by Charmaine Cu-Unjieng (ADB consultant), under the direction of Lisa Studdert (previous ADB health specialist), Emiko Masaki (ADB social sector economist), and Shireen Lateef (director, Social Sectors Division, ADB Southeast Asia Department).

For comments or enquiries, please contact Emiko Masaki via e-mail at emasaki@adb.org

Abbreviations

ADB	Asian Development Bank
AIDS	acquired immunodeficiency syndrome
ASEAN	Association of Southeast Asian Nations
BCC	behavior change communication
FSW	female sex worker
GMS	Greater Mekong Subregion
HIV	human immunodeficiency virus
IDU	injecting drug user
IEC	information, education, and communication
ILO	International Labour Organization
JICA	Japan International Cooperation Agency
JUNIMA	Joint United Nations Initiative on Mobility and HIV/AIDS in South East Asia
Lao PDR	Lao People’s Democratic Republic
M&E	monitoring and evaluation
MSM	men who have sex with men
MPWT	Ministry of Public Works and Transport
NGO	nongovernment organization
PRC	People’s Republic of China
STI	sexually transmitted infection
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNICEF	United Nations Children’s Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNRTF	United Nations Regional Task Force on Mobility and HIV Vulnerability Reduction
WHO	World Health Organization

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Executive Summary

Development partners continue to promote and support increased connectivity and regional integration in the Greater Mekong Subregion (GMS) through significant investments in infrastructure development—railways, electricity, irrigation, telecommunications, and, most especially, roads. The increased connectivity, enhanced competitiveness, and closer sense of community have improved the quality of people’s lives, but it has also created opportunities for the spread of HIV and other communicable diseases within and across the GMS borders. Although the HIV epidemics vary within and between countries, they are centered on common risk behavior, namely, unprotected sex and the sharing of contaminated needles and syringes by injecting drug users. In Asia, men who buy sex are the single most powerful driving force of the HIV epidemics and constitute the largest infected population group. Given that infrastructure development increases the mobility of people—particularly men with disposable income who migrate for work opportunities—it is likely that the demand for commercial sex along transport corridors and in popular transit and destination sites will also rise accordingly. Development partners have recognized the obligation to mitigate HIV risks associated with infrastructure development as an opportunity to contribute to the fight against HIV/AIDS and poverty in the region. With the support of the GMS countries, development partners can help fill the gaps in knowledge and expertise relating to HIV prevention in infrastructure development.

As an important starting point, development partners agreed to strengthen inter-agency cooperation and harmonization in order to scale-up and enhance the effectiveness of HIV and AIDS prevention in future infrastructure interventions. To achieve this, development partners jointly developed a set of practice guidelines

that can provide some standardization of effective program elements, focusing on three different but interacting populations, namely: (i) sex and entertainment workers, (ii) local communities impacted by infrastructure development, and (iii) migrant workers. These guidelines were developed through a participative process using an evidence-informed approach of operational research and experiential learning from different development partners. They are in line with the recommendations made by the Commission on AIDS in Asia and the *Regional HIV/AIDS Strategy for Mobility and HIV Vulnerability Reduction (2006–2008)*. They also advance commitments made by the six signatories of the *Joint Initiative by Development Agencies for the Infrastructure Sectors to Mitigate the Spread of HIV/AIDS*.

This document is divided into two parts. Part I explains the role of the infrastructure sector in the HIV response and why harmonization is needed. Part II contains the practice guidelines in four sections: (i) core principles, (ii) basic elements of an HIV prevention package, (iii) core monitoring and evaluation framework, and (iv) implementation and funding arrangements.

Part I

Context for Harmonizing Approaches

The Greater Mekong Subregion (GMS) is a subgroup that recognizes the common interests, concerns, and challenges of six countries around the Mekong River: Cambodia, Yunnan and Guangxi provinces of the People’s Republic of China (PRC), Lao People’s Democratic Republic (Lao PDR), Myanmar, Thailand, and Viet Nam. Since its inception in 1992, the GMS Economic Cooperation Program (GMS Program) promotes regional development by improving connectivity, strengthening competitiveness, and promoting a sense of community—commonly called the “three Cs.” The GMS leaders have recognized the important role of infrastructure development in achieving the “three Cs”. However, the GMS leaders acknowledge that infrastructure development, such as in the GMS economic corridors, can also contribute to an increase in illicit drug use and human trafficking and the spread of communicable diseases, such as HIV.¹

This section provides a brief overview of the intersection between infrastructure development and the spread of HIV in the GMS. It presents the policy and institutional frameworks that allow for a multisectoral and multistakeholder response, especially among development partners.

¹ Joint Summit Declaration from the Third GMS Summit entitled Enhancing Competitiveness through Greater Connectivity, Vientiane, Lao PDR. 30–31 March 2008.

HIV, Mobility, and the Infrastructure Sector

HIV transmission in Asia is driven primarily by three high-risk behaviors, namely: injecting drug use, unprotected sex between men and women (including commercial sex), and unprotected sex between males. According to the Commission on AIDS in Asia report, men who buy sex are “the single most powerful driving force in Asia’s HIV epidemics and constitutes the largest infected population.” As men who “buy sex” are either married or will get married, “low-risk” women who only have sex with their husbands or partners are placed at risk for contracting HIV. However, it is predicted that the HIV epidemics in Asia will not be sustained in the “general population” independently of commercial sex, drug injecting, and sex between men.²

The HIV epidemics vary considerably within and among GMS countries. There are positive signs that HIV epidemics are slowing down or being controlled in Cambodia and Thailand, but increasing in Viet Nam and some parts of the PRC. HIV prevalence in Lao PDR remains low, although there is evidence of an expanding epidemic among the most vulnerable groups, especially sex workers and their clients, and men who have sex with men (MSM). Some highlights of the local epidemic in the GMS countries are presented below with detailed information provided in Appendix 1.

- National HIV prevalence in **Viet Nam** is at 0.53%,³ but widespread, affecting more than 90% of Viet Nam’s 659 districts, driven by injecting drug use and unprotected sex with non-regular partners.⁴
- The decline in the HIV prevalence of **Cambodia** is noteworthy, dropping from 1.2% in 2003 to an estimated 0.9% in 2006 mainly because of its 100% Condom Use Programme and safe-sex campaigns targeting brothel-based

² Commission on AIDS in Asia. 2008. *Redefining AIDS in Asia: Crafting an Effective Response*. New Delhi: Oxford University Press.

³ UNGASS. 2008. *The Third Country Report on Following up the Implementation to the Declaration of Commitment on HIV/AIDS for the Socialist Republic of Viet Nam (January 2006–December 2007)*. Ha Noi: Ministry of Health.

⁴ United Nations Joint Programme on HIV/AIDS (UNAIDS) and World Health Organization (WHO). 2008. *AIDS Epidemic Update: Asia Regional Summary (2007)*. Geneva.

sex workers and their clients. However, other forms of commercial sex are on the rise and new studies are showing high HIV infections among MSM.⁵

- **Myanmar** also came out of a mature epidemic from an estimated HIV prevalence of 1.3% in 2005 to 0.7% in 2007.⁶ Unfortunately, the most recent behavioral information dates back to 2003 and only surveys young people and the general population, making it difficult to accurately understand the HIV trends and patterns among most-at-risk groups.⁷
- **Thailand** has also seen signs of reductions in new HIV infections, but it still faces a generalized epidemic with a 1.4% HIV prevalence (2005 data). The patterns of HIV transmission in Thailand have changed, but new infections are increasing among women, the majority of whom acquired it from their husbands or partners who had been infected either during unprotected paid sex or through injecting drug use. HIV prevalence among injecting drug users (IDUs) have remained high over the past 15 years, ranging from 30% to 50% in 2007.⁸ A 2007 survey of the Bureau of Epidemiology also showed a high HIV prevalence rate of 24.6% among MSM.⁹
- The national HIV prevalence of the **PRC** is 0.1%, with most HIV infections being reported in Henan, Guangdong, Xinjiang, Guangxi, and Yunnan provinces. The HIV epidemic is mostly driven by the overlap of injecting drug use and sex work. In rural parts of Guangxi province, a 2002 study found an annual average of 3.1% HIV incidence rate (new HIV infections per year) among IDUs studied. In **Yunnan**, where the use of contaminated drug injecting equipment is still the main mode of HIV transmission, injecting drug use is the key factor associated with HIV infection among sex workers.¹⁰

⁵ UNAIDS and WHO. 2008. *AIDS Epidemic Update: Asia Regional Summary (2007)*. Geneva.

