Grant Assistance Report

Project Number: 46490-001
November 2013

Proposed Grant Assistance:
Myanmar: Greater Mekong Subregion (GMS) Capacity Building for HIV/AIDS Prevention
(Financed by the Japan Fund for Poverty Reduction)

Asian Development Bank

CURRENCY EQUIVALENTS
(as of 5 November 2013)

Currency Unit	–	kiat
K1.00	=	$0.001030
$1.00	=	K970.110

ABBREVIATIONS

ADB	–	Asian Development Bank
ART	–	anti-retroviral treatment
ARV	–	anti-retroviral (drugs)
BCC	–	behavioral change communication
CBO	–	community-based organization
DOH	–	Department of Health
EWEC	–	East-West Economic Corridor
GIM	–	Grant Implementation Manual
GMS	–	Greater Mekong Subregion
IEC	–	information, education, and communication
JFPR	–	Japan Fund for Poverty Reduction
JICA	–	Japan International Cooperation Agency
KAP	–	key affected population
LOA	–	letter of agreement
LDH	–	Loan Disbursement Handbook
M&E	–	monitoring and evaluation
M-HSCC	–	Myanmar Health Sector Coordinating Committee
MDG	–	Millennium Development Goal
MOH	–	Ministry of Health
MOU	–	memorandum of understanding
NAP	–	National AIDS Program
NGO	–	nongovernment organization
PIU	–	project implementation unit
PMTCT	–	prevention of mother-to-child transmission
PMU	–	project management unit
PSC	–	project steering committee
RHC	–	rural health clinic
STI	–	sexually transmitted infection
TA	–	technical assistance
THD	–	township health department
UNAIDS	–	Joint United Nations Programme on HIV/AIDS
VCCT	–	voluntary confidential counseling and testing

NOTES

(i) The fiscal year of the Government of Myanmar ends on 31 March.
(ii) In this report, “$” refers to US dollars.

Vice-President	S. Groff, Operations 2
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Team members	N. Calma, Senior Project Officer, SERD E. Gagnon, Principal Procurement Specialist, Operations Services and Financial Management Department A. Musa, Financial Management Specialist, SERD P. Rhee, Counsel, Office of the General Counsel

JAPAN FUND FOR POVERTY REDUCTION (JFPR)

JFPR GRANT PROPOSAL

I. Basic Data	
Name of Proposed Activity	**Greater Mekong Subregion (GMS): Capacity Building for HIV/AIDS Prevention Project**
Country	**Myanmar**
Grant Amount Requested	**$10,000,000**
Project Duration	**4 years**
Regional Grant	**○Yes / ⊙ No**
Grant Type	**⊙ Project / ○ Capacity building**

II. Grant Development Objectives and Expected Key Performance Indicators

Grant Development Objectives:

The grant development objective is to contribute towards achieving the Millennium Development Goal (MDG) targets by reversing/managing the spread of HIV/AIDS in Myanmar. The project will increase the coverage and quality of information and services (prevention, treatment, and care) for targeted populations along and near the economic corridors.

The development objective will be achieved by: (i) strengthened planning and management capacity at national, state or regional, and township levels; (ii) enhanced capacity to provide quality and accessible services; (iii) improved access to community outreach among target populations; and (iv) monitoring and project management.

Expected Key Performance Indicators:

(i) HIV prevalence of general population (15+) reduced from 0.5% in 2012 to 0.4% in 2020;
(ii) HIV prevalence of female sex workers reduced from 9.4% in 2012 to 7% in 2020;
(iii) use of condoms among target population increased by 80% by 2017;
(iv) prevention services to vulnerable populations increased by 50% between 2014 and 2017;
(v) five township plans developed and implementation commenced by 2015;
(vi) local referral system and delivery for target populations established and functional by 2016; and
(vii) studies and research conducted based on results of risk and vulnerability, including outcome-based evaluation, conducted by 2018.

III. Grant Categories of Expenditure, Amounts, and Percentage of Expenditures

Category	Amount of Grant Allocated in $	Percentage of Expenditures
1. Civil works	3,817,000	38.2
2. Equipment and supplies	1,505,000	15.1
3. Training, workshops, and seminars	717,000	7.2
4. Consulting services	2,015,000	20.2
5. Grant management	274,000	2.7
6. Other inputs (NGOs)	967,000	9.7
7. Contingencies	705,000	7.0
TOTAL	10,000,000	100.0
Incremental Cost	184,000	1.8

JAPAN FUND FOR POVERTY REDUCTION

JFPR Grant Proposal
Background Information

A. Other Data	
Date of Submission of Application	
Project Officer	Gerard Servais, Health Specialist
Project Officer's Division, E-mail, Phone	Human and Social Development Division (SEHS) gservais@adb.org Tel. 634-4431
Other Staff Who Will Need Access to Edit and/or Review the Report	Nida Calma, Senior Project Officer, SEHS Grace Cruz, Operations Analyst, SEHS
Sector	Health and social protection
Subsector	Health programs
Themes	Regional cooperation and integration; social development; capacity development; gender equity
Subthemes	Human development; other vulnerable groups; gender equity in (human) capabilities; institutional development; partnership development; civil society participation
Targeting Classification	Targeted Intervention – MDG
Was JFPR Seed Money used to prepare this grant proposal?	Yes [X] No [ ]
Have SRC comments been reflected in the proposal?	Yes [X] No [ ]
Name of Associated ADB-Financed Operation	Greater Mekong Subregion East-West Economic Corridor Eindu to Kawkareik Road Improvement
Executing Agency	Ministry of Health
Grant Implementing Agency	Department of Health/National AIDS Programme Ministry of Health Office No. 4, Nay Pyi Taw The Republic of the Union of Myanmar Tel. +95-67-421646 Fax. +95-67-421203

B. Details of the Proposed Grant

1. Description of Outputs, Monitorable Deliverables and/or Outcomes, and Implementation Timetable

Output 1	
Output Name	**Strengthened Planning and Management Capacity at National, State or Regional, and Township Levels**
Cost ($)	$ 1,092,000 (including contingencies)
Output Description	The activities under this output will focus on strengthening health systems to more effectively plan and manage the HIV/AIDS/STI response at national and local levels (i.e., state or region, district, and township), in particular, building local governments' capacity to identify and connect with national programs supporting anti-retroviral drugs (ARVs), prevention of mother-to-child transmission (PMTCT), tuberculosis control, and malaria treatment. Key activities under the output will include (i) assessment of needs and development of a strengthening plan; (ii) development of standard tools for planning and management at national and local levels; (iii) training of health staff in the use of planning and management tools based on the surveillance and monitoring data; and (iv) training for financial management, procurement, and disbursement at national and local levels.

Monitorable Deliverables/Outputs	By 2017: (i) Improved planning and management capacity at national, state or regional, and township levels (ii) Five township plans developed and implemented (iii) Training in financial management, supply-chain management, and monitoring and evaluation (M&E) delivered to 70% of staff (across all levels)
Implementation of Major Activities: Number of months for grant activities	(i) Commence international and national consultants services by Q1 2014 (ii) Prepare project implementation plan by Q2 2014 (iii) Conduct capacity assessment in three states and five townships on ability to manage effective local responses by Q2/2014 (iv) Complete capacity development plans at national, state or regional, and township level (v) Conduct training activities based on the capacity development plan for the target states and townships, including training in knowing the epidemic in their localities by Q2 2015 (vi) Conduct training at national and state or regional levels in program planning, project management, supply-chain management, and M&E by Q2 2015 (vii) Conduct training at national and state or regional levels in financial management, procurement, and disbursement by Q2 2016

Output 2	
Output Name	**Enhanced Capacity to Provide Quality and Accessible Services**
Cost ($)	$6,066,000 (including contingencies)
Output Description	This will improve the capacity of service providers to ensure the delivery of a continuum of services—including prevention, treatment, and care. In addition, it will support the expansion of coverage to underserviced populations through the government–nongovernment organization (NGO) partnerships for improved service delivery. The partnership arrangements will aim to ensure that effective HIV/AIDS/STI services are available and accessible to high-risk groups and populations that are vulnerable to HIV infection, including migrants and mobile populations. The project will support the enhancement of health facilities, including upgrades, refurbishment of township and station hospitals, and construction of new rural health centers and subcenters on government lands that are unencumbered (not used for residential, business, or productive purposes). Partnerships with international and local NGOs as service providers will improve the referral system across both public and private providers. The integrated services will be designed to reach high-risk groups and vulnerable populations that are difficult to reach under existing programs. Partnership arrangements shall be established at the local level to improve government management of service delivery.
Monitorable Deliverables/Outputs	Enhanced capacity to provide quality and access to services at the township level, including: (i) The number of trained health service providers deployed in project areas increased by 30% by Q4 2017 (ii) The number of patient consultations in townships/village health centers/facilities increased by 80% by Q4 2017 (iii) The number of health centers in project areas providing a continuum of services, including prevention, treatment, and care, increased by 90% by Q4 2017 (iv) Referral system to ensure the provision of health services for target populations established and functional by Q1 2016
Implementation of Major Activities: Number of months for grant activities	(i) Provide training for HIV and STI services in selected health facilities included in five locations by end Q2 2014 (ii) Provide supplies, commodities, and testing materials, and associated training, to strengthen treatment in selected health facilities included in agreed pilot management models in five locations by Q2 2014

	(iii) Procure medical equipment for township and rural health facilities by end Q4 2014; plan and complete civil works for upgrade of facilities by Q2 2017 (iv) Sign service agreements (covering integrated services across outputs 2 and 3) between the DOH and NGOs/private providers for provision of prevention and education, counseling, testing, treatment, and care services to operate under agreed pilot management models by end Q4 2014 (v) Establish referral systems and service coordination mechanisms between community-based facilities and township hospitals within Myanmar and across borders to ensure the provision of health services, including HIV, STI, malaria, and other health concerns for key affected populations, including returnees by Q2 2015

Output 3	
Output Name	**Improved Access to Community-Outreach Among Target Populations**
Cost ($)	$1,103,000 (including contingencies)
Output Description	The key activity is to support delivery of outreach services to initiate and sustain changes in behavior to reduce the incidences of HIV and other health risks, including STIs, tuberculosis, and malaria, in the key affected local groups and communities along the economic corridors and in cross-border areas. Contextually specific interventions will be developed to show high-risk and vulnerable populations, including migrants and mobile populations in remote and border districts, how to reduce their own HIV risks. Key activities will include awareness-raising and behavioral change interventions in partnership with local NGOs and community-based organizations (CBOs) and strengthening of the local planning and implementing of community-based outreach activities for those target populations. Systems for referrals to social welfare agencies for post-treatment counseling and care will be developed and implemented.
Monitorable Deliverables/Outputs	(i) At least 70% of peer educators, health workers, and community volunteers in project areas completed new upgrade training for community outreach by end Q2 2017 (50% of those trained are female) (ii) Information, education, and communication (IEC)/ behavioral change communication (BCC) approaches and tools that are sensitive to cultural, linguistic, ethnic, gender, and religious backgrounds developed and ready for distribution to the targeted populations by Q3 2015 (iii) Functional system for referrals to social welfare agencies for post-treatment counseling and care developed and established by 2015 (iv) Community-outreach programs for consciousness-raising and behavioral change developed and commenced with NGOs/CBOs in targeted townships in or before Q3 2015
Implementation of Major Activities: Number of months for grant activities	(i) Develop an enhanced process for condom distributions by Q4 2014 (ii) Conduct a participatory consultation and training process to involve health staff (e.g., midwives, township medical officers, community health workers) in improving delivery of awareness raising activities by end Q3 2014 (iii) Implement awareness programs through a community outreach program in partnership with local NGOs/CBOs in target communities by end Q4 2017 (iv) Develop appropriate IEC materials for ethnic communities and migrants and mobile populations by end Q3 2015 (v) Develop and establish functional system for referrals to social welfare agencies for post-treatment counseling and care by end Q3 2015

Output 4	
Output Name	**Monitoring and Project Management**
Cost ($)	$1,739,000 (including contingencies)
Output Description	This output will (i) contribute to the ongoing mapping and understanding of the

	geographical distribution of risk in the proposed project areas, specifically through operational research on the risk and vulnerabilities of migrant and mobile populations to HIV infections; (ii) develop a project performance and management system to be applied throughout the project's duration (baseline and endterm) that is linked with the existing national M&E framework; (iii) assess midterm and transition implementation and make recommendations for continuing project implementation; (iv) design and implement an impact evaluation study to assess the project's overall impact; and (v) support project monitoring and evaluation activities and project management.
Monitorable Deliverables/Outputs	Project Monitoring: (i) Project management unit (PMU) fully staffed and operational (ii) Project monitoring and evaluation system and baseline data in place within first 6 months of implementation (iii) Comprehensive monitoring reports submitted on time (iv) Quarterly progress report prepared and submitted (v) Exit strategy prepared and implemented successfully (vi) Midterm and completion reports prepared (vii) Annual audits conducted Monitoring and Evaluation: (i) Baseline vulnerability assessments conducted in all project areas by end Q1, 2014 (ii) Surveillance and monitoring tools developed and implemented in hard-to-reach communities by mid-2014 (iii) Training in effective M&E system management for central and local agencies conducted by mid-2014 (iv) End-line studies conducted to reassess vulnerability results and outcome-based evaluation conducted by end 2017 (v) Assessment of the service partnership arrangements developed and conducted by end 2017
Implementation of Major Activities: Number of months for grant activities	(i) Establish project management unit (PMU) by end Q2 2014. (ii) Develop agreed work plan between ADB and PMU by end Q2 2014. (iii) Conduct of baseline assessment for target populations by end Q1-2014. (iv) Conduct relevant studies on issues identified in the baseline assessment. (v) Conduct inception, midterm and final review missions by end Q 4 2015. (vi) Design and implement surveys to monitor and evaluate MDG targets. (vii) Conduct monitoring and review missions (inception, review, mid-term, final). (viii) Design and implement conduct of end-line assessment and report by Q3 2017. (ix) Impact evaluation designed with implementation arrangements and financing approved by MOH and other parties. (x) Develop and conduct assessment of Government-NGO partnerships by Q3 2017.

2. Financing Plan for Proposed Grant to be Supported by JFPR

1. The estimated cost is $10.8 million of which $10.0 million (or 93% of the total project cost) will be financed by a JFPR grant, while the rest ($0.8 million) will be co-financed through in-kind contributions from the government and NGO partners. The Ministry of Health (MOH) provides $0.7 million equivalent in kind.

Funding Source	**Amount $ (million)**
JFPR	10.0
Government (in-kind)	0.7
NGO partners (in-kind)	0.1
Total	**10.8**

3. Background

2. Economic corridor development is expected to increase connectivity, mobility, and trade across the countries of the Greater Mekong Subregion (GMS). Studies have shown that this type of development is accompanied by social problems, which include increased vulnerability of affected communities[1] and groups to HIV infection and human trafficking.[2] People living in rural communities and border areas, mostly ethnic groups, are the most isolated, the least educated, and the least economically developed. They have the highest levels of poverty and are vulnerable due to their limited knowledge and awareness of HIV risks and poor access to services. The limited access to health services is largely caused by the government's underinvestment in the health infrastructure over the past decades of isolation. This persistent underinvestment has resulted in a limited capacity to provide quality services and to effectively respond to the spread of HIV. New, more effective responses to HIV will also need to acknowledge the distinctive features of emergent risks and vulnerabilities that will occur with changes in the socioeconomic dynamics following new development investments in the economic corridors of the GMS. With the many shared borders and rapid growth in infrastructure and mobility in the subregion, GMS governments are recognizing the need for stronger regional cooperation. Leaders of the GMS have given high priority to the control of HIV/AIDS, and signed a memorandum of understanding (MOU) for Joint Action to Reduce HIV Vulnerability Related to Population Movement in the GMS in December 2011. The Joint Action Plan (2012–2014) to implement the MOU was endorsed at the 11th GMS Human Resource Development Working Group Meeting held on 1–2 November 2012 in Yangon.[3]

3. Myanmar is ranked as a high-burden country in Asia, with an estimated 240,000 people living with HIV. Currently the HIV epidemic in Myanmar is concentrated in key affected populations. HIV prevalence in the adult population peaked in 2000 at 0.94% and was followed by a downward trend to 0.61% in 2009.[4] HIV prevalence in adults is estimated to be 0.5% in 2012.[5] While there is a declining trend in most groups, it is important to note that the prevalence among the key groups remains significantly higher for people who inject drugs (21.9%), female sex workers (9.4%), and men who have sex with men (7.8%).[6] Around 40,000 adults and children receive anti-retroviral treatment (ART). However, the treatment gap is also high, as only one-third of the estimated 120,000 people in need of treatment has access to ART. This gap, together with the greater vulnerability of the isolated and ethnic peoples, confirms the need for effective prevention as well as rapid scale-up of treatment efforts.