⁶ WHO, UNAIDS, and United Nations Children's Fund (UNICEF). 2008. *Epidemiological Fact Sheet on HIV and AIDS for Myanmar (2008 Update)*. Geneva.

⁷ WHO, UNAIDS, and UNICEF. 2008. *Epidemiological Fact Sheet on HIV and AIDS for Myanmar (2008 Update)*. Geneva.

⁸ WHO. 2007. *Global HIV Prevalence Has Leveled Off*. Geneva. www.who.int/mediacentre/news/releases/2007/pr61/en/index.html

⁹ UNGASS. 2008. *Thailand Report*. Bangkok: Department of Disease Control, Ministry of Public Health.

¹⁰ WHO, UNAIDS, and UNICEF. 2008. *Epidemiological Fact Sheet on HIV and AIDS for China (2008 Update)*. Geneva.

- HIV prevalence in **Lao PDR** has remained low at 0.1% with most infections transmitted through heterosexual contact. However, HIV prevalence is rising among sex workers and their clients, as well as MSM. In 2008, it was reported that half of registered people living with HIV were either migrant workers or farmers working outside of the country, especially in neighboring countries with a much higher infection rate, like Thailand.

Mobility is a growing phenomenon in the GMS. With socioeconomic changes, infrastructure development, and improved physical connectivity among the GMS countries, population movement is increasing within and across borders, generating conditions and circumstances that increase the HIV vulnerability especially of migrant and mobile populations. However, the main issue is one of behavior and not the mobility or occupation of the migrants. Newfound freedoms, disposable income, and sometimes exploitation or abuse faced by migrant and mobile populations may lead some to engage in high-risk behaviors, such as unprotected sex or injecting drug use.¹¹ HIV transmission can also occur in source communities if mobile men and women who have contracted HIV while away transmit the virus to their partners when they return home. In 2007, 30% of the registered people living with HIV were returning migrants in the Lao PDR.¹²

Migration can also contribute to the demand for entertainment and sex work. Mobile men with money—commonly termed the “three Ms”—increase the demand for commercial sex since they have disposable incomes, are away from their families, and are mobile. Female migrants become highly vulnerable when they supply commercial sex, as seen in a 2003 survey in southwest PRC, where temporary female migrants were found to be 80 times more likely than non-migrants to sell sex.¹³ Unprotected paid sex can drive the HIV transmission along major transport routes, cross-border areas, and in other areas experiencing high levels of seasonal and long-term population mobility.¹⁴ In Thailand, HIV infection

¹¹ United Nations Regional Task Force on Mobility and HIV Vulnerability Reduction (UNRTF) and Association of Southeast Asian Nations (ASEAN). 2008. *HIV/AIDS and Mobility in South-East Asia: Rapid Assessment*. Bangkok: S. Asia Press.

¹² WHO, UNAIDS, and UNICEF. 2008. *Epidemiological Fact Sheet on HIV and AIDS for China (2008 Update)*. Geneva.

¹³ Yang, X. and G. Xia. 2006. Gender, Migration, Risky Sex and HIV Infection in China. *Studies in Family Planning*, 37 (4): pp.241–250.

¹⁴ ASEAN. 2001. *ASEAN's Efforts in Combating HIV/AIDS*. Jakarta: ASEAN Secretariat.

rates among sex workers in border areas are consistently reported to be higher than elsewhere in the country.¹⁵

Large infrastructure projects—such as the building and rehabilitation of airports, ports, railways, power generation and distribution infrastructure, and roads and highways—can contribute to increased HIV vulnerability among the construction workforce and the local communities with whom they interact. According to the International Labour Organization (ILO), many studies have identified construction workers as being vulnerable to HIV, along with miners and transport workers. This vulnerability is partly attributed to mobility, coupled with poor living and working conditions, and separation from their families.¹⁶

Although the construction workforce is predominantly male, there are also women who work in the construction sites and camps. Female workers may be particularly vulnerable to harassment and violence, especially when they lack secure and private facilities in the construction camps.

Local communities near construction sites are also vulnerable to HIV infection, especially those located in poor areas. Since local people regard the construction project as an opportunity for alternative income generation, they may sell goods and services to the workers, which may include sexual services. Local women from isolated and remote rural areas are particularly at risk since they may not have adequate information and education on sexual and reproductive health, including how to protect themselves from HIV and other sexually transmitted infections (STI). In the post-construction phase, local communities face new vulnerabilities for HIV transmission and human trafficking associated with improved physical connectivity, economic integration, and increased opportunities for in- and out-migration.

However, as emphasized by the Commission on AIDS in Asia, generalizations can mislead. Not all people who are mobile, migrate, or are affected by large construction projects have higher vulnerability to HIV. Some migrant workers move

¹⁵ Raks Thai Foundation. 2004. Reducing Vulnerability of Migrant Fishermen and Related Populations in Thailand. Presented at the International Conference on AIDS, 11–16 July 2004, Bangkok.

¹⁶ International Labour Organization. 2008. *HIV/AIDS + Work: Using the ILO Code of Practice on HIV/AIDS and the World of Work* — Guidelines for the Construction Sector. Geneva.

with their partners and are less likely to engage in high-risk behavior. Research also shows that traditional social norms survive longer among migrants than is commonly thought. For example, engaging in commercial sex largely remains taboo and unacceptable. More adequate data are needed to better understand the underlying dynamics or “social drivers” that generate HIV vulnerability and the factors that undermine or boost an enabling environment for different potentially at-risk populations when they are “on the move.”¹⁷

GMS: National and Regional Strategies

Since the 1990s, the GMS countries have been developing and reassessing regional strategies and joint action plans to combat the spread of HIV within and across its borders, with the support of the United Nations Development Programme South East Asia HIV and Development Programme (SEA-HIV) and UNRTF.¹⁸ In 1999, the members of the ASEAN Task Force on AIDS endorsed the *Chiang Rai Recommendation* requiring contractors, commercial developers, and investors in major construction companies to fund HIV prevention programs in their activities as a precondition for project approval.¹⁹ Two years later, the GMS countries signed the *Memorandum of Understanding for Joint Action to Reduce HIV Vulnerability Related to Population Movement* that included a commitment to allocate 1% of construction costs to fund HIV prevention initiatives—if large infrastructure projects do not adequately address HIV-related issues during project preparation, nor earmark specific funding for HIV programming.²⁰ This has been popularly called the “1% clause.”²¹

¹⁷ Commission on AIDS in Asia. 2008. *Redefining AIDS in Asia: Crafting an Effective Response*. New Delhi: Oxford University Press.

¹⁸ UNRTF was renamed as the Joint United Nations Initiative on Mobility and HIV/AIDS in Southeast Asia in February 2009. For more information please visit: www.junima.org

¹⁹ Countries represented were Brunei Darussalam, Cambodia, the PRC (not a member of ASEAN), Indonesia, the Lao PDR, Malaysia, the Philippines, Singapore, Thailand, and Viet Nam. The Chiang Mai Recommendation was a result of the ASEAN Workshop on Population Movement and HIV Vulnerability held in Chiang Rai, Thailand on 10–12 November 1999. The recommendation was formally endorsed by ASEAN during its 7th ASEAN Task Force on AIDS meeting in Brunei on 16–18 November 1999. Further information on the Chiang Rai Recommendation can be found at: www.junima.org under resources and publications, (i) memorandums of understanding, and (ii) publications of the Former South East Asia HIV and Development Programme *Towards Borderless Strategies Against HIV/AIDS*. Bangkok. 2002. UNDP.

²⁰ This memorandum of agreement (MOU) was signed during the Building Regional HIV Resilience along the ASEAN Highway Network Workshop held on 13–15 October 2003 in Bangkok, Thailand. The MOU was re-signed in 2005. Available at: www.junima.org under resources and publications, (i) memorandums of understanding.

²¹ Some countries, particularly Cambodia, have advocated that 1% of the infrastructure project cost should automatically be earmarked for HIV prevention initiatives, whether or not an HIV-related initial assessment and/or budgeting was done. The Mobility Technical Working Group of Cambodia has tried to make this into policy, but realized that the 1% allocation may be too unreasonable.

Box 1: National Commitments on HIV Prevention in the Infrastructure Sector

Cambodia

- Policies on HIV/AIDS Prevention in Response to Activities of Public Works and Transport Sectors in the Kingdom of Cambodia (Ministry of Public Works and Transport [MPWT], signed on August 2006)
- HIV/AIDS Operation Plan of MPWT (2008–2010)
- Guidelines on Sustainable Integration of HIV/AIDS Education Program into the Curriculum of Driving Schools (MPWT, signed on 18 March 2009)

Lao PDR

- National Strategic and Action Plan on HIV/AIDS/STI (2006–2010) – Strategy 3.1.2.5., which says to “integrate HIV/AIDS/STI prevention into infrastructure projects”

Viet Nam

- Official Letter No. 1695/BGTVT-CGD from the Ministry of Transport requiring the implementation of health care and HIV/AIDS control and prevention programs among the workforce of transportation construction projects (dated 4 April 2007)

In 2002, a GMS-specific HIV prevention strategy was developed to address mobility and HIV vulnerability reduction in program and policy development.²² This was followed by a second, more comprehensive regional strategy in 2006 that included Southeast Asia.²³ Since then, several infrastructure ministries in the GMS have developed, or are in the process of developing, their sectoral HIV/AIDS strategic and action plans, in close consultation with their respective national AIDS authorities.²⁴ Some of the existing national commitments on HIV prevention in the infrastructure sector are presented in Box 1.²⁵

²² The process of developing the *Strategy on Mobility and HIV Vulnerability Reduction in the Greater Mekong Subregion (2002–2004)* was initiated by the Asian Development Bank (ADB) and United Nations Development Programme—South East Asia HIV and Development Programme, as part of a technical assistance project, ADB TA 5881—HIV/AIDS and Mobility in the GMS. This project was implemented by World Vision Australia, Macfarlane Bumet Centre for Medical Research, and the Asian Research Centre for Migration, during 2000 and 2001. UNRTF facilitated the collaborative process of strategy development. Revisions were undertaken by CIDA’s Canada-Southeast Asia Regional HIV/AIDS Program. www.adb.org/Documents/Guidelines/Preventing_AIDS/default.asp

²³ United Nations Regional Task Force on Mobility and HIV Vulnerability Reduction (UNRTF). 2006. *Regional Strategy on Mobility and HIV Vulnerability Reduction in South-East Asia and Southern China (2006–2008)*. Bangkok.

²⁴ The Ministry of Public Works and Transport (MPWT) in Cambodia developed their *Policies on HIV/AIDS Prevention in Response to Activities of Public Works and Transport Sectors in the Kingdom of Cambodia* in 2006. The MPWT in the Lao PDR and the Ministry of Transport in Viet Nam formulated their HIV strategic and action plans in 2009 (with assistance from ADB).

²⁵ Not a comprehensive list.

The GMS countries continue to advocate for strengthened commitments from development partners, as well as private and public contractors, to scale-up HIV prevention and mitigation efforts associated with infrastructure projects.

Development Partners: Support, Experience, and Lessons Learned

Development partners have supported, and continue to support, HIV prevention and mitigation initiatives associated with the infrastructure sector. These HIV interventions range from including HIV clauses in loan covenants requiring civil works contractors or construction companies to provide HIV education to its workforce, to integrating comprehensive HIV prevention packages as main components of the infrastructure project design. Different implementation and funding arrangements have been developed. Some sample initiatives from selected development partners can be found in Appendix 2.

Recognizing the urgency for action and need to improve aid effectiveness, in 2006, six international development agencies²⁶ signed the *Joint Initiative by Development Agencies for the Infrastructure Sectors to Mitigate the Spread of HIV/AIDS* (“Joint Initiative”) (Appendix 3). The Joint Initiative proposes to strengthen cooperation among development agencies to increase the scale, scope, and effectiveness of future HIV interventions in the infrastructure sector. It highlights the need for greater sharing of information and lessons learned based on practical experience of the respective agencies, as well as improved harmonization among key stakeholders to ensure consistency and avoid fragmented assistance.²⁷

In 2007, the Joint Initiative was revisited at a high-level meeting during the 8th International Congress on AIDS in Asia and the Pacific in Sri Lanka. Key stakeholders from governments and development agencies in the Asia region identified concrete ways to operationalize the Joint Initiative, including: (i) developing a minimum standard package and a common monitoring and evaluation framework

²⁶ African Development Bank, ADB, Department for International Development of the United Kingdom, Japan Bank for International Cooperation (now Japan International Cooperation Agency), KfW Entwicklungsbank (KfW Development Bank), and the World Bank.

²⁷ ADB, AfDB, DfID, JBIC, KfW, the World Bank. 2006. *Joint Initiative by Development Agencies for the Infrastructure Sectors to Mitigate the Spread of HIV/AIDS*. Toronto.

for HIV prevention interventions in infrastructure projects, and (ii) establishing a regular mechanism for information exchange among development agencies.²⁸

In March and April 2008, the Joint Initiative partners met through videoconference to exchange information and practical experience, as well as to sustain the momentum for continued collaboration. At the first videoconference, the most urgent issues and needs commonly identified were:

- Lack of systematic and relevant HIV and AIDS data associated with mobility and the infrastructure sector;
- Need for a harmonized approach when engaging government counterparts in advocacy for mainstreaming HIV prevention and mitigation in the infrastructure sector; and
- Urgency to develop and use a minimum package of HIV activities and standardized monitoring and evaluation (M&E) indicators to ensure quality interventions and the ability to effectively assess project impact.²⁹

In direct response to the concrete recommendations made by multistakeholders over the years, development partners have come together to strengthen harmonization and standardization efforts in the GMS. Ensuring the alignment with national and regional HIV/AIDS strategies and the “Three Ones” principles,³⁰ the development partners have agreed on (i) core principles, (ii) basic elements of an HIV prevention package, (iii) a core M&E framework, and (iv) implementation and funding arrangements that should be considered for every HIV and infrastructure intervention in the GMS. As a package, these will be called the “practice guidelines.”

²⁸ Co-organized by ADB and UNDP. Pre-conference high-level meeting entitled Infrastructure, Mobility and AIDS: from Commitment to Action held in Colombo, Sri Lanka on 19 August 2007.

²⁹ The Joint Initiative videoconferences are organized by the World Bank. Content of the videoconferences are available at: www.worldbank.org

³⁰ The “Three Ones” principles are:

- One agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners;
- One National AIDS Coordinating Authority, with a broad-based multisectoral mandate; and
- One agreed country-level Monitoring and Evaluation System.

Part II

Practice Guidelines

The practice guidelines have been developed to assist development partners in harmonizing and standardizing their collective efforts in HIV prevention and risk mitigation in association with infrastructure developments in the GMS. It has been developed through a joint working process involving representatives from a broad range of stakeholders, especially drawing on the practical experience and lessons learned of those who have implemented projects on the ground.

Process and Methodology

The writing process for the practice guidelines was initiated at the *1st GMS Technical Workshop for HIV Prevention and the Infrastructure Sector*, held on 12–13 May 2008 in Bangkok, Thailand.³¹ It was attended by representatives from multilateral and bilateral agencies, government line ministries for health and infrastructure, UN agencies, international and local nongovernment organizations (NGOs), private sector, and other practitioners (or consultants) who have been involved in HIV prevention and risk mitigation work in the infrastructure sector. Based on the meaningful sharing of practical experiences and lessons learned, the participants committed to jointly developing the practice guidelines for the GMS. The participants agreed that ADB would lead the writing process through a series of writing group meetings and peer review consultations.

³¹ Organized by ADB.

Two writing group meetings were held on 18 June³² and 22 October 2008³³ in Bangkok, Thailand to develop the first draft of the practice guidelines. A draft document was presented for peer review to a broad range of stakeholders during the *2nd GMS Workshop for HIV Prevention and the Infrastructure Sector* held on 24–26 November 2008 in Bangkok, Thailand, where the main sections of the document were agreed upon. Based on this, ADB drafted a core M&E framework that was reviewed by regional specialists on 1 April 2009³⁴ in Bangkok, Thailand and through subsequent communication.

The final, consolidated version of the practice guidelines was circulated to development partners for final review and endorsement in October 2009.

The practice guidelines are divided into four sections:

- (i) core principles,
- (ii) basic elements of an HIV prevention package,
- (iii) core monitoring and evaluation framework, and
- (iv) implementation and funding arrangements.

Section A: Core Principles

While there is no standardized blueprint or prescription that is applicable in every setting, key stakeholders in the GMS agreed on a number of core principles that can guide development partners and national authorities to optimize roles and relationships in relation to HIV prevention and risk mitigation in the infrastructure sector.

1. Support the “Three Ones” principles: one agreed HIV/AIDS action framework, one national HIV/AIDS coordinating authority, and one agreed country-level monitoring and evaluation system.

³² Participants were from International Organization for Migration, UNDP, and UN Educational, Scientific and Cultural Organization (UNESCO).