4. Disparities in economic development and periods of political instability have also led large numbers of people from Myanmar to seek economic opportunities in some neighboring countries. It is estimated that over three million migrant workers and their families are currently living in Thailand. Migrant workers from Myanmar constitute the largest single group of migrants

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[1] Key affected communities or populations or groups refer to communities most likely to be living with HIV or those disproportionately affected by it when compared with the general population. In Myanmar, those are people who inject drugs, female sex workers, men having sex with men, and migrant workers.

[2] ADB. 2007. *HIV and the Greater Mekong Subregion: Strategic Directions and Opportunities.* Manila; ADB. 2005. *Development, Poverty, and HIV/AIDS: ADB's Strategic Response to a Growing Epidemic*. Manila.

[3] The Working Group on Human Resource Development (WGHRD) was established at the Fifth GMS Ministerial Conference in 1995 to support human resources development initiatives that facilitate the process of GMS integration while addressing any negative consequences of greater integration. The WGHRD has been addressing the regional HRD issues, including cross-border issues directly linked to GMS integration, such as cross-border transmission of communicable diseases and human trafficking in the GMS.

[4] HIV and AIDS Data Hub for Asia-Pacific Myanmar. *HIV Prevalence and Epidemiological Status*. www.aidsdatahub.org.

[5] Strategic Information and M&E Working Group. *HIV Estimates and Projections Myanmar 2010–2015*. Myanmar.

[6] National AIDS Program. 2012. *Results of HIV Sentinel Sero-Surveilance (HSS) 2011*. Myanmar.

in the GMS, and in Thailand it is estimated that over 78% of migrant workers come from Myanmar. Significant numbers of Myanmar migrants are also found in Yunnan, People's Republic of China, where the majority of them are concentrated in Ruili, Dehong, and Jiegao.[7] Migrants are disproportionately young, of working age, and male, and are, on average, less educated than the average for the populations of origin.[8] Undocumented Myanmar migrants can be particularly vulnerable to HIV infection when they are unable to seek or negotiate appropriate health-care services due to their illegal status (fear of arrest, detention, and deportation), lack of funds, and lack of foreign-language skills. Among the HIV sentinel surveillance of high-risk groups, high rates of infection have been found in Thailand's cross-border points and among migrants.[9] Recent information from field visits indicates that the government expects significant numbers of nationals to return from Thailand (as the ongoing peace process delivers results). Any increase in concentrated cross-border movements into Myanmar will exacerbate the difficulties with the current capacity to service needs and will increase the urgency for new approaches and resources to improve health services to the most vulnerable populations.

5. The national response to HIV and AIDS in Myanmar has been guided by the first (2006–2010) and second National Strategy (2011–2015). The Myanmar National Strategic Plan and Operational Plan on HIV and AIDS (2011–2015) focuses on the prevention of HIV transmission among key affected populations and provides strategies for reaching universal access. However, implementation of the NSP is anticipated to cost $340 million to achieve 70% of the planned outcomes. The government is unable to fully fund this, and does not have sufficient human resources and facilities to implement it effectively. Accordingly, the NSP must continue to rely on significant external donor support. To date, the major source of funding has been the Global Fund to Fight AIDS, Tuberculosis and Malaria; the Three Disease Fund; and bilateral funding.[10]

6. Given donor restrictions, direct engagement between donors and government has been limited. International NGOs are often contracted as third parties who usually forge MOUs with ministries in geographical and sectoral areas. International NGOs, in association with local NGOs and community-based organizations (CBOs), provide the majority of direct HIV services in the country. Over 80% of targeted prevention services are provided by NGOs. The NGOs run drop-in centers, clinics, and outreach programs with peer educators. They also support private sector provision of STI treatment, and commodities such as condoms and lubricants. NGOs focus their interventions mostly on sex workers, clients of sex workers, men who have sex with men, and people who inject drugs. Mobile populations, workplace interventions, and young people have received less attention. In 2011, around 70% of ART was still delivered by NGOs in clinics outside of the public system. With donors now more willing to channel funds to the government, its capacity to support the delivery of HIV services needs to be strengthened.

7. The current situation of NGO-centered service delivery models has evolved within the political and financial environment of the last several decades and represents an effective, yet

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[7] Asian Migrant Center. 2004. *Migration in the GMS*. Mekong Migration Network. 2005.

[8] Labor Migration in the Greater Mekong Sub-region Synthesis Report: Phase I. 2006. Asian Research Center for Migration. Chulalongkorn University.

[9] Chantavanich et al (2000a). *Cross-border Migration and HIV/AIDS Vulnerability at Thai-Cambodia Border*. Asian Research Center for Migration; Chantavanich et al (2000b). *The Study of Labor Shortage in Thailand*. Asian Research Center for Migration; Pairoj Saonuam*, 2012 "Policy Initiatives and Proposed Action for HIV/AIDS and Mobility: Thailand Experiences," presented at consultation meeting for the implementation of the 2011 GMS memorandum of understanding—Joint Action Program*. Bangkok, 10–14 July.

[10] The Three Disease Fund is a multidonor trust fund established in 2006 as a result of withdrawal of the Global Fund in 2005. It has a total of $138 million, funded by a consortium of seven donors (the European Commission, the governments of Australia, Denmark, the Netherlands, Norway, Sweden, and the United Kingdom), to respond to the funding gap for HIV, tuberculosis, and malaria. The Three MDG Fund, launched in September 2012, will also provide limited funding for HIV and AIDS programs.

unintended, “partnership” between government and nongovernment sectors. In the emerging environment, the health system needs overall strengthening in order to improve government regulation, setting and enforcing standards for services, and providing adequate financing to the system. There are few organizations providing the intensive and long-term training needed to build the organizational capacity of private providers and CBOs. As part of its extensive work in HIV prevention in Myanmar since 2000, the Joint United Nations Programme on HIV/AIDS (UNAIDS) has assisted the MOH in implementing the National AIDS Strategy (2011–2015), and, in the process, UNAIDS has gained its trust for its technical and professional capacity and transparency. It likewise provides technical assistance to local NGOs.

8. There is a consensus among the development partners, NGOs, and the MOH that more attention should be paid to strengthening health systems, with a focus on capacity building. Most development partners and NGOs are now shifting from purely humanitarian work to development cooperation that includes capacity building and system strengthening. But questions remain about the breadth and scope of the strengthening, the most effective and acceptable approach, and the appropriate balancing between health systems strengthening and actual service delivery (given the need to respond to people’s immediate health needs). Capacity development in program management is a critical area that needs further assistance at this transition phase. It is crucial to strengthen financial management capacity, including fund management, and compliance with international financial and accounting standards as well as to improve procedures and record keeping. There is also an urgent need to improve procurement planning and process to avoid delays. A number of partners have pointed out that delays in procurement of goods and works have affected the overall implementation of activities.

9. Overall, the main gaps that need to be addressed to contain the epidemic are common among the existing health systems. First, current health systems are inefficient at effectively planning, managing, and coordinating HIV response at local levels (state or region and townships) due to the limited capacity of health staff and weak monitoring and surveillance systems. Second, access to quality prevention, treatment, and care services continues to be a major concern because of inadequate health facilities, laboratory capacity, and a shortage of trained health staff. Third, awareness of HIV risks among high-risk and vulnerable populations, including migrants and mobile populations, remains low in geographically isolated and conflict areas despite increasing risks in cross-border areas. In response, a new concerted effort is needed to expand HIV awareness among vulnerable populations in partnership with local NGOs or CBOs where there is no coverage or limited coverage by the existing government system. Last, the government’s resources and capacity in service delivery are constrained.

4. Innovation and Knowledge Sharing

10. The project includes two areas of innovation. The first involves partnership arrangements between the government and NGOs and private providers. These arrangements aim to strengthen the government’s management capacity of service delivery in townships and rural areas and to promote effective partnerships between the public and the NGO and private providers. The partnership arrangements will involve the delivery of public services through private and NGO or CBO partners to improve referral systems and integration of services (including linking continuum of care to government services). Adapting these partnership arrangements will support the sustainability of future scale-up of government funding and service coverage. The project activities for service delivery will cover 739 villages in five townships – Mawlamyine in Mon State; Kawkareik, Hpa-an and Myawaddy in Kayin State; and Tachilek in Shan State – that have large numbers of key affected populations.

11. The second innovation provides for a two-phased approach to capacity building and project implementation by the government, while addressing implementation risks associated with Myanmar's public financial management systems. The project proposes to establish two distinct phases in project implementation arrangements, including a period for a transition review to establish the timing of and conditions for the shift from Phase 1 to Phase 2. The first phase will allow for close monitoring and support from the Asian Development Bank (ADB) in managing the initial procurement and disbursement. The executing and implementing agencies will gradually develop the capacity to take on normal project management responsibilities in Phase 2. The two-phased approach will include gradually moving management of project funds to the government based on evidence of changes in the government as demonstrated by reaching specified milestones. The phased approach has been agreed upon in recognition that this is the first ADB grant assistance to the Myanmar MOH since ADB's recent re-engagement and that the MOH will need time to become familiar with ADB requirements, standards, and procedures for grant management. The phased approach will also allow more time for assessments of the MOH procurement, disbursement, and financial management systems.

12. ADB will engage UNAIDS and international NGOs as implementing partners. It will administer the service agreement with UNAIDS throughout the duration of the project since UNAIDS does not usually operate under contractual conditions in advising national governments. ADB will engage the NGOs during Phase 1 of the project, as they have not engaged previously with the government. One crucial outcome during Phase 1 will be the strengthened capacity of government to engage NGOs, leading to improved contract relationship between the two parties; the government will take full responsibility for contracting NGOs during Phase 2. Given the need to strengthen the MOH's capacity in project management, and that the government will be managing the majority of the grant funds, a full-time set of PMU consultants will be engaged to assist the government in project implementation, including procurement and financial management. The MOH, with the support of the PMU consultants, will administer the majority of the contracts. MOH staff will be provided with training in ADB project management, financial management, and procurement. The two phases will allow time for the MOH to develop its capacity to take on the role of executing and/or implementing agency in full after 2 years. Commencement of Phase 2 will be determined by agreement between ADB and the government, based on the project review missions.

5. Sustainability

13. Sustainability will involve the government's capacity to (i) sustain the operations and maintenance of the improved health facilities, including sufficient allocation for anti-retroviral drugs (ARV) after project completion; (ii) maintain functional integrated referral networks and close working relationships between the government health facilities and private and first-line community medical services that offer expanded coverage and access at more affordable rates in rural areas; and (iii) continue providing for the range of new, improved services for treatment and prevention from its own funds after completion of the project.

14. Sustainability will be facilitated by four project design features. First, the partnerships for delivering the integrated prevention programs will be more efficient at delivering public services with limited funding. Second, by developing integrated referral networks and effective working relationships between the government and private providers, they can offer expanded coverage and access at more affordable rates in rural areas. These approaches will be rigorously evaluated to see which service delivery models are most responsive to localized conditions.[11] Third, significant investments in the improvement and/or refurbishment of health facilities and in

[11] Baseline and endline surveys will be conducted for the project's outcome-based and impact evaluations.

medical equipment will enhance the quality of and access to service for ethnic minorities, rural women and children, and migrant and mobile populations. Fourth, the most important factor for sustainability will be strengthening the health system through a phased process for capacity building of the government's management of funds and service delivery.

6. Participatory Approach

15. Consultations were held in Myanmar with government agencies, development partners, NGOs, the Japan International Cooperation Agency (JICA), and the Embassy of Japan during project preparation and fact-finding and consultation missions in September 2012, and in January, March, and July 2013. Field visits were made to health centers in Mon and Kayin states in January 2013 and consultations were held with project stakeholders and beneficiaries, including women, villagers, health staff, local government officials, and NGOs and CBOs. At all levels project stakeholders were invited to provide suggestions on the project's design, scope, implementing arrangements, opportunities for partnerships, and lessons learned from similar interventions in the region and in the country. Opportunities to partner with the UN and NGOs or CBOs on key focus areas were also identified during project preparation. The views of stakeholders consulted have been incorporated into the project's design and implementation arrangements.

16. The MOH requested technical and grant assistance to implement the Joint Action Program for the MOU to reduce HIV vulnerability associated with the population movement that was endorsed during the GMS Human Resource Development Working Group Meeting in November 2012 in Yangon. A planning workshop was held on 13–14 December 2012 with representatives from the MOH and UN partners to discuss and confirm the proposed project's scope and implementation arrangements. Further consultations with local NGOs and communities to identify specific groups targeted by the project were undertaken during the project design and fact-finding mission in January 2013 and the further consultation missions in March and July 2013. Complementary linkages to other development partners' assistance and multi-donor–funded programs—in particular the Three MDG Fund; the Global Fund to Fight AIDS, Tuberculosis and Malaria; and JICA—are built into the project's design.

17. During implementation, the project will promote stakeholder participation through stronger partnerships and greater involvement of civil society organizations, community-based groups, NGOs, and the private sector to improve access to quality services and promote awareness and positive behavioral changes among target populations. Participatory planning, monitoring, and evaluation will be regularly reviewed and improved during implementation. Special attention will be given to implementing the gender action plan and the ethnic groups' plan (details in Appendixes 8 and 9, respectively). Each of these will ensure improved collection of epidemiological data by sex and ethnic group, analysis to improve knowledge of inequalities in access to and use of services, interventions designed to address specific needs, and improved awareness of health staff of those specific needs.

Primary Beneficiaries and Other Affected Groups and Relevant Description	Other Key Stakeholders and Brief Description
Key Affected Populations (KAPs) of about 1.4 million residents in 739 target villages most vulnerable to HIV/AIDS infection in border regions and along economic corridors will be the primary beneficiaries. These include: • Migrants and mobile populations (approx. 19,540) • Ethnic minorities (approx. 10,560)	Women are at significant risk in the project regions. The most vulnerable are female sex workers, ethnic women, and migrant women. Married women in rural villages are also vulnerable to infection from returning mobile worker husbands as are children born to these vulnerable women. Ethnic women in remote and hard-to-reach areas

Primary Beneficiaries and Other Affected Groups and Relevant Description	Other Key Stakeholders and Brief Description
• People who inject drugs (numbers not available) • Men who have sex with men (approx. 305) • Male and female sex workers (female sex workers 590) • People living with HIV (approx.1080). These groups overlap and are present in each of the project sites.	are especially vulnerable due to low education and lack of access to BCC information. Project locations include ethnic minorities of Mon, Shan, and Kayin peoples. Sex workers, drug users, and men who have sex with men are also vulnerable due to their reluctance to engage with official services, fearing public exposure or punishment or harassment. Sensitive design of service delivery is important to ensure these are not excluded from information, diagnosis, and treatment.
Government-sector health staff at the national and local levels will be the direct beneficiaries of the project's capacity-building components. Up to 920 are estimated to benefit from training. Staff of local community-based organizations will also have access to new training and employment opportunities as they form partnership arrangements for expanded service delivery models.	Government is a key stakeholder and its capacity building is a core development objective. Innovative service management models to be tested will include the government working cooperatively with community partners and international NGOs to support capacity building for CBOs to contribute to long-term sustainability.

7. Coordination

18. At the national level, the Myanmar Health Sector Coordinating Committee (M-HSCC) is the highest-level multi-stakeholder representational body in the health sector and includes UN agencies and development partners such as the Department for International Development (DFID), JICA, the World Bank, and ADB. Chaired by the Minister of Health, this body comprises representatives from the full range of stakeholders in the health sector. State or regional, district, and township AIDS committees coordinate service delivery implementation at the township level. The proposed project will use the existing coordinating mechanism at national, state or regional, district, and township levels for project coordination. The MOH will establish and chair a project steering committee (PSC), which will include senior officials from the concerned ministries. The chair from the Department of Health (DOH) will invite observers at the township level, NGOs from the project townships, and representatives of ADB, UNAIDS, and other development partners. The PSC will meet every 6 months to review progress and provide guidance on continuing project development priorities. PSC meetings will be held, to the extent possible, during ADB review missions in case project-related strategic decisions need to be made such as cost reallocations and changes of scope. Issues raised and major decisions reached during the PSC meetings will be recorded and distributed to all members and ADB. In addition to internal coordination, the project will also link to and work cooperatively, as appropriate, with the (proposed) project for advisory and technical services for health systems strengthening to be implemented by the MOH, jointly supported by the World Bank, with financing from the Three MDG Fund.[12]

[12] The proposed World Bank project will support a sector-wide analysis and capacity development for the MOH in a range of reform areas in policy, planning, service delivery, and institutional development, which will be relevant to the planned activities in this JFPR proposal during the implementation period.

8. Detailed Cost Table

19. Please refer to Appendix 2 for the summary cost table, Appendix 3 for the detailed cost estimates, and Appendix 6 for the fund flow arrangement.

C. Link to ADB Strategy and ADB-Financed Operations

1. Link to ADB Strategy

20. The project will contribute to accelerating the country's progress in achieving the MDG targets on health. ADB's long-term strategic framework 2008–2020 (Strategy 2020) identifies HIV/AIDS prevention as a regional public good priority. ADB's interim country partnership strategy for Myanmar (2012–2014) supports interventions to address social and health issues, including HIV/AIDS, in relation to increased connectivity and infrastructure development in the country. The proposed project is fully in line with ADB's Strategic Directions Paper on HIV/AIDS 2011–2015 and the Myanmar National Strategic Plan and Operational Plan on HIV and AIDS (2011–2015), which aims to achieve universal access to prevention and care and scale up effective initiatives through capacity building. The project takes on a multisectoral approach and will ensure links with ADB's transport projects and urban-sector development projects.

Document	Document Number	Date of Last Discussion	Objective
ADB Strategy 2020	R51-08	2008	The project is aligned with Strategy 2020's goal of poverty reduction and its strategic development agenda of inclusive growth. The project supports the government's request to strengthen public expenditure management for cost-effective delivery of health programs and services.
Myanmar: Interim Country Partnership Strategy 2012–2014	M64-12	2012	The project addresses ADB's initiatives to mitigate the potential adverse environmental and social impacts of increased movement of people and goods, including the prevention of HIV/AIDS.
ADB's Strategic Directions Paper on HIV/AIDS 2011–2015	n/a	2011	The proposed project is in line with ADB's effort to mitigate HIV risks in economic corridors. Moreover, the project features key aspects cited in the Strategic Directions Paper, supporting policy discussion and reforms to strengthen government response to HIV prevention, support of cost-effective interventions, and development of tools and knowledge products.
Country Operations Business Plan (COBP) Myanmar 2014–2016	For ADB management approval in December 2013	September 2013	The proposed project is in line with ADB's support of the government's efforts to expand human resources and institutional capacity with grants and technical assistance (TA) for mainstreaming capacity development for project design and implementation, especially in project preparation, environmental and social safeguards, financial management, and public procurement. In particular, the project will directly address improved management systems to strengthen regional and national HIV/AIDS response in border areas and along the economic corridors.

2. Link to Specific ADB-Financed Operation

21. Proposed East-West Economic Corridor (EWEC) transport project

Project Name	Greater Mekong Subregion East-West Economic Corridor Eindu to Kawkareik Road Improvement
Project Number	Technical Assistance 8330
Date of Board Approval	21 Feb 2013
Grant Amount	$1,500,000.00

3. Development Objective of the Associated ADB-Financed Operation

22. The proposed ADB assistance pipeline includes project assessment and development for upgrading the regional connection of the Greater Mekong Subregion (GMS) EWEC between Eindu and Kawkareik, which will be about 70 kilometers long. This will improve Myanmar's regional connectivity and economic development and help it play a larger role in the region. Improvements to the GMS EWEC in Myanmar would significantly improve connectivity within Kayin State, between the state and the economic hub of Yangon, between Myanmar and Thailand, and across the GMS region.

4. Main Components of the Associated ADB-Financed Operation

No.	Component Name	Brief Description
1.	Project assessment and development of the GMS EWEC between Eindu and Kawkareik	Assessment of the road upgrade includes the selection of the preferred route alignment, extensive consultations with stakeholders, and the preparation of safeguard requirements and social and environmental assessments. The component will also include the detailed design, construction supervision, preparation of tender documents, and selection of contractors.
2.	Capacity development program	This component focuses on government staff to develop the project to a stage where it is ready for implementation. The capacity development program includes the development of training programs in road alignment and project prioritization, economic analysis of project, safeguard aspects of project assessment and implementation, and social and environmental impacts of road project development and implementation, including sensitization of mobile construction workers to HIV prevention and delivery of behavioral change communication activities.

5. Rationale for Grant Funding Versus ADB Lending

23. Myanmar remains one of the poorest countries in the Asia and Pacific region, with a per capita GDP of $857 and a Human Development Index rank of 149 out of 187 countries; 26% of its population was living in poverty in 2010.[13] Poverty is highest in the rural and remote border regions, which are the target areas for this development assistance. Myanmar's health sector has long been underfunded and had very low levels of spending. Out-of-pocket spending comprised the majority of health spending, followed by government and donor assistance. Project funds are designed to address urgent needs for improved health planning and delivery of HIV services in the most vulnerable areas. The project is ADB's first grant assistance for health in Myanmar since its recent re-engagement and will facilitate mutual learning for working

[13] ADB Interim Country Partnership Strategy, October 2012, p. 2.

together and developing a better understanding of the needs and priorities for future assistance programs.

D. Implementation of the Proposed Grant

1. Implementing Agency: Department of Health

24. The MOH will be the project's executing agency responsible for oversight. The implementing agency is the DOH's National AIDS Program (NAP). Implementing partners will be engaged to assist the implementing agency during implementation. UNAIDS will support the implementing agency in implementing Output 1 and the M&E activities of Output 4. International NGOs (working in association with local NGOs or CBOs) will be engaged separately as service providers to support the government-NGO partnership arrangements in implementing outputs 2 and 3. ADB will administer and manage the letter of agreement (LOA) with UNAIDs throughout the duration of the project and the contracts with international NGOs during Phase 1. The implementing agency will procure relevant international and local expertise, using a combination of consulting firms, individuals, local NGOs, and CBOs, which will be engaged through fixed-budget selection, quality cost-based selection, consultants' qualification selection, individual consultant selection, and/or single-source selection. Selection methods will be determined during implementation according to each specific situation. ADB's Guidelines on the Use of Consultants (2013, as amended from time to time) will be applicable.

25. A project management unit (PMU) will be established within the DOH to manage the day-to-day implementation of the project. The PMU will include government and project staff. The main functions of the PMU will be to ensure timely and effective project planning, management, coordination, procurement, financial control, monitoring, and reporting to DOH and ADB. The PMU will be composed of (i) a project director; (ii) a project management-cum-procurement specialist; (ii) a financial management specialist; and (iii) national specialists to assist with M&E, financial management and procurement, and general operations and administration for regional visits and training. The PMU will help the implementing agency procure the service providers to conduct required needs assessments and M&E surveys. The PMU will also establish project implementation units (PIUs) in the township health departments (THDs) that will be responsible for the day-to-day activities in their respective locations and for coordination with the central DOH, other PIUs, and local NGO or CBOs. The PIUs at THDs will be supported by full- and part-time counterpart staff, including a project coordinator or township medical officer and an accountant.

26. ADB will directly engage UNAIDS for capacity building and policy advisory services through a partnership arrangement or LOA throughout the duration of the project. UNAIDS is preselected due to its unique position as the only long-established body with the necessary policy expertise in Myanmar, working with the MOH to offer policy advice and support. It has forged the strongest and most effective partnership with the MOH. ADB will also directly engage two international NGOs that will act as partner service providers during Phase 1. They will be selected among those with an existing presence in Myanmar that have local experience in delivering relevant services in the five project locations (townships of Mawlamyine, Kawkareik, Hpa-an, Myawaddy, and Tachilek), are willing to be involved in building the capacity of local NGOs and CBOs, and have or will obtain an MOU from the government to operate in the project area. Several potential international and local NGO partner groups have been identified that have a strong presence in the area and the capacity to deliver services throughout the country, including, and especially, in remote regions. During Phase 2, subject to satisfactory performance, the government, instead of ADB, may re-engage these two NGOs. The implementation arrangements are further detailed in Appendix 4.

27. A combination of individual consultants (among others, to staff the PMU); international and local NGOs; consulting firms specializing in surveys, studies, M&E, and audits; and others will be recruited in accordance with ADB's Guidelines on the Use of Consultants (2013, as amended from time to time).

28. All goods and civil works will be procured in accordance with ADB's Procurement Guidelines (2013, as amended from time to time). Goods and civil works estimated to cost above $25,000 will be procured through national competitive bidding (NCB). Goods and civil works estimated to cost $25,000 or less will be procured by shopping. All equipment procured will remain the property of the executing agency. A comprehensive review of NCB procedures will be conducted during Phase I to assess whether they could be used and under which conditions. Any minor equipment and material costing less than $10,000 may be procured through direct contracting through price comparison, subject to ADB's prior approval of the selected contractor.

2. Risks Affecting Grant Implementation

29. The key risks and mitigated measures are summarized in Table 1.

Table 1. Summary of Risks and Mitigating Measures

Risks	Mitigating Measures
Weak implementation capacity	• Strengthen PMU and implementing agency • Ensure timely availability of consultants • Conduct detailed planning of project activities • Provide training for project staff at national and township levels • Ensure regular supervision and reporting
Weak government finance system and limited banking services	• Perform a financial management assessment at the national and local level • Provide a technical advisor in finance system and management • Conduct audits for the project by the Auditor-General's Office (AGO) • Provide training in finance management and accounting procedures, ADB procurement and disbursement procedures, and implementation management at national and township levels • Engage an international financial management specialist on an intermittent basis and a national financial management specialist full time to act as long-term advisors in finance system and management • Require submission of full documentation to support withdrawal applications and conduct regular audits and monitor expenditures during review missions • Make direct payments from ADB to contractors in the initial phase, until the implementing agency develops sufficient capacity to manage the payments to ADB standards
Lengthy administrative procedures	• PMU to prepare ADB procurement and financial procedures to implementing agency staff • Engage a project manager-cum-procurement advisor to ensure competent application of ADB's Procurement Guidelines and reporting mechanisms to minimize delays • Ensure support of core ministries and states for timely processing.
Weak capacity to implement activities and/or lack of cooperation from NGO/CBOs/private partners	• Allow adequate time for designing and fine-tuning the innovative service-delivery partnership protocols, drawing on the experience of the international NGOs in design and delivery of integrated prevention services • Conduct consultations with key stakeholders, including local NGOs and CBOs, to develop effective partnerships • Provide technical assistance through TA 6467 in design and development

Risks	Mitigating Measures
	of the partnership agreements
Governance and corruption	• PMU and the implementing agency receive training in ADB's anticorruption policy and relevant government policies, regulations, and guidelines on anticorruption • Conduct spot checks of suppliers, prices, and contracts • Ensure the project's public visibility, including a complaint and grievance system

3. Incremental ADB Costs

Component	Incremental Bank Cost
Amount requested	$184,000.00
Justification	Incremental costs will finance the recruitment of specialists and consultants for special monitoring and project completion reviews.
Type of work to be rendered by ADB	Specialists and consultants (international and national) will be engaged to assist with preparation of the inception, midterm, and/or transition reviews and project completion reports.

4. Monitoring and Evaluation

Key Performance Indicator	Reporting Mechanism	Plan and Timetable for M&E
Target migrants and mobile populations and other vulnerable populations reached, with prevention services increased by 50% between 2014 and 2017	National and provincial annual HIV reports Project-supported surveys at end-line to assess impact	• Data obtained in the baseline survey by mid-2014 and end-line survey by end 2017
Improved planning and management capacity at national, state or regional, and township levels Project funds directly managed by the executing agency increased by 100% by Q4 2016	Regular project monitoring reports Timely submission of budget expenditures	• Data to be collected regularly throughout the project between 2013 and 2017 from annual progress reports
Increased health centers in project areas providing a continuum of services, including prevention, treatment, and care (increased to 90% by end 2017) Government has enhanced capacity to design innovative services and manage their delivery using a range of more appropriate management models and has established a readiness for future scale-up	National and provincial annual HIV reports Regular project monitoring reports Project-supported surveys at end-line to assess impact	• Data to be collected regularly throughout the project between 2013 and 2017 from annual progress reports • Data obtained in the baseline survey by mid-2014 and end-line survey by end 2017
Use of condoms among target population increased by 80% by end 2017 Appropriate IEC/BCC	National and provincial annual HIV reports Regular project monitoring reports	• Data to be collected regularly throughout the project between 2013 and 2017 from annual progress reports

Key Performance Indicator	Reporting Mechanism	Plan and Timetable for M&E
approaches and tools developed for target groups	Project-supported surveys at end-line to assess impact	• Data obtained in the baseline survey by mid-2014 and end-line survey by end 2017
End-line studies conducted to reassess vulnerability results and outcome-based evaluation conducted by end 2017	Project-supported surveys at end-line to assess impact	• End-line survey to be conducted by June 2017

5. Estimated Disbursement Schedule

30. Details of the disbursement pattern will be calculated during the inception phase as the more detailed implementation plan will be prepared in consultation with the executing and implementing agencies.