³³ Participants were from ADB, the Australian Agency for International Development, the United States Agency for International Development (USAID), International Labor Organization (ILO), and the United Nations Regional Task Force on Mobility and HIV Vulnerability Reduction (UNRTF).

³⁴ Participants were from International Organization for Migration, Family Health International, Mahidol University, Southeast Asia Regional Cooperation in Human Development, UNESCO, UNRTF, and USAID.

2. Follow the key principles of the ILO Code of Practice on HIV/AIDS and the World of Work (Appendix 4).
3. Consider international, regional, national, and local policies and commitments relevant to HIV prevention in the infrastructure sector.
4. Use an evidence-informed approach in developing project designs based on technically sound social, cultural, behavioral, and biological research about the underlying dynamics that generate HIV vulnerability and the factors that undermine or boost the provision and use of HIV services.
5. Build community resilience through capacity building initiatives at pre-, during, and post-construction stages.
6. Ensure community participation at all stages of the project (design, implementation, monitoring and evaluation, and post-construction), especially among women, migrant and mobile populations, and people living with HIV (where appropriate).
7. Emphasize “safe mobility” messages in information, education, and communication activities.
8. Ensure the rights of the construction worker to employment, protection from discrimination, and a healthy work environment.
9. Ensure HIV-related stigma and discrimination is addressed in the infrastructure settings and affected communities.
10. Promote a gender-responsive, culturally and linguistically appropriate, and socially inclusive approach.
11. Address other relevant health and social issues affecting the construction workforce and local communities (e.g., malaria, road safety, human trafficking, and child labor).

12. Guide the workplace response with a view to solidarity, care, and support of workers infected and affected by HIV.

Section B: Basic Elements of an HIV Prevention Package

The basic elements of an HIV prevention package have been developed based on the collective experience of agencies, governments, and practitioners. When designing every HIV prevention and mitigation intervention associated with infrastructure projects, the following issues, strategies, and actions should be considered. Each element should be analyzed for relevance, sensitivity, and applicability based on the unique local context of each proposed project area and affected community, then adopted accordingly.

A. Advocacy and Capacity Building

Awareness and institutional capacity should be raised to prevent and/or mitigate the spread of HIV and other health and social impacts (e.g., malaria, human trafficking, etc.) to ensure stakeholders' sustained commitment and participation. The following guidelines may be considered:

1. Conducting HIV prevention advocacy activities targeting:
 - a. the construction workforce, management, consultants, contractors, subcontractors;
 - b. provincial and district government authorities (e.g., immigration, customs, and border police if in cross-border areas);
 - c. local community leaders;
 - d. surrounding community, especially young women;
 - e. local public and private health providers and pharmacies;
 - f. commercial and entertainment establishment owners and controllers.
2. Consulting with the designated government authority for coordinating HIV/AIDS initiatives within the infrastructure project, especially at provincial and district levels.

3. Promoting capacity building and coordination among national AIDS authorities, line ministries for the infrastructure sectors, especially in provinces and districts.
4. Assessing and addressing the capacity of local health providers for HIV and STI prevention, advocacy, counseling, diagnosis and treatment, including for migrant, mobile, and ethnic minority populations.
5. Ensuring that protocols on HIV and STI voluntary confidential counseling and testing, treatment, and care, and support are available and aligned with national and internationally agreed guidelines, including for migrant and mobile populations.
6. Ensuring the availability of condoms, STI diagnostic tools, and drug treatments in project-affected districts.
7. Advocating the inclusion of HIV vulnerabilities associated with infrastructure development and cross-border areas within HIV surveillance systems.
8. Ensuring that pre- and post-construction activities are also considered in the project design to build local community resilience and government capacity to address HIV vulnerabilities and other negative social impacts of the infrastructure development in a sustainable way.
9. Strengthening cross-border cooperation and unified regional approaches for prevention and risk mitigation for HIV and other health and social impacts, including the promotion of access to HIV-related treatment and health care services (if the project is near a cross-border area).
10. Developing HIV/AIDS policies in the construction workplace, which include preventing HIV screening for employment, ensuring confidentiality of medical records and medical status, provision of a non-discriminatory work environment, and promotion of workers' rights to continued employment if tested positive for HIV and other STIs.³⁵

³⁵ For a list of ILO's essential components of a workplace policy, refer to Appendix 4.

11. Integrating HIV prevention and other relevant issues into any existing occupational health and safety program of construction consultants, contractors, subcontractors, and workplace committees.
12. Linking with the resettlement and social development teams of infrastructure projects to implement HIV and human trafficking prevention activities, as well as road safety (where appropriate).
13. Collaborating and/or supporting agencies and/or organizations that work on crosscutting issues, such as human trafficking and safe migration.
14. Ensuring that Greater Involvement of People living with or affected by HIV/AIDS (GIPA) is observed in designing the interventions and in the delivery of HIV education.

B. Core HIV/AIDS Services

Awareness on HIV and other identified health and social issues should be raised, positive behavior changes promoted, and quality, user-friendly, gender-responsive, and linguistically appropriate health services and commodities should be made available to the construction workforce, local communities, and entertainment workers. Consider adopting a “settings approach” focusing on interactions between various subgroups rather than isolated targeting of vulnerable groups.

1. Construction Setting

- a. *Awareness and Behavior Change*
 - i. Developing, customizing, and using information, education, and communication (IEC) materials and behavior change communication (BCC) methods tailored to the different sets of opportunities, vulnerabilities, and high-risk behaviors of different construction personnel, such as managers, consultants, and office staff; field supervisors and foremen; skilled and unskilled construction workers;

transport workers (e.g., mechanics, truck drivers, and auxiliary workers); and construction camp laborers (e.g., cooks, cleaners, security, etc.);

- ii. Consider including HIV prevention campaigns in the workplace, and health and safety programs as well as in-site induction training, if they exist;
- iii. Ensuring that IEC materials and BCC methods are gender responsive, culturally and linguistically appropriate (especially when foreign construction workers are present), developed and tested through stakeholder participation, designed to consider different literacy and education levels, and address key social drivers of the local HIV/AIDS epidemic;
- iv. Ensuring that advocacy and BCC campaigns in the construction sites and camps are conducted at an appropriate time for men and women to attend, considering the different roles, responsibilities, and work schedules. Consider separate sessions for males and females; and
- v. Conducting capacity building workshops and providing ongoing technical support to staff responsible for occupational health and safety, including those employed by the supervision consultants, contractors, subcontractors, and workplace committees.

b. *Condom Availability and Distribution*

- i. Facilitating sustained risk-reduction activities, including social marketing, by ensuring that high-quality condoms are readily available and accessible at the construction site and to the construction workforce free of charge.

c. *Sexual and Reproductive Health Services*

- i. Conducting capacity building workshops for public and private health service providers near the construction sites and camps to ensure provision of integrated sexual and reproductive health services (including for HIV and STI) that are gender-responsive, respect

client confidentiality, avoid coercive and mandatory approaches (such as HIV screening for employment), and are available to accommodate the work hours of the construction workers; and

- ii. Ensuring that voluntary and confidential counseling and testing services are promoted for HIV and other STIs and a confidential referral system is established throughout the construction period in or near construction sites.

2. Community Setting

a. *Awareness and Behavior Change*

- i. Developing and customizing IEC materials and BCC methods appropriate for the different local communities affected by the infrastructure project that are gender responsive, and culturally and linguistically appropriate (especially among ethnic minority populations);
- ii. Implementing the BCC activities using a participatory approach involving the community (including people living with HIV, if appropriate);
- iii. Promoting evidence-informed safe migration and anti-trafficking messages especially targeting young women; and addressing key social drivers of the local HIV/AIDS epidemic; and
- iv. Ensuring that separate education and training sessions are conducted for males and females taking into account the harvest season, seasonal migration patterns, and difference in women's roles, responsibilities, and work schedules.

b. Condom Social Marketing

- i. Ensuring that quality and affordable condoms are available and easily accessible in the community during and after the construction period through social marketing and/or mobilization of local resources (e.g., community health volunteers).

c. Sexual and Reproductive Health Services

- i. Conducting capacity building workshops for public and private health and pharmacy workers in affected communities to provide integrated sexual and reproductive health services (including STI diagnosis and treatment) that are gender-responsive, age-specific, respect client confidentiality, and address the needs of migrant, mobile, and ethnic minority populations; and
- ii. Ensuring that voluntary and confidential HIV counseling and testing services are promoted and a confidential referral system is available or established throughout the construction period and sustained in the post-construction phase.