Fiscal Year (FY)	**Amount** ($)
2014	800,000
2015	3,020,000
2016	2,780,000
2017	2,360,000
2018	1,040,000
Total Disbursements	10,000,000

Appendixes

1. Design and Monitoring Framework
2. Summary Cost Table
3. Detailed Cost Estimates
4. Implementation Arrangements
5. Phased Approach for Project Implementation
6. Fund Flow Arrangement
7. Summary Poverty Reduction and Social Strategy (SPRSS)
8. Gender Action Plan
9. Ethnic Groups' Plan
10. Project Target Beneficiaries

Supplementary Appendixes (available upon request)

1. Grant Implementation Manual (GIM)
2. Sector Assessment (Summary)
3. Financial Management Assessment
4. Procurement Capacity Assessment

DESIGN AND MONITORING FRAMEWORK

Design Summary	Performance Targets and Indicators with Baselines	Data Sources and Reporting Mechanisms	Assumptions and Risks
Impact Contribute towards achieving the MDG targets by reversing/ managing the spread of HIV/AIDS in Myanmar	HIV prevalence of general population (15+) reduced from 0.5% in 2012 to 0.4% in 2020 HIV prevalence of key affected populations (female sex workers) reduced from 9.4% in 2012 to 7% in 2020	Integrated biological and behavioral survey of MOH National annual HIV reports	**Assumption** Prevention programs are effective and continue to receive support and funding **Risk** Increasing risk factors result in increased HIV transmission
Outcome Increased coverage and quality of information and services (prevention, treatment, and care) for targeted populations along and near the economic corridors	Target migrants and mobile populations and other vulnerable populations reached, with prevention services increased by 50% between 2014 and 2017 (sex disaggregated data) [a] Target populations report satisfactory service quality for STI/HCT services increased by 80% between 2014 and 2017 (sex disaggregated data) [a] Use of condoms among target groups increased by 80% between 2014 and 2017 (sex disaggregated data) [a] Project funds directly managed by the executing agency increased by 100% by Q4 2016	National and provincial annual HIV reports Routine DOH monitoring reports Project-supported baseline and end-line surveys MOH triannual surveys on condom use	**Assumption** Government and communities are willing and able to institutionalize mechanisms for local HIV response **Risk** Limited acceptance of provided services and weak targeting
Outputs 1. Strengthened planning and management capacity at national, state or regional, and township levels	Capacity assessment for planning and project management conducted and analyzed at national, state or regional, and township levels by end Q3 2014 All 5 comprehensive township plans developed, approved, and commenced implementation by end Q1 2015 At least 70% of managerial staff (60% are women) at national and state or regional level trained on planning and project management (i.e., financial management, supply-chain management, M&E) by Q4 2017 At least 70% of health staff (of which 60% are women) at township level trained in planning and project management (i.e., financial management, supply-chain management, data management, and reporting) by end Q4 2017	Project reports on planning activities Baseline survey Project training reports Project monitoring reports	**Assumptions** Township-level coordination functional and supported by key officials Willingness and capacity of government at all levels to support the project **Risks** Potential government restrictions in some project areas HIV prevention receiving lower priority

Design Summary	Performance Targets and Indicators with Baselines	Data Sources and Reporting Mechanisms	Assumptions and Risks
2. Enhanced capacity to provide quality and accessible services	The number of trained health service providers deployed in project areas increased by 30% between 2014 and 2017 (sex disaggregated data) [a] The number of patient consultations in township or village health centers or facilities increased by 80% by Q4 2017 (sex disaggregated data) [a] The number of health centers in project areas providing a continuum of services, including prevention, treatment, and care, increased by 90% by Q4 2017[a] Referral system to ensure the provision of health services for target populations established and functional by Q1 2016	National/state/ township health departments' reports Project monitoring reports Project baseline and end-line survey Project monitoring reports	**Assumption** Willingness of international and local NGOs to provide services in hard-to-reach areas **Risk** Potential government restrictions in some project areas
3. Improved access to community outreach among target populations	At least 70% of peer educators, health workers, and community volunteers in project areas have completed new upgrade training for community outreach by end Q2 2017 (50% of those trained are female) IEC/BCC approaches and tools that are sensitive to cultural, linguistic, ethnic, gender, and religious backgrounds developed and ready for distribution to the targeted populations by Q3 2015 Community-outreach programs for gender sensitive behavioral change developed and commenced with NGOs/CBOs in targeted townships in or before Q3 2015	Project training reports National/state/ township health departments' reports Project monitoring reports	**Assumptions** Willingness of NGOs to provide services Target communities willing to participate in the project **Risks** Potential restrictions in accessing some project areas Arrest of sex workers by police authorities under national laws that criminalize prostitution
4. Monitoring and project management	Baseline surveys conducted within the 6-month inception phase. Risk and vulnerability assessment and baseline survey conducted in all project areas by Q3 2014 Surveillance and monitoring tools developed or enhanced and implemented for target populations in hard-to-reach communities by Q3 2014 Training programs for effective M&E system management for national and local agencies conducted by Q3 2014 Studies and researches based on results	Baseline assessment Project monitoring reports Project assessment reports Survey reports	**Assumption** High-risk populations can be identified **Risks** Potential government restrictions in some project areas High mobility of target populations

Design Summary	Performance Targets and Indicators with Baselines	Data Sources and Reporting Mechanisms	Assumptions and Risks
	of risk and vulnerability, including outcome-based evaluation, conducted by end Q4 2017 Impact evaluation designed with implementation arrangements and financing approved by MOH and other parties Assessment of the value added of government-NGO partnerships conducted		

Key Milestones and Activities	Inputs
Output 1: Strengthened planning and management capacity at national, state or regional, and township levels 1.1 Commence international and national consultants services by Q1 2014 1.2 Prepare project implementation plan by Q2 2014 1.3 Conduct capacity assessment in three states and five townships on ability to manage effective local responses by Q2/2014 1.4 Complete capacity development plans at national, state or regional, and township level 1.5 Conduct training activities based on the capacity development plan for the target states and townships, including training in knowing the epidemic in their localities by Q2 2015 1.6 Conduct training at national and state or regional levels in program planning, project management, supply-chain management, and M&E by Q2 2015 1.7 Conduct training at national and state or regional levels in financial management, procurement, and disbursement by Q2 2016 **Output 2: Enhanced capacity to provide quality and accessible services** 2.1 Provide training for HIV and STI services in selected health facilities included in five locations by end Q2 2014 2.2 Provide supplies, commodities, and testing materials, and associated training, to strengthen treatment in selected health facilities included in agreed pilot management models in five locations by Q2 2014 2.3 Procure medical equipment for township and rural health facilities by end Q4 2014; plan and complete civil works for upgrade of facilities by Q2 2017 2.4 Sign service agreements (covering integrated services across outputs 2 and 3) between the DOH and NGOs/private providers for provision of prevention and education, counseling, testing, treatment, and care services to operate under agreed pilot management models by end Q4 2014 2.5 Establish referral systems and service coordination mechanisms between community-based facilities and township hospitals within Myanmar and across borders to ensure the provision of health services, including HIV, STI, malaria, and other health concerns for key affected populations, including returnees by Q2 2015 **Output 3: Improved access to community-outreach among target populations** 3.1 Develop an enhanced process for condom distributions by Q4 2014 3.2 Conduct a participatory consultation and training process to involve health staff (e.g., midwives, township medical officers, community health workers) in improving delivery of awareness raising activities by end Q3 2014 3.3 Implement awareness programs through a community outreach program in partnership with local NGOs/CBOs in target communities by end Q4 2017 3.4 Develop appropriate IEC materials for ethnic communities and migrants and mobile populations by end Q3 2015 3.5 Develop and establish functional system for referrals to social welfare agencies for post-treatment counseling and care by end Q3 2015	**Inputs** Trust Fund: $10.0 million Government in-kind contribution: $0.7 million NGO/community in-kind contribution: $0.1 million

Output 4: Monitoring and project management 4.1 Establish project management unit (PMU) by end Q2 2014. 4.2 Develop agreed work plan between ADB and PMU by end Q2 2014. 4.3 Conduct of baseline assessment for target populations by end Q1-2014. 4.4 Conduct relevant studies on issues identified in the baseline assessment. 4.5 Conduct inception, midterm and final review missions by end Q 4 2015. 4.6 Design and implement surveys to monitor and evaluate MDG targets. 4.7 Conduct monitoring and review missions (inception, review, mid-term, final). 4.8 Design and implement conduct of end-line assessment and report by Q3 2017. 4.9. Impact evaluation designed with implementation arrangements and financing approved by MOH and other parties. 4.10 Develop and conduct assessment of Government-NGO partnerships by Q3 2017.	

ADB = Asian Development Bank; BCC = behavioral change communication; CBO = community-based organization; DOH = Department of Health; HCT = HIV counseling and testings; IEC = information, education, and communication; M&E = monitoring & evaluation; MDG = Millennium Development Goal; MOH = Ministry of Health; NGO = nongovernment organization; Q = quarter; STI = sexually transmitted infection.

[a] Baseline for some indicators will be assessed by the project baseline survey in Q3 2014.

Source: Asian Development Bank.

Leah C. Gutierrez
Director, SEHS

James Nugent
Director General, SERD

SUMMARY COST TABLE
($)

Category	Output 1 Strengthened planning and management capacity	Output 2 Enhanced capacity to provide quality and accessible health services	Output 3 Improved access to community outreach	Output 4 Monitoring and project management	Total ($)[a/]	Percentage
1. Civil works	**0**	**3,817,000**	**0**	**0**	**3,817,000**	**38.2**
2. Equipment and supplies	**0**	**1,394,000**	**73,000**	**38,000**	**1,505,000**	**15.0**
Medical equipment	0	800,000	0	0	800,000	
Medical supplies (drugs, testing kits)	0	462,000	10,000	0	472,000	
Hospital and office equipment	0	133,000	0	4,000	137,000	
Vehicles (including motorbikes)	0	0	63,000	35,000	98,000	
2. Training, workshops, and seminars	**292,000**	**141,000**	**284,000**	**0**	**717,000**	**7.2**
3. Consulting services	**665,000**	**0**	**0**	**1,350,000**	**2,015,000**	**20.2**
International	485,000	0	0	900,000	1,385,000	
National	180,000	0	0	330,000	510,000	
Surveys and studies	0	0	0	120,000	120,000	
4. Grant management	**64,000**	**0**	**0**	**210,000**	**274,000**	**2.7**
5. Other inputs	**0**	**291,000**	**676,000**	**0**	**967,000**	**9.7**
NGOs	0	291,000	0	0	291,000	
Awareness program (Including IEC materials)	0	0	676,000	0	676,000	
8. Contingencies	**71,000**	**423,000**	**70,000**	**141,000**	**705,000**	**7.0**
Total Grant Financed	**1,092,000**	**6,066,000**	**1,103,000**	**1,739,000**	**10,000,000**	**100.0**
8. Government contribution (in-kind)	185,000	104,000	28,000	305,000	622,000	
9. NGO/Private sector contributions (in-kind)	35,000	59,000	24,000	0	118,000	
10. Community contributions (in-kind)	0	5,000	8,000	0	13,000	
Total Project Costs	**1,312,000**	**6,234,000**	**1,163,000**	**2,044,000**	**10,753,000**	

[a] Includes taxes and duties of $0.662 million in the base cost, financed from both the government and ADB. Of this amount, ADB will finance an estimated $0.267 million. Including taxes and duties in ADB-financed project expenditures is consistent with the country partnership strategy. Taxes and duties are not an excessive share of the project cost and are material to the success of the project

Source: Asian Development Bank estimates.

DETAILED COST ESTIMATES

		Costs							Contributions		
Code	Supplies and Services Rendered	Unit	Quantity Unit	Cost Per Unit	Total ($)	JFPR Amount	Procurement Method	Procured by	Government	Private Sector/INGO	Communities
Component 1: Strengthened planning and management capacity at national, state/regional, and township levels				**Subtotal**	**1,241,000**	**1,021,000**			**185,000**	**35,000**	**-**
1.1	Engagement of UNAIDS				176,000		LOA-UNAIDS	ADB	141,000	35,000	-
1.1.1	International Institutional Strengthening Specialist	Person-month	24	20,000	480,000	480,000			-	-	-
1.1.2	National Institutional Strengthening Specialist	Person-month	36	2,500	90,000	90,000			-	-	-
1.1.3	National Strategic Information Specialist	Person-month	36	2,500	90,000	90,000			-	-	-
1.1.4	Supporting Staff	Person-month	-	-	-	-			-	-	-
1.1.5	Air Travel (international and domestic)	Lump sum	0	5,000	5,000	5,000			-	-	-
1.1.6	Office Equipment	Lump sum	Multiple	-	-	-			-	-	-
1.1.7	Vehicle	Number	0	-	-	-			-	-	-
1.1.8	Operation Costs (Running and maintenance costs)	Lump sum		-	33,000	-			33,000	-	-
1.1.9	Office Space	Month	0	-	11,000	-			11,000	-	-
	Subtotal				**885,000**	**665,000**					
1.2	Workshop and Training								-	-	-
1.2.1	Planning and Consultation Workshop	Lump sum	1	37,300	37,000	37,000			-	-	-
1.2.2	Training - Capacity Development Plan	Lump sum	1	104,800	105,000	105,000			-	-	-
1.2.3	Training - Program planning, project management, supply-chain management, and M&E	Lump sum	1	104,800	106,000	105,000			1,000	-	-
	Subtotal				**248,000**	**247,000**			**-**	**-**	**-**
	Total UNAIDS				1,133,000	912,000			-	-	-
	Project Support Cost				64,000	64,000			-	-	-
					1,197,000	976,000			-	-	-
1.2.4	Training - Financial management and procurement	Lump sum	1	44,900	45,000	45,000	Small Value Contracts	DOH-PMU	-	-	-
Component 2: Enhanced capacity to provide quality and accessible services				**Subtotal**	**5,811,000**	**5,643,000**			**104,000**	**59,000**	**5,000**
2.1	Provision of training for HIV and STI services in selected health facilities included in five locations		0	140,900	144,000	141,000	QBS-INGO	ADB/DOH	3,000	-	-
2.2	Provide supplies, commodities and testing materials, and associated training, to strengthen treatment in selected health facilities included in agreed pilot management models in five locations	Lump sum (Goods)	0	90,700	91,000	91,000	QBS-INGO	ADB/DOH	-	-	-
2.3.1	Plan and complete civil works for upgrade of facilities		7	-	3,918,000	3,817,000	ADB Works/[b] Shopping	DOH-PMU	101,000	-	-
2.3.2	Medical equipment for township and rural health facilities in township locations.		Multiple	932,500	933,000	933,000	ADB Goods/[b] Shopping/PSA	DOH-PMU	-	-	-
2.4	Partnership service agreement with INGO								-	-	-
2.4.1	Provision of public health services on prevention and education, counseling, testing, treatment, and care services	Lump sum (Goods)	Multiple	371,200	371,000	371,000	ADB Goods/[b] Shopping/PSA	DOH-PMU	-	-	-
2.4.2	Service agreements (covering integrated services across components 2 and 3) signed between the DOH and NGOs/ private providers for provision of prevention and education, counseling, testing, treatment, and care services to operate under agreed pilot management models	Lump sum (Services)	1	120,000	184,000	120,000	QBS-INGO	ADB/DOH	-	59,000	5,000
2.5	Establish referral systems and service coordination mechanisms		1	170,700	171,000	171,000	QBS-INGO[c]	ADB/DOH	-	-	-

DETAILED COST ESTIMATES (Continued)

		Costs							Contributions		
						JFPR					
Code	Supplies and Services Rendered	Unit	Quantity Unit	Cost Per Unit	Total ($)	Amount	Procurement Method	Procured by	Government	Private Sector/INGO	Communities
Component 3: Improved access to community-outreach among target populations				**Subtotal**	**1,092,000**	**1,032,000**			**28,000**	**24,000**	**8,000**
3.1	Develop an enhanced process for condom distribution	Lump sum	1	43,000	43,000	43,000	QBS-INGO	ADB/DOH	-	-	-
3.2	Participatory consultation and training in improving delivery of awareness-raising activities	Lump sum	1	126,000	126,000	125,000	QBS-INGO	ADB/DOH	1,000	-	-
3.3	Implement awareness programs through a community/key affected populations outreach program in partnership with local NGOs/CBOs in target communities	Lump sum	1	279,000	279,000	234,000	QBS-INGO	ADB/DOH	13,000	24,000	8,000
3.4	Procurement of moterbikes	Unit	50	1,240	62,000	62,000	QBS-INGO	ADB/DOH	-	-	-
3.5	Functional system for referrals to social welfare agencies for post-treatment counseling and care developed and established	Lump sum	1	582,000	582,000	568,000	QBS-INGO	ADB/DOH	14,000	-	-
Component 4: Monitoring and project management				**Subtotal**	**1,903,000**	**1,598,000**			**305,000**	**-**	**-**
4.1	Project Management Unit				254,000			DOH-PMU	254,000	-	-
4.1.1	International Consultant - Project Management /Procurement Specialist	Person-month	36	20,000	720,000	720,000	ICS		-	-	-
4.1.2	International Consultant - Financial Management Specialist	Person-month	8	20,000	160,000	160,000	ICS		-	-	-
4.1.3	National Consultant - Project Management/M&E Specialist	Person-month	40	2,500	100,000	100,000	ICS		-	-	-
4.1.4	National Consultant - Financial Management Specialist	Person-month	40	2,500	100,000	100,000	ICS		-	-	-
4.1.5	National Consultant - Procurement Specialist	Person-month	44	2,500	110,000	110,000	ICS		-	-	-
4.1.6	Supporting Staff - 1 -- Secretary and Admin Clerk	Person-month	48	1,000	48,000	48,000	ICS		-	-	-
4.1.7	Supporting Staff - 2 -- Office Support and Security	Person-month	96	400	41,000	41,000	ICS		-	-	-
4.2	Operation Costs (Equipment, running, and maintenance costs)		1	175,400	176,000	124,000	Small Value Contracts		51,000	-	-
4.3	Vehicle	Unit	1	35,000	35,000	35,000	ADB Goods		-	-	-
4.4	Surveys and Studies	Unit	2	60,000	120,000	120,000	CQS		-	-	-
4.5	External Audit	Unit	4	10,000	40,000	40,000	CQS		-	-	-
					1,650,000	1,598,000		DOH-PMU	-	-	-
									-	-	-
	Components 1 - 4				10,048,000	9,295,000			-	-	-
	Contingency	7.05%			705,000	705,000			622,000	118,000	13,000
	Total Grant Costs				10,753,000	10,000,000			622,000	118,000	13,000
									-	-	-
	ADB Categories					**1,837,000**			-	-	-
	GOM Categories					**7,518,000**			-	-	-
									-	-	-
					UNAIDS	**976,000**			-	-	-
					INGO	**1,615,000**			-	-	-

a Includes taxes and duties of $0.662 million included in the base cost and financed from both the government and ADB JFPR. Of this amount, ADB will finance an estimated $0.267 million. Including taxes and duties in ADB-financed project expenditures is consistent with the country partnership strategy. Taxes and duties are not an excessive share of the project cost and are material to the success of the project

b Consists of several packages with multiple contracts.

c "At cost" = Provisional sum to NGO (INGO) contracts.