3. Entertainment Setting

a. Awareness and Behavior Change

- i. Developing and customizing IEC materials and BCC methods appropriate for the different entertainment settings that recognize the social and geographic diversity of sex work, the rapid changes that may occur in patterns of sex work (including transactional sex) and in various sex work settings,³⁶ such as casinos in border towns and special economic zones; semi-urban towns with motels, karaoke

³⁶ UNAIDS. 2009. *UNAIDS Guidance Note on HIV and Sex Work*. Geneva.

bars, and beer shops; roadside establishments and truck stops; and mobile or temporary entertainment settings that develop near construction camps;

- ii. Ensuring that IEC materials and BCC campaigns are gender responsive, including transgender sex workers, culturally and linguistically appropriate for migrant and foreign sex workers; developed and tested with the engagement of service providers, clients, and managers of entertainment establishments; consider different literacy and education levels; and address key social drivers of the local HIV/AIDS epidemic; and
- iii. Ensuring that IEC and BCC sessions in the entertainment settings are conducted at an appropriate time for managers and workers that takes into account their work schedules.

b. Availability and Distribution of Commodities

- i. Ensuring that sex and entertainment workers and their clients have reliable and affordable access to commodities, including high-quality condoms and water-based lubricants either free or at low cost in the entertainment establishment.

c. Sexual and Reproductive Health Services

- i. Ensure access and availability of integrated sexual and reproductive health services (including for HIV and STI) near the entertainment settings;
- ii. Conducting capacity building workshops for public and private health service providers in the delivery of services that respect gender and client confidentiality, avoid coercive and mandatory approaches (such as mandatory medical treatment or procedures,

forced rehabilitation or programs implemented by police or based on detention),³⁷ and address the needs of migrant sex workers;

- iii. Ensuring access to regular STI diagnosis and case management, voluntary and confidential HIV counseling and testing services, and a confidential referral system for those who test positive for HIV and who are victims of trafficking and commercial sexual exploitation; and
- iv. Ensuring that service hours and delivery strategies are flexible to meet the needs of entertainment workers.³⁸

C. Research, Monitoring, and Evaluation

With the involvement of the National AIDS Authority and local communities, an effective monitoring and evaluation program will be developed through:

1. Establishing an M&E steering committee that involves the national, provincial, and/or district AIDS committees, local community leaders, construction management, etc.
2. Ensuring that the output-level M&E indicators developed inform, and are informed by, national M&E frameworks.
3. Training selected community leaders and local government staff in participatory learning and action (PLA) skills to conduct regular, technically sound rapid analyses of the impact of infrastructure development on their respective communities at pre-, during, and post-construction stages and use the data for targeting future interventions.

³⁷ For a list of ILO's essential components of a workplace policy, refer to Appendix 4.

³⁸ For a list of ILO's essential components of a workplace policy, refer to Appendix 4.

4. Ensuring that baseline studies are conducted with the participation of the construction workforce and local communities, and collected data are disaggregated by sex, age, ethnicity, and legal status.
4. Conducting ethnographic research in project areas affecting ethnic minority populations.
5. Conducting mid- and end-of-project workshops among key stakeholders to discuss lessons and recommendations to allow for midterm remedial measures and improved strategies for future HIV prevention programs.

Section C: Core Monitoring and Evaluation Framework

The core M&E framework is central to the practice guidelines. It serves to monitor and assess the implementation and impact of a harmonized approach to HIV prevention in the infrastructure sector. It also addresses one of the major challenges facing governments, development partners, civil society, and practitioners in the current response, which is the lack of monitoring (and surveillance) data relating to HIV/AIDS and mobility. At national- and project-level, there is a lack of systematic data collection on risk behaviors and vulnerabilities of people on the move and those with whom they interact.

Four outcome-level M&E indicators have been identified as the basic benchmark for assessing HIV prevention efforts in infrastructure projects (Table 1). These indicators are based on global M&E commitments of the United Nations General Assembly Special Session on HIV/AIDS (UNGASS), which can contribute to, or inform, each country's UNGASS *Country Progress Report*.³⁹

It is imperative that preliminary data gathering and analyses are done before developing project-specific M&E frameworks through (i) baseline mapping using national census and/or demographic data; and (ii) baseline surveys on knowledge, attitude, beliefs, and practices at project areas. This ensures that projects are based

³⁹ UNAIDS. 2009. *Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on Construction of Core Indicators (2010 Reporting)*. Geneva.

Table 1. Core Monitoring and Evaluation Indicators

Setting	Indicators	Data Collection Frequency	Method of Data Collection
Construction Setting	Male construction workers and managers who reported condom use the last time they had sex with a female sex worker Percentage of male construction workers and managers aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse	Every 6 months	Special survey
Local Communities	Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse*	Annual	Special survey
Entertainment Setting	Percentage of female and male sex workers reporting the use of a condom with their most recent client	Every 6 months	Special survey

* Millennium Development Goals indicator.

on a deep understanding of the social drivers of the local HIV epidemics and would allow for future assessments that can measure a program's outcomes.

Section D: Implementation and Funding Arrangements⁴⁰

Over the years, varying implementation and funding arrangements have been used for HIV prevention and mitigation in infrastructure projects, influenced mainly by two factors: (i) the line ministry that is ultimately responsible for addressing HIV issues in the infrastructure sector, and (ii) the type of funding available and acceptable. Based on a multisectoral approach against the AIDS epidemic, development partners should discuss with government the possibility of assigning

⁴⁰ Adapted from Module 3 of the following publication: ADB. 2007. *ADB, Roads and HIV/AIDS: A Resource Book for the Transport Sector*. Manila.

the respective infrastructure line ministry the responsibility for addressing HIV vulnerabilities associated with its sector.

Two types of implementation and funding arrangements have been identified as key options for responding to varying structural and contextual settings. These are presented in Table 2.

Table 2. Options for Implementation and Funding Arrangements

Model	Type of Project	Executing Agency	Type of Funding
A	Infrastructure Line Ministry		
	A.1. Main or integrated component of transport project	Infrastructure line ministry	Project funds (loan or grant) or government subsidy
	A.2. Separate grant component added on to the transport project	Infrastructure line ministry	Grant
B	Ministry of Health (or National AIDS Authority)		
	Stand-alone project	Ministry of Health (or National AIDS Authority)	Grant

AIDS = acquired immune deficiency syndrome.

Model A: Infrastructure Ministry – Executing Agency

Model A is possible if the government strongly supports and implements a multi-sectoral, programmatic approach to HIV prevention. This means that non-health line ministries are responsible for addressing HIV issues in their respective sectoral work, with support from the National AIDS Authority. The infrastructure line ministry will ensure that projects in the sector are not facilitating or contributing to the spread of HIV by arranging adequate prevention and mitigation measures.

Over the years, several infrastructure line ministries in the Greater Mekong Sub-region (GMS) have demonstrated strong leadership on HIV advocacy, prevention, and mitigation in these sectors. The ministries of public works and transport in Cambodia and the Lao People’s Democratic Republic (Lao PDR), and the Ministry

of Transport in Viet Nam are some of the region's champions for mainstreaming HIV prevention in the infrastructure sector. These ministries have established their own HIV/AIDS committees and developed, or are in the process of developing, HIV/AIDS strategies and action plans. They have designated specific departments and/or units to be responsible for HIV issues, along with other social development issues, such as resettlement. However, the ministries recognize that these departments and/or units need to be strengthened in terms of technical capacity, human resources, and funding.

There is ongoing debate on whether HIV interventions in infrastructure projects should be financed using project loan funds or funded through grants. This was discussed at length during the High-Level Meeting on Mobility, AIDS, and Infrastructure at the 8th International Congress on AIDS in Asia and the Pacific.⁴¹ While some development partners would like to see governments subsidizing the HIV initiatives as a demonstration of their political commitment, some infrastructure line ministries express the view that development partners should instead fund HIV prevention initiatives through separate grants as part of a comprehensive development assistance package. Dialogue between development partners and government partners on this issue is ongoing.

The key issues to consider for Model A include:

- Support sustained programmatic approaches to complement stand-alone HIV interventions that exist only in conjunction with a specific infrastructure project. Technical support and capacity building for key stakeholders in infrastructure and health ministries will increase the potential for sustainability.
- Ensure that adequate funding is earmarked for HIV prevention activities throughout the duration of the infrastructure project, considering that some arrangements may be subject to government tax (e.g., HIV prevention programs that are placed under the construction contractor's contract).

⁴¹ The Joint Initiative videoconferences are organized by the World Bank. Content of the videoconferences are available at: www.worldbank.org

- Collaborate with local health providers and a multisectoral HIV/AIDS committee, where they exist (particularly at the local provincial or district level), in planning, implementation, and M&E.