ADB = Asian Development Bank, CBO = community-based organization, DOH = Department of Health, GOM = Government of Myanmar, INGO = international nongovernment organization, ICS = individual consultant selection, JFPR = Japan Fund for Poverty Reduction, LOA = Letter of Agreement, M&E = monitoring and evaluation, NGO = nongovernment organization, PMU = project management unit, PSA = Procurement from Specialized Agencies, QBS = quality cost based selection, SHP = shopping;

Source: Asian Development Bank estimates.

IMPLEMENTATION ARRANGEMENTS

A. Project Management

1. **Project organization structure.** The Ministry of Health (MOH) will be the executing agency of the project and responsible for project oversight. The implementing agency will also be the MOH, through the National AIDS Program (NAP) within the Department of Health (DOH). Partners will be engaged to assist the implementing agency. The Joint United Nations Programme on HIV/AIDS (UNAIDS) will support the implementing agency with Output 1 and the monitoring and evaluation (M&E) activities of Output 4. International nongovernment organizations (NGOs), working in association with local NGOs (including community-based organizations [CBOs]) will be engaged separately as service providers to support the government-NGO partnership arrangements in implementing outputs 2 and 3. The Asian Development Bank (ADB) will engage and administer the letter of agreement (LOA) with UNAIDS throughout the duration of the project and contract with international NGOs during Phase 1. The implementing agency will procure relevant international and local consulting services (except the international NGOs, which ADB will initially recruit), using a combination of consulting firms, individuals, local NGOs, and CBOs. All consulting firms and NGOs will be recruited through fixed-budget selection, quality cost-based selection, consultant's qualification selection, individual consultant selection, and/or single-source selection. Selection methods will be determined during implementation according to each specific situation. ADB's Guidelines on the Use of Consultants (2013, as amended from time to time) will be applicable. Any procurement of assets will be undertaken following ADB's Procurement Guidelines (2013, as amended from time to time). Upon completion, the asset will be turned over to the executing agency.

2. A project management unit (PMU) will be established within the Department of Health to manage the project's day-to-day implementation. The PMU will include government staff and individual consultants. The main functions of the PMU will be to ensure timely and effective project planning, management, coordination, procurement, financial control, monitoring, and reporting to the DOH and ADB. The PMU will be composed of (i) the project director, (ii) a project management-cum-procurement specialist, (iii) a financial management specialist, and (iv) national specialists to assist with M&E, financial management, procurement and general operations, and administration for regional visits and training. The PMU will assist the implementing agency with procuring the service providers to implement needs assessments and M&E surveys. The PMU consultants will provide additional training in administrative procedures in further support of the capacity building for project management.

3. The PMU will also establish project implementation units (PIUs) in the township health departments (THDs) that will be responsible for the day-to-day activities in their respective locations and for coordination with the central DOH, other PIUs, and local NGOs or CBOs. The PIUs at THDs will be supported by full- and part-time counterpart staff, including a project coordinator or township medical officer and an accountant. The implementation arrangements are further detailed in the Grant Implementation Manual (GIM).

B. Procurement and Consulting Services

4. **Procurement.** All procurement to be financed by the project will be undertaken in accordance with ADB's Procurement Guidelines (2013, as amended from time to time). Civil works will consist of seven packages with multiple lots or contracts to allow small contractors to bid. Procurement of goods and civil works above $25,000 shall follow national competitive

bidding (NCB) procedures. Goods costing $25,000 or less shall be procured by shopping. Any minor equipment and materials costing less than $10,000 may be procured through direct contracting. Supplies for the outreach programs and service delivery could also be procured through specialized agencies. Further details on procurement and the procurement plan are provided in the GIM.

5. **Consulting Services.** A combination of individual consultants, international and local NGOs, and two consulting firms specializing in surveys and studies (M&E) will be recruited in accordance with ADB's Guidelines on the Use of Consultants (2013, as amended from time to time). A full-time international project management and procurement specialist and a national procurement specialist with strong experience in procurement procedures and practices of the Government of Myanmar and, preferably, ADB procurement procedures will be engaged to oversee recruitment of international NGOs (during Phase 2) and local NGOs as well as procurement of civil works, equipment, and supplies. An international financial management specialist will be engaged on an intermittent basis and a national financial management specialist full time, to set up a financial management system for the project, including the strengthening of the financial management capacity of the MOH. A national project management and monitoring as well as evaluation specialist will be recruited for almost the entire duration of the project, to lead a project evaluation study, support the design and conduct of the midterm and end-line surveys and the impact evaluation, formulate policy recommendations (including on the various service delivery models under Output 2), and will assist NAP with the public health strategic planning. The DOH, with assistance from ADB, will be responsible for selecting consultants for the initial recruitment stage. UNAIDS will be engaged for capacity building and policy advisory services. UNAIDS is preselected due to its unique position as the only long-established body in Myanmar with the necessary policy expertise. It will be working with the MOH to offer policy advice and support. The other international NGOs to act as partner service providers will be selected from those with an existing presence in Myanmar, who have local experience in delivering relevant services in the five project locations, are willing to be involved in building the capacity of local NGOs and CBOs, and who have or will obtain a memorandum of understanding (MOU) from the government to operate in the project area. Several potential international and local NGO partner groups have been identified that have a strong representational presence and the capacity to deliver services throughout the country, including, and especially, in the remote regions. The implementing partners will recruit local NGOs to support the services delivery under outputs 2 and 3, using processes consistent with quality-based selection; any other local NGOs required to support services under outputs 1 and 2 (e.g., local data collections) will be recruited by the PMU through the consultants' qualification or fixed-budget selection method. The details of consulting services are found in the GIM.

C. Disbursement

6. **Disbursement arrangements.** ADB will administer the contract with UNAIDS throughout the duration of the project, and the contracts with the two NGOs during Phase 1 only. This portion of the grant, administered by ADB, will be disbursed in accordance with ADB's *Technical Assistance Disbursement Handbook* (2010, as amended from time to time). The rest of the grant proceeds will be disbursed in accordance with ADB's *Loan Disbursement Handbook* (2012, as amended from time to time) and detailed arrangements agreed upon between the government, ADB, UNAIDS, and international NGOs. The MOH should establish and maintain a separate imprest account. The imprest account is in US dollars. The imprest account is to be used exclusively for ADB's share of eligible expenditures. The MOH is accountable and responsible for proper use of advances to the imprest account, including advances to the DOH

township subaccount for a specific activity. The ceiling of the imprest account is $150,000. The MOH may request initial and additional advances to the imprest account based on an estimate of expenditure sheet setting out the estimated expenditures to be financed through the account for the forthcoming six (6) months.[1] Supporting documents should be submitted to ADB or retained by the MOH in accordance with ADB's *Loan Disbursement Handbook* when liquidating or replenishing the imprest account. An increase in the ceiling of the imprest account may be considered during the transition to Phase 2. Civil works and equipment that comprise 53% of the grant amount will generally be paid directly. Throughout the project implementation period, the implementing agency may use the imprest account for payments for project-related travel and per diems for counterpart staff and project consultants. Checks may be issued via the authorized bank; they must be co-signed by three authorized persons (in accordance with MOH procedures). The rates will be based on standard government rates or cost norms issued by the Ministry of Finance and updated from time to time. The township DOH will open and maintain separate subaccounts. The subaccounts are to be used exclusively for ADB's share of eligible expenditures. Payment of expenditures at the township level will initially be advanced to these accounts for a specific activity; the accounts will be liquidated immediately upon completion of the activity. Reimbursement of eligible expenditures and liquidation of advances paid into the imprest account will be based on submission of full supporting documentation to ADB. The use of simplified statement of expenditures (SOE) procedures may be considered during Phase 2. The administrative procedures will be further detailed in a finance manual to be prepared by the international and national financial specialists to be hired under the project. Disbursement arrangements are detailed in the GIM.

D. Safeguards

7. Project implementation will closely follow ADB social and environmental safeguard policies and guidelines as articulated in ADB's Safeguard Policy Statement (2009).

8. **Resettlement (Category C).** The project will not involve any involuntary resettlement impacts. Health facilities will be constructed on government land that is unencumbered or free from any temporary users (not used for residential, business, or productive purposes).

9. **Environment (Category C)**. The project will support the construction, rehabilitation, and operation of health facilities, including improved water, sanitation, and waste management systems. No significant impact on environment is expected.

10. **Indigenous people (Category B).** Myanmar is one of the most ethnically diverse countries in the world. The project sites are home to majority populations of Shan, Karen, and Mon peoples. The project includes a significant proportion of ethnic groups among its beneficiaries in the targeted townships. Remoteness and language differences constrain effective STI/HIV and communicable disease programs in areas populated by minority groups. Furthermore, periods of internal conflict have aggravated health threats among some minority ethnic groups due to constraints on resources, displacement, and migration. These factors can lead to an increased prevalence of disease. Surveys near the Myanmar-Thai border show high levels of STIs and malaria. The ethnic groups' plan ensures analyses of ethnic peoples' needs and their participation in and access to benefits of the project. The project's design gives high priority to including ethnic minority peoples in training and community-based activities, as well as ensuring that HIV prevention services reach these populations and are culturally appropriate.

[1] Appendix 10B of the Loan Disbursement Handbook .

The ethnic groups' plan is included in Appendix 9 and has been posted for disclosure on ADB's website in August 2013.

E. Gender

11. The project is classified under category II (effective gender mainstreaming) under the guidelines for gender mainstreaming categories for ADB projects.[2] The proposed project sites are the five townships of Mawlamyine in Mon State; Kawkareik, Hpa-an and Myawaddy in Kayin State; and Tachilek in Shan State. These sites are characterized by high levels of internal and external migration, which creates health problems for women in terms of exposure to communicable disease and limited access to services. High levels of mobility often result in family separations and an increased burden on women to care for other family members. Cross-border migrants also include large numbers of young women who can face sexual and reproductive health problems, for example illegal abortions, due to their illegal status in the destination country. The gender action plan is included in Appendix 8.

E. Auditing

12. Overall, the PMU will review and consolidate the physical and financial progress of the project, including unaudited project financial statements, on a quarterly basis, from the MOH, UNAIDS, and international NGOs. The project financial statements will be audited annually in accordance with auditing standards acceptable to ADB. The annual audit report will include auditor's opinions on whether (i) the project financial statements present a true and fair view, in all material respects, in accordance with the applicable financial reporting framework; and (ii) grant proceeds were used only for the purposes of the project. The annual audit report will offer separate opinions on utilization of the imprest fund and compliance with financial covenants specified in the service agreement and the GIM. Audit reports, management letters, and related financial statements will be submitted to ADB in English no later than 6 months after the end of the fiscal year to which they relate, or the project closing date, if earlier. Since the World Bank will rely on the Auditor-General's Office (AGO) for project audits, ADB will communicate with the World Bank to harmonize approaches. The initial draft terms of reference for the AGO are given in the GIM. Based on ADB's Public Communications Policy (2011), the government has agreed that ADB shall post the annual audited project financial statements on its website.

F. Reporting

13. The PMU will submit an inception report with the work plan for the first year and an update of the GIM by the end of the extended (6 months) inception period. The PMU will prepare a project midterm review after 2 years, assessing project performance against agreed indicators and scope of work, and propose any adjustments in scope, implementation arrangements, and allocations. The PMU will prepare quarterly and annual reports in English for submission to ADB within 30 days after the reporting period. The PMU will also prepare a project completion report within 6 months of physical completion of the project (and before final project closing). All project covenants will be monitored monthly by the PMU, and discussed during ADB review missions. The PMU will include information on the gender action plan, ethnic groups' plan, and other social dimensions in all project reports, and project data will be disaggregated by gender and ethnic groups to the extent possible. The PMU will build up township staff capacity to enhance and monitor social and gender impacts.

[2] ADB. 2012. *Guidelines for Gender Mainstreaming Categories of ADB Projects.* Manila.

G. Project Review

14. **Grant Reviews and Transition Review.** ADB and the government will jointly undertake reviews of the project at least twice a year, and preferably more frequently (quarterly) until the midterm review. The reviews will assess progress, specify issues and constraints, and determine necessary remedial action and adjustments. During each review the progress that has been made in the executing and implementing agencies to assume full project management and to move into Phase 2 procedures will be assessed. As aspects of capacity are satisfied the review may recommend to ADB a progressive move to apply Phase 2 arrangements. These may be done one aspect at a time or with several aspects in a group, as readiness is agreed. The aim is to complete the move to Phase 2 arrangements by about the midterm review, if not earlier. More information on the transition is set out in Appendix 5.

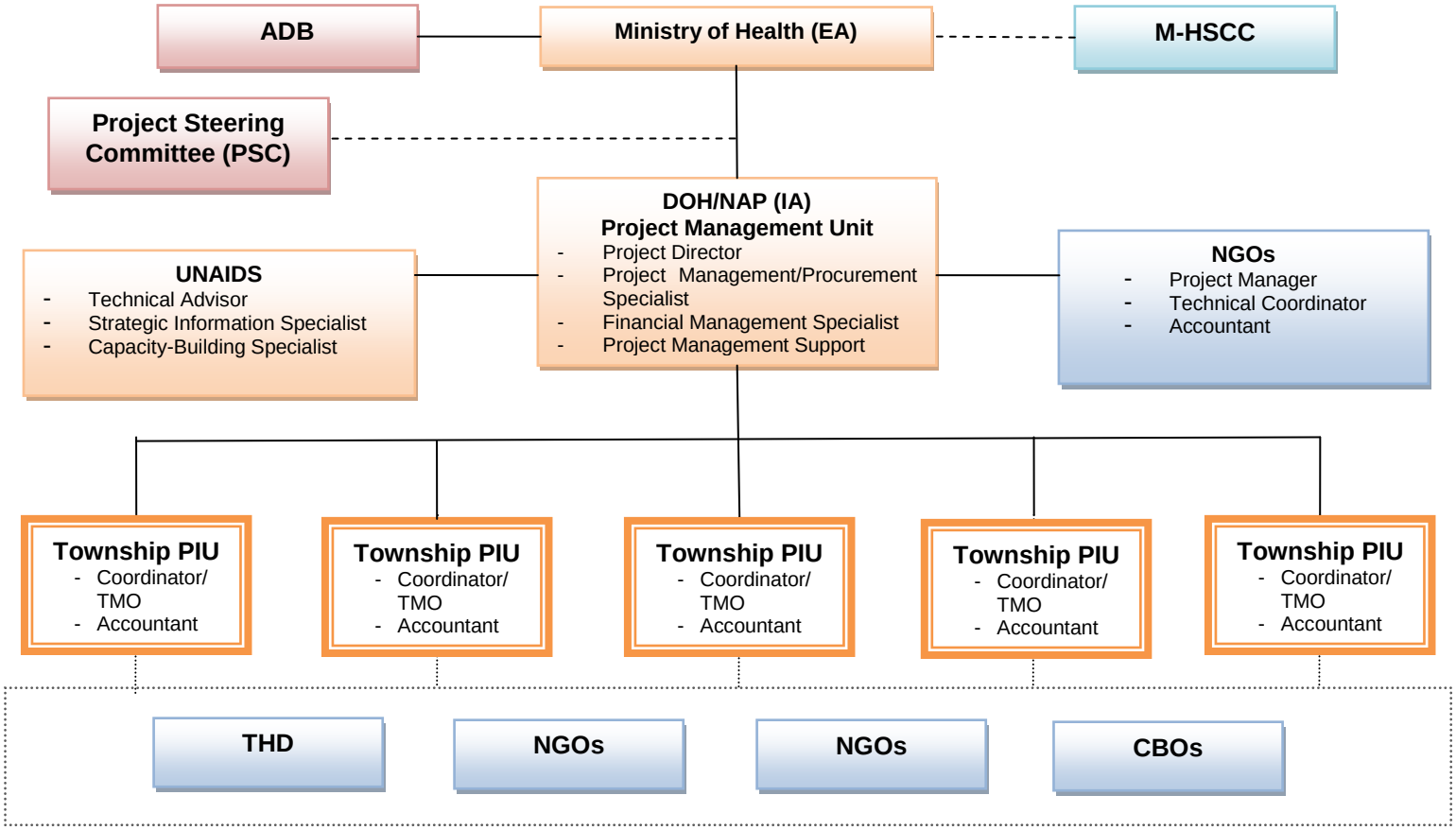
15. **Midterm Review.** A midterm review will be conducted by the project's counterpart staff together with ADB in the second year and will (i) review the project scope, design, and implementation arrangements; (ii) identify changes in scope or implementing arrangements since project appraisal; (iii) assess the project's progress toward meeting its stated objectives; (iv) identify problems and suggest ways to overcome them during the final 18 months of the project; and (v) determine compliance with the service agreement.