Model B: Ministry of Health (or National AIDS Authority) – Executing Agency

Model B is appropriate if the government—after thoroughly discussing alternate options with the development partners—decides that the Ministry of Health (or National AIDS Authority) should be the executing agency of the HIV intervention in the proposed infrastructure project. This means that the Ministry of Health (or National AIDS Authority) will have the lead responsibility for designing, implementing, and monitoring all HIV activities associated with the infrastructure project. Although the government may provide counterpart funding, development partners will most likely have to provide grant funding for the HIV component.

A key issue to consider for Model B is ensuring the involvement of infrastructure line ministries. There is a risk that non-health line ministries will regard HIV as just a health issue—unrelated to their sectoral work. Thus, the Ministry of Health will need the commitment and collaboration of the infrastructure line ministry to ensure that (i) the HIV project design fits the unique demands and context of the construction setting; and (ii) road project consultants, contractors, and subcontractors fully support and cooperate with the HIV program (e.g., allowing the workforce to attend HIV awareness sessions and peer education training).

Key Recommendations

Based on a 2007 assessment of HIV prevention activities associated with GMS infrastructure projects, key lessons and recommendations were identified that include the following:

- **Integrate HIV prevention into the contractor’s occupational health and safety program.** In countries that require an occupational health and safety (OHS) program in association with infrastructure projects, HIV-prevention messages could be integrated into the OHS program.

- **Partner with specialized agencies.** If social development issues apart from HIV (such as illicit drug use and human trafficking) are identified as important in the project area, implementation arrangements should allow for subcontracting specialized agencies that can address these issues competently and comprehensively.
- **Responsive implementation schedules.** HIV prevention activities need to be adapted to peak construction periods and when construction activities subside (such as in the rainy season) as the number and types of construction workers will vary accordingly. It should consider turnover of workers and ensure coverage of new recruits. It should also consider the unique work schedules of male and female construction workers at the construction sites and camps.⁴²

⁴² ADB. 2007. *HIV & Infrastructure: ADB Experience*. Manila.

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Appendix 1

HIV/AIDS Situation in the Greater Mekong Subregion¹

Cambodia. About 64,750 people in Cambodia were living with HIV in 2007, out of whom 3,350 were children under the age of 15.² The total number of people living with HIV who received antiretroviral therapy has more than doubled from 12,247 in December 2005 to 25,353 in September 2007. The adult national HIV prevalence decreased to 0.9% in 2006 from 1.2% in 2003 following the successful implementation of the 100% Condom Use Programme and extensive information campaigns on condom use and HIV transmission risks targeting sex workers and their clients.³ In 2006, among the total number of people living with HIV, 52% were estimated to be women compared to 37% in 1998.⁴ In 2005, the Joint United Nations Programme on HIV/AIDS (UNAIDS) reported that married women accounted for almost half of new infections. The sex trade has driven the HIV epidemic in Cambodia and female sex workers remain one of the most at-risk groups of HIV infection, despite a significant decrease of the HIV prevalence among this group from 21.4% in 2003 to 12.7% in 2006.⁵

Lao People's Democratic Republic (Lao PDR). In June 2007, the official cumulative number of registered HIV infections reached 2,400, of whom 1,523 were known to be AIDS cases and 775 had died of AIDS. Reportedly, 85% of such infections were transmitted through heterosexual contact. By the end of 2007, an estimated 700 people received antiretroviral therapy, which represents 60% of those in need, compared to 300 in 2005. While the HIV prevalence has remained low in the Lao PDR at 0.1%, HIV infections among the most vulnerable groups, including sex workers and their clients, and men who have sex with men (MSM), are on the

¹ There are excerpts taken from the publication: United Nations Regional Task Force on Mobility and HIV Vulnerability Reduction and Association of Southeast Asian Nations. 2008. *HIV/AIDS & Mobility in South-East Asia: Rapid Assessment*. Bangkok: S. Asia Press.

² United Nations General Assembly Special Session on HIV/AIDS (UNGASS). 2008. *Country Progress Report for Cambodia (Reporting period January 2006–December 2007)*. National AIDS Authority, Kingdom of Cambodia.

³ Annual reports for 2005 and 2006 and Third Comprehensive Quarterly Report 2007 from the National Centre for HIV/AIDS, Dermatology and STDs in Phnom Penh.

⁴ UNAIDS. 2006. *Overview of the Global AIDS Epidemic for 2006*. Geneva.

⁵ United Nations Regional Task Force on Mobility and HIV Vulnerability Reduction (UNRTF). 2006. *Regional Strategy on Mobility and HIV Vulnerability Reduction in South-East Asia and Southern China (2006-2008)*. Bangkok.

rise.⁶ In 2004, 2.2% of tested sex workers were HIV positive, compared to 0.9% in 2001. In addition, a recent survey on HIV infections among MSM in Vientiane has shown that 5.6% tested HIV positive and that 43% of them also had a female sex partner in the last three months.⁷ The National Committee for the Control of AIDS of the Lao PDR recently reported that more than half of registered people living with HIV/AIDS in the country were either migrant workers or farmers working outside of the country (especially in Thailand) and their partners.⁸

Myanmar. In 2007, an estimated 240,000 people were living with HIV in Myanmar, with the national HIV prevalence at 0.7% that year.⁹ Myanmar's eastern provinces remain the most affected by HIV. Recent national responses to the epidemic have led to a decline in HIV infection rates among pregnant women (prevalence of 1.8% in 2004, down from 2.2% in 2000), but infection rates among other groups, including female sex workers (FSWs) and injecting drug users (IDUs), are still high and rising.¹⁰ In 2003, HIV infection rates among IDUs tested ranged from 50% to 85% in Yangon and Mandalay. From 1992 to 2003, HIV infection rates among sex workers rose to 31% from 5%.¹¹ In 2004, one in four FSWs were infected with HIV as were one in three IDUs.¹² AIDS-related deaths were estimated at 24,000 in 2007.¹³ According to latest estimates, primary modes of transmission are heterosexual contact (65%), injecting drug use (26%), and contaminated blood (5%).¹⁴ Treatment, care, and support services still fall short of needs, with less than 10% of AIDS patients receiving antiretroviral treatment. The high incidence of unsafe injecting drug use and unprotected sex along

⁶ UNGASS. 2008. *Country Progress Report, Lao PDR (Reporting period January 2006–December 2007)*. National Committee for the Control of AIDS.

⁷ Data from the Centre for HIV/AIDS/STI: Second Generation Surveillance Round 1 and 2.

⁸ The National Committee for the Control of AIDS. 2005. *National Strategic and Action Plan on HIV/AIDS/STI (2006-2010)*. Vientiane.

⁹ World Health Organization (WHO), UNAIDS, and United Nations Children's Fund (UNICEF). 2008. *Epidemiological Fact Sheet on HIV and AIDS for Myanmar (2008 Update)*. Geneva.

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¹¹ WHO. 2005. *Summary Country Profile for HIV/AIDS Treatment Scale Up*. Myanmar. p.1.

¹² Joint Summit Declaration from the Third GMS Summit entitled *Enhancing Competitiveness through Greater Connectivity*, held in Vientiane, Lao PDR on 30–31 March 2008.

¹³ WHO, UNAIDS, and UNICEF. 2008. *Epidemiological Fact Sheet on HIV and AIDS for Myanmar (2008 Update)*. Geneva.

¹⁴ UNAIDS/WHO. 2006. *Epidemiological Fact Sheet on HIV/AIDS and Sexually Transmitted Infections for Myanmar*. Geneva.

well-established internal migratory routes has contributed to the HIV epidemic's expansion in Myanmar.¹⁵

People's Republic of China (Yunnan and Guangxi). The national HIV prevalence of the People's Republic of China is 0.1%, with most HIV Infections being reported in Henan, Guangdong, Xinjiang, Guangxi, and Yunnan provinces. The HIV epidemic is mostly driven by the overlap of injecting drug use and sex work. In rural parts of **Guangxi** province, a study begun in 2002 found an annual average of 3.1% HIV incidence rate (new HIV infections per year) among IDUs studied. As HIV enters injecting drug user networks, it tends to spread rapidly. In **Yunnan**, where the use of contaminated drug injecting equipment is still the main mode of HIV transmission, IDU is the key factor associated with HIV infection among sex workers.¹⁶

Thailand. The implementation of national strategic HIV interventions in Thailand since the late 1990s, including the 100% Condom Programme and the increased provision of care and treatment services for people living with HIV/AIDS, has led to a decline in HIV infection rates in Thailand. Estimates of the number of new infections for 2007 reached 13,936 and are projected to decline to 10,097 by 2011, which would result in the decline of the total cumulative number of people living with HIV/AIDS from 546,578 in 2007 to 481,770 by 2011. In 2007, 52.9% of reported adults and children with advanced HIV infection received antiretroviral therapy compared to 41% in 2006.¹⁷ Despite encouraging efforts that reduced new HIV infections, the country still faces a generalized epidemic with a 1.4% HIV prevalence. New HIV infection patterns, especially among women in stable relationships who are infected by their long-term partners or their sexual partners, have been of concern. In 2005, an estimated 37% of women newly infected with HIV contracted HIV through sexual contact with their male partner, 80% of whom acquired HIV through paid sex.¹⁸ In addition, a 2007 survey of the Bureau of Epidemiology showed a high HIV prevalence among MSM, reaching 24.6%.

¹⁵ Ministry of Health. 2007. *National Strategic Plan on HIV and AIDS, Operational Plan, April 2006–March 2009*. Yangon.

¹⁶ WHO, UNAIDS and UNICEF. 2008. *Epidemiological Fact Sheet on HIV and AIDS for Myanmar (2008 Update)*. Geneva.

¹⁷ UNGASS. 2008. *Country Progress Report for Thailand (Reporting period January 2006–December 2007)*. National AIDS Prevention and Alleviation Committee.

¹⁸ UNAIDS. 2007. *AIDS Epidemic Update: Asia Regional Summary*. Geneva.

In Bangkok, a recent survey has shown an increase in HIV infections among MSM from 18.9% in 2005 to 27% in 2007. Injecting drug use and the sharing of injecting equipment also remains a source of concern with an estimated 27.8% of IDUs being HIV positive in 2006.¹⁹

Viet Nam. It is estimated that there were 293,000 people living with HIV in Viet Nam in 2007. The national HIV prevalence among the general population is estimated at 0.53%. Cumulative reported data has indicated that there were 132,628 HIV infection cases; 26,828 AIDS cases; and 15,007 deaths due to AIDS as of 31 August 2007. Out of all reported HIV infection cases, 78.9% are in the 20–39 age group and 85.2% were among men. There are concerns that HIV infections among young people are on the rise as well as HIV transmission through heterosexual contact. Viet Nam currently experiences a concentrated epidemic with at-risk populations including IDUs, FSWs, and MSM. The national HIV prevalence among IDUs has been estimated at 28.6% and at 4.4% for FSWs. In 2006, the HIV prevalence among MSM was 9.4% in Hanoi and 5.3% in Ho Chi Minh City. Studies show that IDUs have engaged in unprotected sex with different partners, including FSWs. Unprotected sex between IDUs and FSWs reached 55% in An Giang and 54.8% in Ho Chi Minh City. The rate of condom use between street FSWs and their clients was low at 37%, and condom use among MSM remains also low. There are concerns on the high rate of FSWs injecting drugs. The Ministry of Health of Viet Nam has estimated that 72,970 people living with HIV will need to receive antiretroviral treatment by 2010.²⁰

¹⁹ Yang, X. and G. Xia. 2006. Gender, Migration, Risky Sex and HIV Infection in China. *Studies in Family Planning*, 37 (4). pp. 241–250.

²⁰ UNGASS. 2008. *The Third Country Report on Following up the Implementation to the Declaration of Commitment on HIV/AIDS for the Socialist Republic of Viet Nam (Reporting period: January 2006–December 2007)*. Ministry of Health.

Appendix 2

Sample HIV and Infrastructure Initiatives in the Greater Mekong Subregion

Asian Development Bank

- **Baolong Healthy and Safe Action (BHSA) Project.** This project was designed as a stand-alone technical assistance project to help prevent the spread of HIV during the construction of the Baolong Highway, under the Asian Development Bank (ADB) Western Yunnan Roads Development Project in the People's Republic of China (PRC). The total cost of the road project was estimated at \$582 million, while the total budget for the HIV prevention program was \$1 million (0.17% of the road project cost). The BHSA project was executed by the provincial AIDS authority (Office of Yunnan Provincial Working Committee for HIV/AIDS Control) and implemented by an international nongovernment organization (NGO) (Marie Stopes International Australia/PRC) under a contract awarded by ADB. The BHSA project used an innovative approach that focuses on "settings" rather than the more narrowly defined "risk groups" usually described and targeted in HIV-focused interventions. The monitoring and evaluation (M&E) surveys showed that all groups had improved correct knowledge and beliefs about HIV; and in all groups, except unskilled workers, there was a decline in the number of commercial sex contacts. Similarly, all groups reported an increased use of condoms with commercial sex partners, except drivers and unskilled workers.¹
- **Northern Economic Corridor Project.** This transport project upgraded a 22-kilometer (km) road in the north-western area of Lao People's Democratic Republic, linking Thailand and the PRC. The project incorporated an awareness and prevention education program on HIV, illicit drug use and human trafficking as a stand-alone project component. The total cost of the road project was \$95.8 million, while the total budget of the HIV, illicit drug use and human trafficking component was \$340,459 (0.36%). The HIV, illicit

¹ ADB. 2003. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the People's Republic of China for the Western Yunnan Roads Development Project*. Manila.

drug use, and human trafficking component was executed by the Ministry of Public Works and Transport and implemented by a local nongovernment organization (Lao Red Cross). The groups targeted were local communities along Route 3, construction workers, service workers, and local businesses via tailored approaches using peer educators, group discussions, and support visits; establishing condom distribution networks; and providing appropriate and varied information, education, and communication (IEC) materials. The M&E surveys revealed that the beneficiaries' knowledge levels were high and their response to the effectiveness of project training and support activities was very positive.²

Japan International Cooperation Agency

- **Can Tho Bridge Construction Project.** The bridge project aims to link the Hau River connecting Can Tho City in Can Tho province to Binh Minh district in Vinh Long province in Viet Nam. An HIV/AIDS Program was incorporated to improve HIV/AIDS/Sexually Transmitted Infection (STI) awareness and promote behavior change among construction workers and surrounding communities. It received funding from the Yen Loan for \$150,000. It was implemented by CARE International from 2006 onwards. The project (i) increased the capacity of the contractor's health workers and associated health service providers, (ii) maintained various IEC channels in the construction site and in the surrounding neighborhoods to provide HIV/AIDS risk-reduction information to the target groups, (iii) developed a referral mechanism between the company and the community-based HIV/AIDS program and services, (iv) increased condom use availability—70.9% of the surveyed workers who reported having sex in the previous month admitted that project activities helped them have more access to condoms, and (v) provided construction workers with better knowledge about HIV/AIDS and its transmission ways.³
- **O Mon Thermal Power Project.** The project constructed a thermal power plant generating 300 megawatts of power located on the Mekong River

² ADB. 2007. *Northern Economic Corridor Project: Promoting HIV Prevention in the Lao PDR. A case study in HIV & Infrastructure: ADB Experience*. Manila.

³ Japan International Cooperation Agency. 2008. HIV/AIDS Prevention in JICA Financed Projects in Viet Nam (slide presentation). Presented at the 2nd Workshop on HIV Prevention and the Infrastructure Sector in the GMS. Bangkok. 24–26 November 2008.

18 kilometers upstream of Can Tho City in Viet Nam. An HIV/AIDS program was incorporated to improve HIV/AIDS/STI awareness and promote behavior change among construction workers, health care providers, community population, and commercial sex workers. It received funding from the Japan Trust Fund and the International Planned Parenthood Foundation for \$223,048. It was implemented by the Viet Nam Family Planning Association from June 2007 to March 2009. The project (i) conducted a Knowledge-Attitude-Behavior-Practice baseline survey; (ii) developed a set of IEC and training materials for peer motivators, club members, and target groups; (iii) established three intervention models on HIV/AIDS prevention that was integrated into the service provision for sexual reproductive health: Peer Motivator Team, Female Server Club, and Mobile Service Team; (iv) implemented behavior change communication (BCC) activities on HIV/AIDS/STIs targeting high risk groups; and (v) built up a good network and partnerships among stakeholders.⁴

The World Bank

- **Third Jiangxi Highway Project.** With funding from the Institutional Development Fund (IDF) Grant Program, the Jiangxi Center for Disease Control developed its first phase intervention scheme for the HIV/AIDS Education Program associated with the Third Jiangxi Highway Project in August 2007. The baseline survey results revealed that general HIV/AIDS awareness rates among construction personnel and villagers were very low, both less than 20%. After the intervention, general HIV/AIDS knowledge increased to about 50% for both these groups. Additionally, over 90% of construction workers report to using condoms while having nonmarital intercourse, which indicates an 80% plus increase over the baseline survey results. The AIDS Prevention and Control Plan, developed by the Jiangxi Provincial Communications Department as part of this project, describes how to implement HIV/AIDS education work focusing on these objectives from four aspects: (i) working principles and policy, (ii) using HIV education materials, (iii) optimizing working requirements