16. **Project Completion.** The PMU will prepare an implementation completion memorandum or project completion report during the last month of the project, taking account of advice from ADB on the coverage and format to be used.

H. Implementation Schedule

17. The project will be implemented over 4 years, from January 2014 to December 2017.

Organization Chart



ADB = Asian Development Bank, CBO = community-based organizations, DOH = Department of Health, EA = executing agency, IA = implementing agency, M-HSCC = Myanmar Health Sector Coordinating Committee, NAP = National Aids Program, NGOs = non-government organization, PIU = project implementation unit, PSC = project steering committee, THD = township health department, TMO = township medical officer, UNAIDS = Joint United Nations Programme on HIV/AIDS;
Source: Asian Development Bank.

PHASED APPROACH FOR PROJECT IMPLEMENTATION
(Transition from Phase 1 to Phase 2)

1. There will be two distinct phases, with different implementation arrangements, together with a clear period for a transition review to establish the timing of and conditions for the shift from Phase 1 to Phase 2.

2. The two phases will allow for a progressive development of the Ministry of Health's (MOH's) capacity to establish and manage the implementation arrangements and finances over the project period. The phased approach has been agreed in recognition that this is the first grant assistance to be made available to the Myanmar MOH from the Asian Development Bank (ADB) and that the Ministry has experienced a depletion of system resources and capacity over several decades of limited budget provision. The Ministry will need time to become familiar with ADB requirements, standards, and procedures for grant management and for assessments of the MOH procurement and financial management systems, as well as to establish any modifying arrangements and receive training in the use of revised systems before it will have the capacity to assume control of project implementation using the normal procedures under funding from the Japan Fund for Poverty Reduction (JFPR). Given the need to strengthen the MOH's capacity in project management, and the reality that the government will be managing the majority of the grant funds, a full-time set of project management unit (PMU) consultants will be engaged to assist with project implementation, including procurement and financial management. The adapted implementation process in Phase 1 reflects a recognition by ADB and the government that it is undesirable to delay the availability of new funds designed to improve delivery of urgently needed quality services for HIV prevention in the most vulnerable areas while the government agencies develop the necessary capacity, and that government capacity may be developed more effectively through an assisted "learning by doing" process during the early years of project implementation. ADB will engage the Joint United Nations Programme on HIV/AIDS (UNAIDS) and international nongovernment organizations (NGOs) as implementing partners. It will administer the service agreement with UNAIDS throughout the duration of the project since UNAIDS does not usually operate under contractual conditions in advising national governments. ADB will engage the NGOs during Phase 1 of the project, as they have a history of disengagement with the government. One crucial outcome during Phase 1 will be the government's strengthened capacity to engage NGOs, leading to an improved contract relationship between the two parties. The government will take full responsibility for contracting NGOs during Phase 2. The MOH, with the support of the PMU consultants, will administer the majority of the contracts.

3. The phased approach will include: (i) an extended inception period (up to 6 months), during which the government will receive technical assistance (TA) in establishing its executing agency and implementing agency roles, including specific training by ADB in its procurement requirements; ADB will also assess the adequacy of the MOH's procurement and financial systems and detail specific needs for further TA to be provided by the implementing partners during Phase 1; (ii) service agreements and contracting to allow for the rapid establishment of "first generation implementing partners" through their engagement under direct contracts from ADB in the initial phase, with provision for those contracts to be novated to the control and

management of the government implementing agency after an agreed transition time[1]; and (iii) a staged funds flow mechanism to allow a small portion of the grant (i.e., the amount advanced to the imprest account) to be managed through the government system in the first phase and to gradually move more funds to the government's management based on growing confidence in its capacity as demonstrated through reaching specified milestones[2]; and (iv) progressive capacity building to the MOH, Department of Health (DOH), National AIDS Program (NAP), and DOH township administrations for the sustained maintenance and operation of health facilities constructed, improved, and/or refurbished by the project and for managing project implementation arrangements with international and local NGOs and community-based organizations (CBOs).

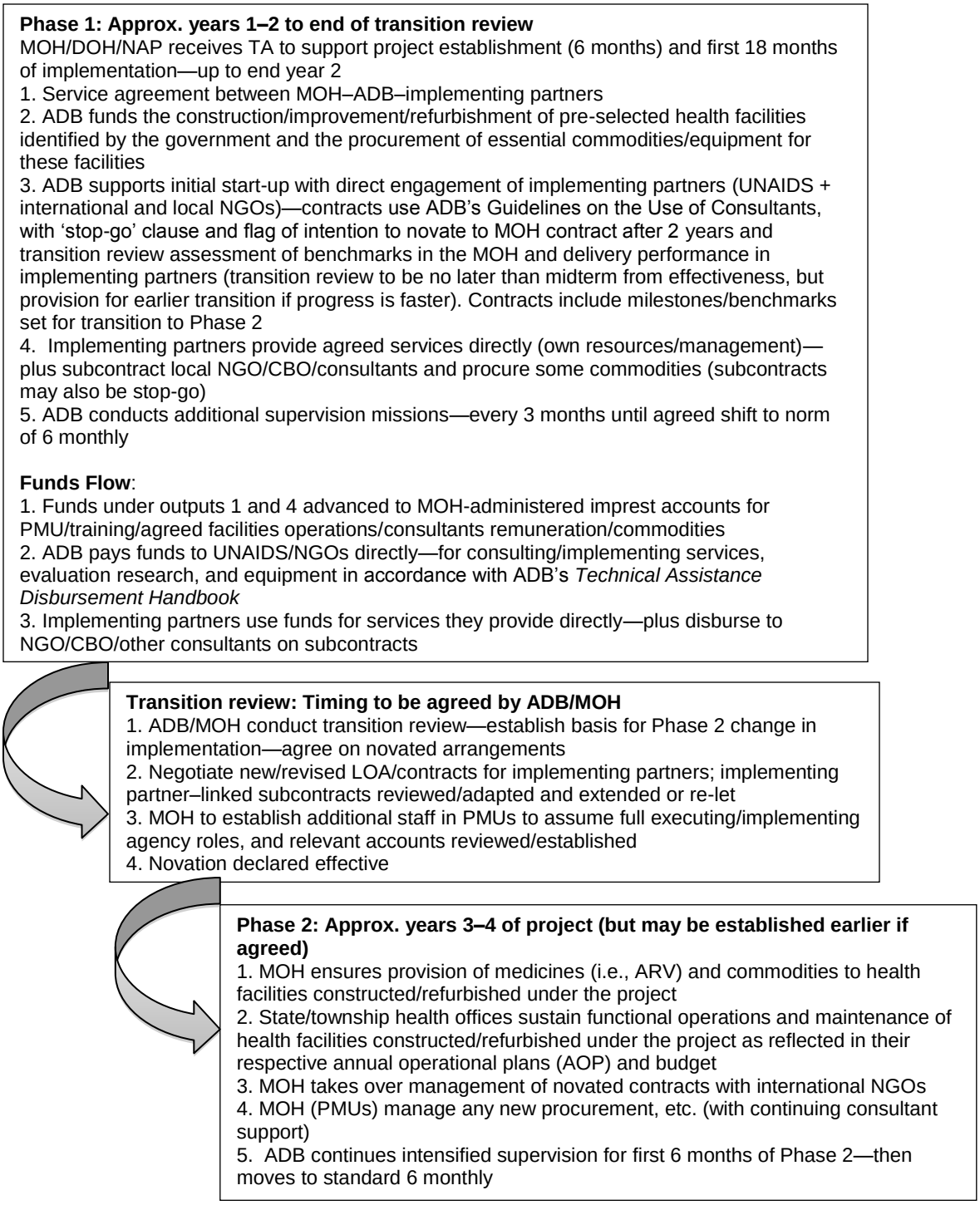
4. The duration of Phase 1, and the commencement of Phase 2, will be determined by an agreement between ADB and the government, based on assessments made by ADB during an intensified supervision program of 3 monthly administrative missions and a specific mission dedicated to a transition review. If the transition review occurs close to the end of year 2, it will be absorbed into the midterm review.

5. An outline of the arrangements for the two-phase approach is in Figure 1.

[1] Novation is a legal term to describe when the rights and obligations of one party under an existing contract (e.g., ADB) against a contractor are assumed (i.e., novated) by a new party (e.g., the MOH). Novation does not change the contract's contents, nor the obligations of the contractor; the main difference is that Party B (i.e., the MOH) will assume the rights and obligations of Party A (i.e., ADB) under the novated contract such that Party B (the MOH) will now assume all of Party A's rights (e.g., to sue for breach of contract) and obligations (e.g., to pay the contractor upon satisfactory completion of services).

[2] Specific performance milestones may include (i) the MOH's increased capacity to manage contracts, disburse funds, and supervise the implementing partners directly; (ii) the adequacy of the financial management system, including the banking payment system, in making timely payments to contractors; (iii)) increased capacity in effectively managing the project's continuing monitoring and evaluation requirements. During the inception mission ADB and the government will review and agree on the criteria and capacity targets on which the assessment for the transition to Phase 2 will be based.

Figure 1 Key features of two-phase implementation arrangements



A. Phase 1 Implementation Arrangements

6. **First Step.** It is proposed that the MOH will be the executing agency and the DOH/NAP will be the implementing agency, covering all four of the outputs. The implementing agency will use the support services of specialized organizations and/or technical agencies to assist in implementation throughout the project. These will be known as implementing partners. UNAIDS

is pre-identified as the implementing partner for Output 1 (as it is the only agency with the required expertise and experience in Myanmar that is acceptable to the government) and will support the implementing agency with implementation of Output 1 and with the monitoring and evaluation (M&E) activities in Output 4. International NGOs, together with associated local NGOs, will be selected as partner service providers to assist the implementation of outputs 2 and 3. They will be selected from among those with an existing presence in Myanmar, that have local experience in delivering relevant services in the five project locations, are willing to be involved in building the capacity of local NGOs/CBOs, and that have or will obtain a memorandum of understanding (MOU) from the government to operate in the project area. Organizations such as Malteser International, PSI, and Mary Stopes International may have sufficient qualifications as international NGOs.

7. **Second Step.** In Phase 1, ADB will engage the implementing partners directly, at the government's request, to allow for rapid mobilization ahead of the development of the government's capacity for managing ADB procurement processes and contract management. The contracts will specify that the implementing partners will work with and be responsible to the government and report simultaneously to it and to ADB. These contracts will be established for the duration of the project. The international NGO contracts will be novated to the government after the transition review has been completed, and may be adjusted or adapted in scope and responsibility, as per agreements made between ADB, the government, and the implementing partners during the review. The contracts will include a "stop-go" clause, which will allow ADB and the government to agree to replace any international NGO in Phase 2 if so agreed during the transition review. Decisions on any such replacement will be made in accordance with specified performance criteria and milestones. Similarly, the subcontracts established by the international NGOs with local providers will also include stop-go clauses.

8. **Third Step.** The implementing partners will implement the range of activities consistent with what is agreed in each approved township plan. They will provide consulting and advisory services in support of planning and staff training directly relevant to the new services, plus the organization and management of the services. The partner international NGO will also advise on the appropriate style for the partnership arrangements and the service agreements needed to support it. The implementing partners will provide agreed services that may be sourced directly from their own experienced staff and established systems, and will also procure and subcontract local NGOs or CBOs and other local firms, social enterprises, or individuals for related services in any of the outputs. The implementing partners will also supply local organizations and staff engaged with targeted capacity-building activities to improve local capabilities to supply services under contract. Details of activities to be sourced from the implementing partners' own resources and implemented directly, and those to be provided by local subcontractors, will be finalized during the inception and added to the contracts by supplementary annexes or service orders.

9. **Supervision and Transition Reviews.** ADB will undertake an intensified program of supervision, consisting of administrative missions at least quarterly, initially, and adjusted as progress becomes established. During each review the progress that has been made by the executing and implementing agencies toward assuming full project management and moving to Phase 2 procedures will be assessed. As aspects of capacity are satisfied the review may recommend Phase 2 arrangements. These may be done one aspect at a time or with several aspects in a group, as readiness is agreed. The aim is to complete the move to Phase 2 arrangements by about the midterm review, if not earlier.

10. For the transition readiness assessments ADB will assess its degree of confidence in the government in the following areas: (i) the capacity of the MOH (including at the district and township level) to manage contracts, disburse funds, and supervise the implementing partners directly; (ii) the adequacy of the financial management system, including the banking payment system, for making timely payments to contractors (ADB reserves the right to conduct further updated financial management assessments, if necessary); (iii) the need for continuing TA for capacity building in management of procurement; (iv) the level of change in government supervision, direct financial control, and reporting to apply from Phase 2 through the end of the project; and (v) the government's capacity to effectively manage the project's continuing M&E requirements. ADB and the government reserve the right to agree to a partial transfer of control and a continuing transition after the transition review, and to determine the duration of an extended transition in Phase 1, including whether or not to conduct a second transition review to establish if and when full government control under the indicated Phase 2 will be feasible. During the inception mission ADB and the government will review and agree on the criteria and capacity targets on which the assessment for the transition to Phase 2 will be based.

11. **Funds Flow (Phase 1).** For MOH-managed expenditures funds will initially be disbursed via two processes: (i) to the MOH through the imprest account, for payment of small training activities, national consultants, and operational costs under outputs 1 and 4; and (ii) by direct payment to the contractors, international consultants, and suppliers under outputs 2 and 4 in accordance with ADB's *Loan Disbursement Handbook* (July 2012, as amended from time to time). Funds paid via the MOH imprest account will be primarily for the hiring of national PMU support staff and some consultant services to provide training and other implementation services in outputs 1 and 4. Payment for office equipment and supplies will be managed from the imprest account. Some contracts under outputs 2 and 4 may be excluded from the imprest account and be managed via direct ADB payment to the supplier. This may apply to complex contracts for research services for data collection for the M&E and the possible reform of aspects of the IT and financial system in the MOH. All payments to be made through the imprest account will be supported by advice and scrutiny from the PMU financial expert. Full supporting documents for the expenditures will be submitted to ADB in the first phase of the project. AGO will be the project's external auditor.[3]

12. ADB will disburse funds to the implementing partners through direct transfers to approved accounts, in accordance with ADB's *Technical Assistance Disbursement Handbook* (2010, as amended from time to time), for consulting or implementing services, evaluation research, and equipment. Implementing partners will submit their claims for payment directly to ADB but may copy the government for monitoring and reporting purposes.

13. The implementing partners will use funds for services they provide directly and disburse to NGOs, CBOs, and/or other consultants on subcontracts. Funds for the subcontractors will be included in the regular invoices and be separately identified within them.

B. Phase 2 Implementation Arrangements

14. **First Step**. The MOH will take over management of novated contracts with implementing partners and assume full responsibility for project implementation until completion. The government may need to increase its deployment of its staff to PMUs to ensure they are adequately resourced for full management control, including for disbursement of funds in accordance with ADB's Loan Disbursement Handbook.

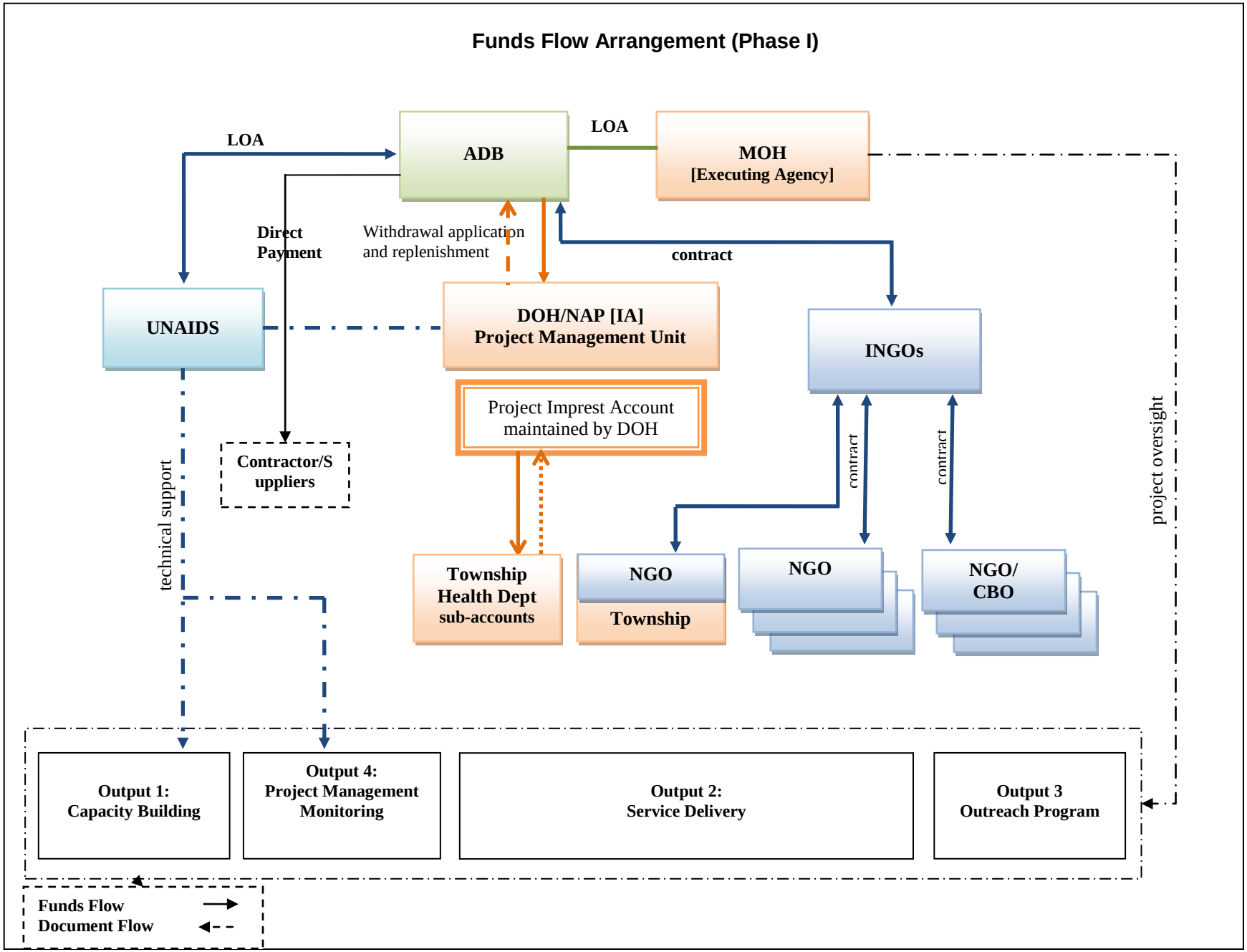
[3] A budget of $40,000 has been allocated in case a need for an independent external auditor arises.

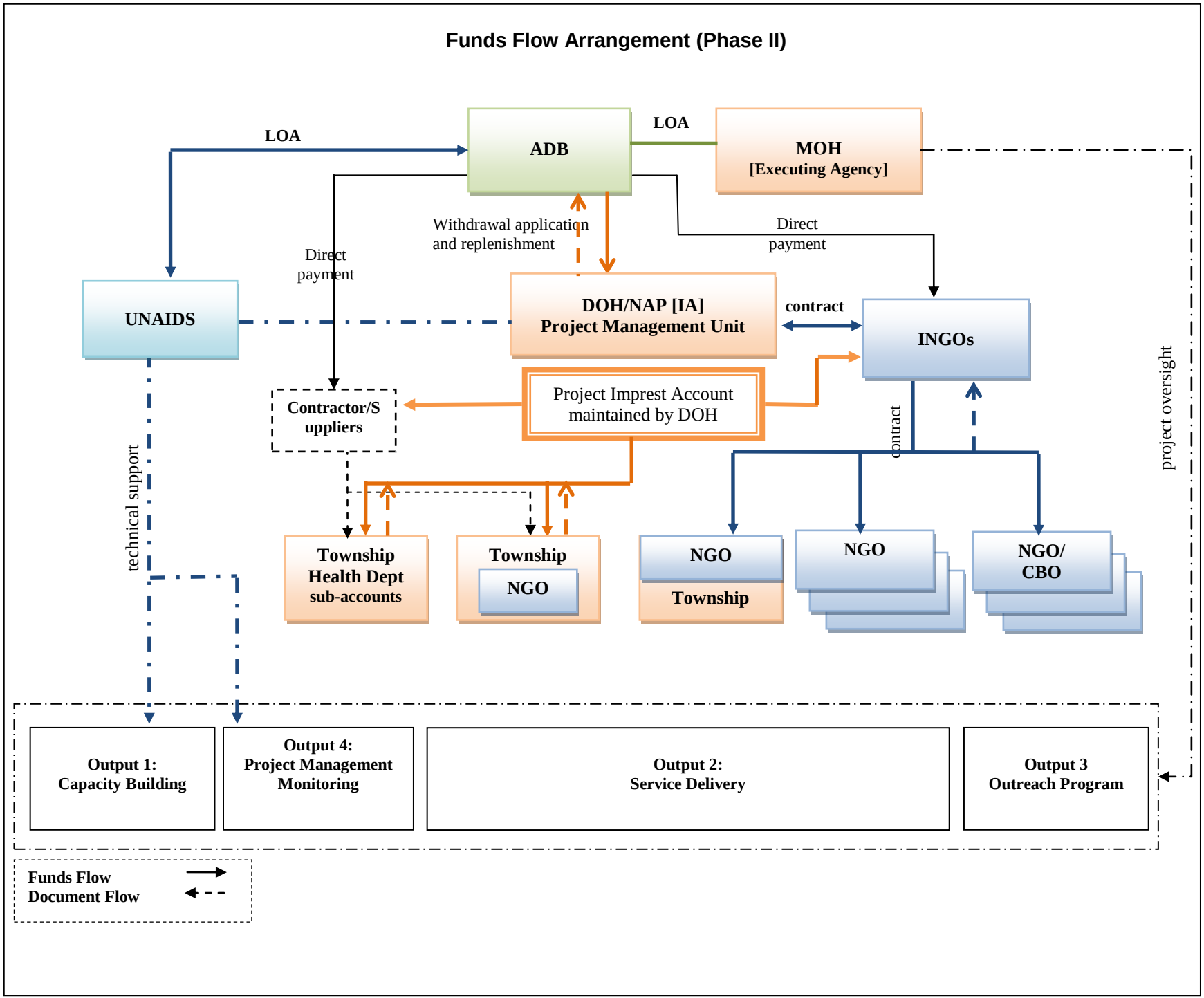
15. The PMUs may manage any new procurement (with continuing support from the project manager-cum-procurement specialist.

16. **Second Step.** ADB continues intensified supervision for first 6 months of Phase 2 and moves to standard biannual supervision thereafter until completion.

17. **Funds Flow (Phase 2).** ADB pays UNAIDS directly in accordance with ADB's *Technical Assistance Disbursement Handbook* (2010, as amended from time to time), and the MOH pays international NGOs in accordance with ADB's *Loan Disbursement Handbook* (2012, as amended from time to time. Appropriate external auditing will be managed by the government and reported to ADB. As in Phase 1, the AGO will be the external auditor for the project.

18. These intentions about the project's phased implementation will be included in the LOA (by cross-referencing the arrangements in Appendix 5 with the JFPR's grant proposal) between ADB and the government to establish the project. The details at a minimum will cover: (i) the initial and intended changes to the roles and responsibilities of the executing authority, the government implementing agency, and the agreed implementing partners, as expressed through the two phases; (ii) the contracting lines, including an agreement for the government to ask ADB to initiate the procurement and direct contracting of the implementing partners to allow Phase 1 to commence rapidly; (iii) the intentions for the novation procedure to set up Phase 2 and the conditions for the novation to be effective; and (iv) the details of the funds flow to be used in Phase 1, and the intentions of the change to funds flow in Phase 2 (as may be agreed during the transition review).


Funds Flow Arrangement (Phase I)
LOA
ADB
LOA
MOH
[Executing Agency]
Direct
Payment
Withdrawal application
and replenishment
contract
UNAIDS
DOH/NAP [IA]
Project Management Unit
INGOs
Project Imprest Account
maintained by DOH
Contractor/S
uppliers
technical support
contract
contract
project oversight
Township
Health Dept
sub-accounts
NGO
Township
NGO
NGO/
CBO
Output 1:
Capacity Building
Output 4:
Project Management
Monitoring
Output 2:
Service Delivery
Output 3
Outreach Program
Funds Flow
Document Flow


Funds Flow Arrangement (Phase II)
LOA
ADB
LOA
MOH
[Executing Agency]
Withdrawal application
and replenishment
Direct
payment
Direct
payment
UNAIDS
DOH/NAP [IA]
Project Management Unit
contract
INGOs
Project Imprest Account
maintained by DOH
Contractor/S
uppliers
contract
project oversight
technical support
Township
Health Dept
sub-accounts
Township
NGO
NGO
Township
NGO
NGO/
CBO
Output 1:
Capacity Building
Output 4:
Project Management
Monitoring
Output 2:
Service Delivery
Output 3
Outreach Program
Funds Flow
Document Flow

SUMMARY POVERTY REDUCTION AND SOCIAL STRATEGY

Country:	MYANMAR	Project Title:	GMS: Capacity Building for HIV/AIDS Prevention
Lending/Financing Modality:	JFPR Grant	Department/ Division:	Southeast Asia Department Human and Social Development Division

I. POVERTY AND SOCIAL ANALYSIS AND STRATEGY

Targeting classification: **General intervention (GI)**

A. Links to the National Poverty Reduction and Inclusive Growth Strategy and Country Partnership Strategy

Myanmar made some modest progress toward the MDGs between 2005 and 2010 but still remains one of the poorest countries in the world. The Government of Myanmar has indicated new priorities to focus on national reconciliation, peace, and stability, using strategies for improving the rule of law and addressing poverty reduction. The government is finalizing its 5-year National Development Plan 2012–2016, together with a framework for economic and social reforms to guide its implementation. ADB will use both the NDP and the framework document to guide its emerging strategy and program for development grants and loans. ADB understands that the government aims to achieve economic growth rates of 7.7% per annum, and to reduce the incidence of poverty from 26% currently to 16% by 2015. With respect to its HIV/AIDS strategy, the government aims to achieve universal access to prevention and care, and to scale up effective initiatives through capacity building.

ADB's objectives for reengagement in Myanmar will concentrate on building human resources and capacities. This is consistent with the government's priorities and with ADB's long-term strategic framework 2008–2020, which identifies HIV/AIDS prevention as a regional public good priority. The proposed project is also fully in line with ADB's Strategic Directions Paper on HIV/AIDS 2011–2015.

B. Results from the Poverty and Social Analysis during Project Preparatory Technical Assistance or Due Diligence

1. *Key poverty issues*. The poor in rural areas and near transport corridors are key groups at risk for HIV/AIDS transmission. These groups could experience deeper poverty if infected with HIV/AIDS as a result of the new vulnerabilities associated with opening up the communities to new development along transport corridors.

Poverty Data. Myanmar is one of the poorest countries in the world, with a per capita GDP of around $860, a Human Development Index rank of 149 of 187 countries, and with about 26% of the population living in poverty (in 2010). Poverty is greatest in regional and rural areas, which account for about 84% of total poverty. There are disparities in levels of poverty across regions and population groups**.**

Beneficiaries. Specific beneficiaries will include those who are most at risk of HIV/AIDS transmission—those who inject drugs, female sex workers, and men who have sex with men—as well as rural village communities that are likely to be at higher risk as development activities expand. Project sites include townships in Mon, Kayin, and Shan states along the East-West corridor and border with Thailand. These locations include a significant proportion of minority ethnic groups. Young female sex workers and women partners of mobile workers are highly vulnerable and specialized treatment is essential for pregnant women to reduce transmission from mother to child. Same-sex relations and drug use remain criminalized in Myanmar, making it harder for these marginalized people to access prevention information and diagnostic and treatment services.

3*. Impact channels.* The impact of improved access to prevention information and treatment services will reduce the general risk that an epidemic will emerge that will exacerbate poverty in affected communities and undercut the benefits of other development support. Contracting HIV/AIDS and living with AIDs leads to loss of livelihoods for the infected and their dependents, and loss of education gains for children of HIV/AIDS sufferers, which in turn keeps families in poverty. Prevention strategies avoid the spread of HIV/AIDS to epidemic levels, which can reduce the adverse effect across whole communities or regions. The gender action and ethnic peoples' plans will support integration of the beneficiaries' needs and interests into each of the project outputs, and ensure effective participation in and access to the benefits of the project.

4. *Other social and poverty issues.* Agriculture is the predominant industry for the bulk of rural areas. Difficulties in climate, water, and infrastructure, as well as a lack of skills, trade opportunities, and investment constrain productivity and lead to poverty and migration. Since July 2012 ADB has approved 14 projects to support development in Myanmar covering a range of sectors and institutional development relevant to improving rural incomes, including public sector and financial management, inclusive development, roads improvement, tourism, trade policy development, skills development, and strengthening of community engagement in projects.

5. *Design features*. The project targets capacity building at national and local levels for HIV/AIDS and other sexually transmitted diseases and the construction and/or refurbishment of appropriate health facilities in the five township projects. It will support development of new approaches to government management of service delivery. It will also introduce progressive capacity building designed to support MOH development of project management capacity. Four outputs will focus on developing MOH institutional capacity in planning and management for HIV/AIDS responses, build and/or improve health facilities, and provide necessary equipment and supplies to strengthen local service delivery. A comprehensive M&E plan is to be developed and implemented. DMF indicators are linked to improvements in planning and delivery of quality services (refer to VI).

II. PARTICIPATION AND EMPOWERING THE POOR

1. *Participatory approaches*. During the project preparation and fact-finding and rescoping missions, consultations were held in Myanmar with government agencies, development partners, NGOs, JICA, and the embassy of Japan and field visits were made to consult directly with local communities in the target locations. All were invited to provide suggestions on the project's design, scope, and implementation arrangements. Expert NGO and UN partners were identified, including UNAIDS. DMF indicators will measure the level of community participation and improved access to services.

2. *Civil society participation*. The project will be implemented with support from local NGOs and/or CBOs, which will be partnered with international NGOs to provide health and outreach services in HIV/AIDS prevention.

3. *How civil society organizations will participate*. NGOs or CBOs will be subcontracted by the international NGO implementing partners during the first phase, and by the government during the second phase to provide staff and resources for service delivery to remote communities.

4. *Forms or Level of civil society organization participation*.