⁴ JICA. 2008. HIV/AIDS Prevention in JICA Financed Projects in Viet Nam (slide presentation). Presented at the 2nd Workshop on HIV Prevention and the Infrastructure Sector in the GMS. Bangkok. 24–26 November 2008.

and strategies, and (iv) establishing mechanisms and evaluation for safeguard protections.⁵

- **Hubei Shiman Expressway Project.** The HIV/AIDS education program under this project was the first AIDS intervention associated with a transport project in the PRC. The project, which began in 2005, was funded by a Global HIV/AIDS Grant of \$50,000. After nearly 3 years of implementation, this effort has demonstrated positive results in terms of raising awareness and generating positive behavior changes. This project resulted in an increase in HIV/AIDS awareness among construction workers and local residents by over 70% in 2005 and another 50% in 2006. This knowledge resulted in behavior change among target groups as indicated by an approximately 20% decrease in sexually transmitted disease cases from 2004–2005, and another 40% decrease in 2006.⁶

⁵ World Bank. 2008. *HIV/AIDS Activities in Transport: East Asia and Pacific Region (2007–2008)*. Washington, DC: World Bank.

⁶ WB. 2008. *HIV/AIDS Activities in Transport: East Asia and Pacific Region (2007–2008)*. Washington, DC: World Bank.

Appendix 3



Joint Initiative by Development Agencies for the Infrastructure Sectors to Mitigate the Spread of HIV/AIDS

August 11, 2006
Toronto, Canada

1. We six development agencies consisting of African Development Bank (AfDB), Asian Development Bank (ADB), UK Department for International Development (DFID), Japan Bank for International Cooperation (JBIC), KfW Entwicklungsbank (KfW development bank) and the World Bank ("the Development Agencies" collectively), have recognized the urgency for action in the infrastructure sectors to tackle the global HIV/AIDS crisis, have supported important interventions to deal with the problem, and propose to strengthen cooperation in order to increase the scale, scope and effectiveness of future infrastructure interventions for combating AIDS in developing countries.
2. In addition to supporting specific programs to combat AIDS, the Development Agencies have funded related interventions in other sectors including transport, energy, water, urban and rural development. In view of the success of such interventions, the Development Agencies propose to coordinate their activities in order to mainstream HIV/AIDS prevention and treatment programs in infrastructure sectors, to reduce the impacts of HIV/AIDS as a result of infrastructure interventions, to take opportunities for implementing further countermeasures against HIV/AIDS and to contribute to strengthening the HIV/AIDS strategies of partner countries.
3. The Development Agencies endorse the ILO Code of Practice for Addressing HIV/AIDS and are encouraging the recipients to incorporate HIV/AIDS programs into infrastructure support, especially where this involves (i) large-scale construction projects which mobilize many construction workers, service providers, and communities who could be vulnerable to HIV/AIDS, or (ii) increased transport activity which may facilitate the spread of HIV infection. HIV/AIDS mitigation clauses are included in the sample/standard bidding documents used for the large-scale civil works funded by the Development Agencies. Under these clauses contractors are required to take necessary measures to raise the awareness of construction workers and other employees of behavior to prevent HIV/AIDS transmission. The Development Agencies have also assisted HIV/AIDS programs for cross-border transport corridors in Africa and South East Asia regions.
4. This joint initiative to promote HIV/AIDS interventions in the infrastructure sectors acknowledges that there has not yet been a comprehensive assessment of the impact of these interventions. Greater sharing of information and lessons learned between the Development Agencies and partner countries is crucial for achieving better effectiveness and for scaling up successful experience by ensuring sustainability and replicability. Cooperation and harmonization with the national AIDS strategy, health system, other agencies and local activities including those of NGOs are important to avoid fragmentation of assistance.

5. Based on the above recognition and practical experience, the Development Agencies agree to take the following actions in this joint initiative, to:
- strengthen the framework for sharing experience of good practice in planning, implementation and scaling-up of HIV/AIDS interventions in infrastructure programs to improve their targeting, impact and sustainability;
 - ensure that interventions are consistent with each partner country's national strategy for combating HIV/AIDS;
 - encourage close cooperation and partnership between communities, local government and other authorities, related donors, NGOs, private enterprises and their employees;
 - carry out joint assessment of key interventions particularly from the viewpoint of the impact, sustainability and cost-effectiveness.
 - seek to scale up this initiative to other projects funded either by domestic or external sources as well as to encourage the partner country governments to incorporate good practice lessons into their own legal and administrative systems (such as regulations related to public investment, construction, transport, work place and labor environment) and into the partner countries' strategies for HIV/AIDS, health and infrastructure development.
6. The Development Agencies will welcome the participation of other development organizations in this joint initiative for enhancing partnership and effectiveness in fighting against HIV/AIDS through the infrastructure sectors.

For AfDB



Mandla S.V. Gantsho
Vice President, Operations III,
(Infrastructure and Regional
Integration)

For ADB



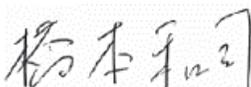
G.H.P.B. van der Linden,
Vice-President
Knowledge Management and
Sustainable Development

For DFID



Nemat Shafik
Director General,
Country Programmes

For JBIC



Kazushi Hashimoto
Director General,
Sector Strategy Development
Department

For KfW Entwicklungsbank



Dr. Wolfgang Bichmann
Chief Sector and Policy Division
Health

For World Bank



Katherine Sierra
Vice President, (Sustainable
Development Network)

Appendix 4

ILO Code of Practice on HIV/AIDS and the World of Work¹

Key Principles of the Code of Practice

4.1 Recognition of HIV/AIDS as a workplace issue

HIV/AIDS is a workplace issue, not only because it affects the workforce, but also because the workplace can play a vital role in limiting the spread and effects of the epidemic.

4.2 Non-discrimination

There should be no discrimination or stigmatization of workers on the basis of real or perceived HIV status.

4.3 Gender equality

More equal gender relations and the empowerment of women are vital to successfully preventing the spread of HIV infection and enabling women to cope with HIV/AIDS.

4.4 Healthy work environment

The work environment should be healthy and safe, and adapted to the state of health and capabilities of workers.

4.5 Social dialogue

A successful HIV/AIDS policy and programme requires cooperation and trust between employers, workers, and governments.

4.6 Screening for purposes of employment

HIV/AIDS screening should not be required of job applicants or persons in employment and testing for HIV should not be carried out at the workplace except as specified in this code.

¹ International Labour Organization. 2001. *An ILO Code of Practice on HIV/AIDS and the World of Work*. Geneva.

4.7 Confidentiality

Access to personal data relating to a worker's HIV status should be bound by the rules of confidentiality consistent with existing ILO codes of practice.

4.8 Continuing the employment relationship

HIV infection is not a cause for termination of employment. Persons with HIV-related illnesses should be able to work for as long as medically fit in appropriate conditions.

4.9 Prevention

The social partners are in a unique position to promote prevention efforts through information and education, and support changes in attitudes and behaviour.

4.10 Care and support

Solidarity, care and support should guide the response to AIDS at the workplace. All workers are entitled to affordable health services and to benefits from statutory and occupational schemes.

Practice Guidelines for Harmonizing HIV Prevention Initiatives in the Infrastructure Sector

Development partners have recognized the obligation to mitigate HIV risks associated with infrastructure development as an opportunity to contribute to the fight against HIV/AIDS and poverty in the Greater Mekong Subregion (GMS). With the support of GMS countries in the region, development partners can help fill the gaps in knowledge and expertise relating to HIV prevention in infrastructure development. This document explains the role of the infrastructure sector in the HIV response and why harmonization is needed. It also contains the practice guidelines in core principles, basic elements of an HIV prevention package, a core monitoring and evaluation framework, and implementation and funding arrangements.



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www.adb.org

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International Organization for Migration
www.iom.int

Japan International Cooperation Agency
www.jica.go.jp

Joint United Nations Initiative on Mobility and HIV/AIDS in South East Asia
www.junima.org

Swedish International Development Cooperation Agency
www.sida.se

International Organization for Migration
www.iom.int

United Nations Educational, Scientific and Cultural Organization
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World Bank
www.worldbank.org

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