☒ M Information gathering and sharing ☒ M Consultation ☒ M Collaboration ☒ Partnership

5. *Will a project participation plan be prepared?* ☐ Yes. ☒ No The participation of key stakeholders, women, and ethnic minorities will be detailed in the gender action and ethnic peoples' plans.

III. GENDER AND DEVELOPMENT

Gender mainstreaming category: Effective Gender Mainstreaming

A. Key issues. In the Myanmar project locations women are vulnerable to HIV infection due to cultural attitudes and unequal gender relations that make it more difficult for them to be knowledgeable about HIV/AIDS, to negotiate safe sex, or to suggest condom use. Women become highly vulnerable due to the high-risk behavior of their spouses or partners. Poverty and unequal access to resources, assets, and income opportunities can force them into sex work. In Myanmar the proportion of women in the general population with HIV is increasing, while less than half of all HIV-positive pregnant women have access to ART; there is some increase in the number of women who access PMTCT services. Cross-border migrants also include large numbers of young women who can face sexual and reproductive health problems due to their illegal status in the destination country. Factors that limit women's access to HIV services include their lower status in the household, lower literacy rates, limited access to health information, and exclusion from decision making on household health action and expenditures, as well as the stigma and fear of being ostracized by the community.

B. Key actions. ☒ Gender Action Plan ☐ Other actions or measures ☐ No action or measure

A Gender Action Plan has been developed that features an emphasis on a gender sensitive approach with: (i) collection of epidemiological data by sex and age and provision of disaggregated data indicators for outcomes (to show the female share of a total and where 50% indicates gender equality): (ii) gender analysis (e.g., to describe and analyse gender inequalities in access to services, experience with health providers, prevention and treatment options, needs, challenges, gaps, and opportunities; and (iii) gender-sensitive interventions (following the gender analysis, to design specific interventions to reach women according to their specific needs). It also provides for all training and capacity-building activities to strive for 50–60% participation by women health workers and volunteers.

IV. ADDRESSING SOCIAL SAFEGUARD ISSUES

A. Involuntary Resettlement **Safeguard Category:** ☐ A ☐ B ☒ C ☐ FI

1. Key impacts. ☒ No
2. Strategy to address the impacts. Given the nature of project activities, no land acquisition resulting in physical or economic displacement of people will take place. Health facilities will be constructed on government land that is unencumbered or free from any temporary users (not used for residential, business, or productive purposes).
3. Plan or other actions:

☐ Resettlement plan
☐ Resettlement framework
☐ Environmental and social management system arrangement
☒ No action
☐ Combined resettlement and indigenous peoples' plan
☐ Combined resettlement framework and indigenous peoples' planning framework
☐ Social impact matrix

B. Indigenous Peoples **Safeguard Category:** ☐ A ☒ B ☐ C ☐ FI

1. *Key impacts*. The project is expected to have a significant positive impact on the well-being of ethnic groups, particularly those in the selected project township sites
Is broad community support triggered? ☒ Yes ☐ No

2. *Strategy to address the impacts*. The project's design gives high priority to including ethnic minority peoples in training and community-based activities, as well as ensuring that HIV prevention services reach these populations and are culturally appropriate.

3. *Plan or other actions.*

☒ Indigenous peoples' plan
☐ Indigenous peoples' planning framework
☐ Environmental and social management system arrangement
☐ Social impact matrix
☐ No action
☐ Combined resettlement plan and indigenous peoples' plan
☐ Combined resettlement framework and indigenous peoples' planning framework
☐ Indigenous peoples' plan elements integrated in project with a summary

V. ADDRESSING OTHER SOCIAL RISKS

A. Risks in the Labor Market

1. *Relevance of the project for the country's or region's or sector's labor market*.
☐ unemployment ☐ underemployment ☐ retrenchment ☒ core labor standards

Contractors for the construction and/or refurbishment of health facilities would be required to follow national and ADB guidelines on core labor standards.

B. Affordability

Mild impact possible where higher quality and more accessible services are provided. New services under the new management models will be mostly without user charges, except for some limited GP services that are integrated into the referral networks.

C. Communicable Diseases and Other Social Risks

1. *Indicate the respective risks, if any, and rate the impact as high (H), medium (M), low (L), or not applicable (NA):*
☐ Communicable diseases ☐ Human trafficking
☒ Others (please specify). The Project will not create social risks—it addresses health and poverty risks of people vulnerable to communicable diseases.
2. *Describe the related risks of the project on people in the project areas*. The project will ensure, through covenants with the government, that no people will be displaced at the project site during the construction and/or improvement of health facilities. Similar covenants will be made to ensure that the civil works will not have any adverse environmental or health effects. IEC materials and peer education will address disposal issues for needles, syringes, condoms, chemicals, and other waste materials.

VI. MONITORING AND EVALUATION
1. *Targets and indicators*: Measurements for: (i) **Impact**, through reductions in HIV infection rates; (ii) **Outcomes,** through increases in the number and proportion of the population having access to HIV risk information, and diagnostic and treatment services, and improvements in quality through patient satisfaction surveys; and (iii) **Outputs**, through records of increases in numbers and/or proportions of staff trained, planning systems adjusted, facilities improved, and community members accessing new services. 2. *Required human resources*: The project will fund engagement of specialists to develop a comprehensive M&E plan, design survey instruments, and conduct impact evaluations specifically for the pilot models. Local staff will be engaged to support data collection in rural and border communities for the baseline and end-line surveys. DOH staff will be trained in data collection for the health management information system (HMIS). 3*. Information in GIM*: Details are included of an intensified program of ADB administrative missions (up to the MTR), standard monitoring thereafter, the MTR and project completion reviews. 4. *Monitoring tools*: The project provides for a baseline and end-line survey to evaluate the project outcomes and impact. Government data on HIV/AIDS prevalence will also be used and administrative data on service delivery will be improved to serve the project and ongoing MOH management.

ADB = Asian Development Bank; ART = anti-retroviral treatment; CBO = community-based organization; DMF = design and monitoring framework; DOH = Department of Health; GAP = gender action plan; GIM = Grant Implementation Manual; HMIS = health management information system; IEC = Information, education, and communication; JICA = Japan International Cooperation Agency; M&E = monitoring and evaluation; MDG = Millennium Development Goal; MOH = Ministry of Health; MTR = midterm review; NDP = National Development Plan; NGO = nongovernment organization; PMTCT = prevention of mother-to-child transmission; UNAIDS = Joint United Nations Programme on HIV/AIDS.

Source: Asian Development Bank.

GENDER ACTION PLAN

A. Background

1. In the 2011 United Nations Development Programme (UNDP) Gender Inequality Index, which combines measures from a range of sectors, Myanmar ranked 96 out of 146 countries.[1] As noted in the Asian Development Bank's (ADB's) Interim Strategy, cultural values related to women's roles and responsibilities still shape familial relationships, contribute to the gendered division of labor, and limit women's participation in decision making. Key issues of ongoing concern include (i) the high maternal mortality ratio and insufficient access to reproductive and basic health services in a context where reproductive and sexual health services are already extremely limited, especially for female sex workers and unmarried young women and men; (ii) the increase in HIV among women; (iii) low levels of participation by women in public decision making and the labor market; and (iv) the lack of reliable and sex-disaggregated data across all sectors, which hampers evidence-based policy and program interventions.[2]

B. Reproductive Health

2. Myanmar has a high maternal mortality ratio (240 deaths per 100,000 live births) and is unlikely to meet the Millennium Development Goal (MDG) Target #5. Postpartum hemorrhage, eclampsia, and complications from unsafe abortions are the leading causes of maternal death, according to the government's 2006–2011 National Health Plan. Although abortion is illegal in Myanmar, nearly 10% of all maternal deaths are abortion related because the procedure is often undertaken by untrained attendants. In addition, there is about a 20% unmet need for contraception among married women, which may also contribute to abortions. In 2010, 78% of births were attended by a skilled birth attendant. However, the figures differ significantly between the poor (69%) and non-poor (81%) and between rural residents (74%) and urban residents (93%). About 83% of women obtain prenatal care, although access differs between the poor (77%) and non-poor (86%) and between rural residents (81%) and urban residents (93%). In Myanmar, 76% of deliveries take place at home, where nearly 90% of maternal deaths occur. Myanmar also has a high adolescent fertility rate (16.9%), mainly because of the lack of sex education.[3]

C. HIV and AIDS

3. In Myanmar there has been a gradual increase in the proportion of women in the general population with HIV.[4] Women's vulnerability to HIV is increased by the high-risk behavior of their spouses or partners, as well as their inability to negotiate safe sexual practices. Mother-to-child transmission accounts for nearly 3% of new HIV infections.[5] Although less than half of all HIV positive pregnant women have access to anti-retroviral treatment (ART), there has been a sustained increase in the number of women accessing prevention of mother-to-child transmission (PMTCT) services.[6] A number of factors limit women's access to HIV services: their lower status in the household, lower literacy rates, limited access to health information, and

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[1] United Nations Development Programme. *Human Development Report 2011: Sustainability and Equity: A Better Future for All*. New York.
[2] ADB. 2012. Interim Country Partnership Strategy. Gender Analysis. Manila.
[3] United Nations Country Team (Myanmar). 2011. *Thematic Analysis 2011: Achieving the Millennium Development Goals in Myanmar*. Yangon.
[4] Murphy, C. 2012. *Country Report: The HIV Epidemic and Response in Burma (Myanmar)*. Australian Aid. p. 7.
[5] United Nations General Assembly Special Session on HIV/AIDS, 2010.
[6] Murphy, C. 2012. *Country Report: The HIV Epidemic and Response in Burma (Myanmar)*. Australian Aid. p. 12.

exclusion from decision making on household health action and expenditures, as well as the stigma and fear of being ostracized by the community.[7]

4. Gender Issues in Project Sites

(i) Project sites include townships in Mon, Kayin, and Shan states. These sites are characterized by high levels of internal and external migration, which create health problems for women in terms of exposure to communicable disease and access to services. High levels of mobility often result in family separation and an increased burden on women to care for other family members. Cross-border migrants also include large numbers of young women who can face sexual and reproductive health problems, for example illegal abortions, due to their illegal status in the destination country.

(ii) Data from sentinel sites indicates levels of HIV among pregnant women in the project townships equal to or above the national median of 0.8.

	No. of Pregnant Women	%
Mawlamyine	400	0.8%
Myawaddy	399	1.5%
Hpa-an	400	1.0%
Tachilek	400	1.3%

(iii) Data reported by local township voluntary confidential counseling and testing (VCCT) show a high prevalence of HIV in some sites. For example, Myawaddy reports 24.4% prevalence among men and women being tested through VCCT, with women showing a slightly higher rate than men (25.1%: 23.8%).

(iv) In some project sites, the numbers of women receiving ART outnumber men significantly. The general explanation for the higher number of women on ART is that men come for treatment at later stages of illness and die sooner than their partners, highlighting the need for gender-specific targeting that reaches men infected with HIV sooner to allow for more timely uptake of ART.

Receiving ART	Men	Women
Mon State	500	1000
Mawlamyine	200	300
Kayin State		
Myawaddy	18	36
Hpa-an	36	60

5. The gender action plan (GAP) is aligned with national and sector-specific gender-equality commitments detailed in the Department of Health's Gender and Health Plan, as well as the National Strategic Plan and Operational Plan for HIV and AIDS (2011–2015).

Project Outputs	Actions
Output 1: Strengthened planning and management	▪ Situation analysis conducted to assess gender disparities in health providers, access to services, prevention, and treatment options at township and rural levels ▪ Gender issues related to service delivery, capacity of service providers, and needs of target populations are integrated into national, state or regional, and

[7] United Nations Population Fund. 2010. *Report on Situation Analysis of Population and Development, Reproductive Health and Gender in Myanmar*. Yangon.

Project Outputs	Actions
capacity at national, state or regional, and township level	township plans and appropriate budgets allocated ▪ 60% of staff trained in management and planning are women ▪ Gender indicators are integrated in all planning, management, and M&E tools. ▪ All STI/HIV/AIDS, tuberculosis, and malaria implementation activities use sex-disaggregated data for planning and M&E
Output 2: Enhanced capacity to provide quality and accessible services	▪ Undertake capacity assessment and training of health staff, including gender- and age-specific needs and behavioral factors associated with transmission among KAPs as well as social contexts that can support or hinder prevention efforts ▪ Ensure health staff at the various levels (township, RHC, outreach workers) are trained to provide comprehensive services for migrant and ethnic women and girls and female sex workers, including ARV provision, STI and malaria prevention and treatment, VCCT, family planning/reproductive health, antenatal care for PMTCT, condom distribution, home-based care and support, and other issues such as drug abuse and violence ▪ Integrate gender issues related to KAPs into all training and communication materials developed and/or adapted for various service providers ▪ Ensure that 60% of those trained by the project in service provision are female ▪ Ensure facilities are adequately staffed and resourced to provide efficient and quick services for women and families who travel from remote areas for STI/HIV, tuberculosis, and malaria diagnosis and treatment, including ARV provision ▪ Ensure that comprehensive services for marginal groups such as female sex workers and men who have sex with men are available, including dedicated facilities such as drop-in centers that can focus both on medical services and life skills and on counseling needs (including age-appropriate counseling and life skills to make informed choices and negotiate condom use with their clients and intimate partners) ▪ Develop strategies, including more efficient outreach and contact tracing, to reach mobile men infected with STI/HIV in order to ensure more timely uptake of treatment and/or ART
Output 3: Improved access to community-outreach among target populations	▪ Ensure mapping and risk analyses of KAPs (female sex workers, migrants and mobile populations, mobile men with high-risk behavior, people who use drugs, men who have sex with men) cover gender, age, and ethnicity-specific vulnerability ▪ Ensure situation assessment and risk analyses present findings disaggregated by sex, age, and ethnicity and separate consultations are held with men and women in the development of outreach strategies ▪ Develop strategies to reach migrant women prior to departure (safe migration) and highly mobile and freelance female sex workers (those not connected to entertainment establishments) ▪ Develop gender-sensitive or adapt existing IEC/BCC materials in appropriate language for KAPs that promote gender-responsive behavior to STI/HIV, tuberculosis, and malaria risks, break down gender stereotypes, and reduce stigma associated with STI/HIV ▪ Gender preferences related to media, outreach activities, timeframe integrated in BCC/IEC strategies and/or plans ▪ Ensure 100% of peer educators are from the same peer group and are the same sex/gender as the target beneficiaries ▪ Ensure capacity development plan for all peer educators, outreach workers, volunteers (including refresher training, mentoring, and supervision) so that BCC activities are gender sensitive and address the changing needs and contexts of key affected populations ▪ Ensure that IEC materials for young migrant and ethnic women and female sex workers are gender and age appropriate and improve their life skills

Project Outputs	Actions
	▪ Ensure IEC materials target intimate partners of migrants, female sex workers, men who have sex with men, mobile men with high-risk behavior on HIV transmission, use of condoms, and safe-sex practices ▪ Ensure that 80% of female sex workers, female migrants, and ethnic women reached through project report easy access to condoms ▪ 80% of female sex workers, migrants, ethnic women, housewives, men with high risk behavior, and community residents, disaggregated by sex, correctly identify ways of preventing HIV transmission
Output 4: Monitoring and project management	▪ All mapping and risk-analysis data collection to include gender issues and disaggregated findings ▪ All quality assurance tools and M&E to integrate gender issues and indicators and monitor gender-sensitive service delivery ▪ Pilot a feedback mechanism and exit survey for male and female clients who have received HIV, STI, and VCCT services (facility-based or mobile) to determine quality of care

ART = anti-retroviral treatment; ARV = anti-retroviral (drugs); BCC= behavioral change communication; IEC = information, education, and communication; KAP = key affected population; M&E = monitoring and evaluation; PMTCT = prevention of mother-to-child transmission; RHC = rural health clinic; STI = sexually transmitted infection; VCCT = voluntary confidential counseling and testing.
Source: Asian Development Bank.

6. The overall responsibility for implementation of the GAP will rest with the Department of Health (DOH) at the national and township medical offices (TMOs) at the subnational levels. Nongovernment organizations (NGOs) and community-based organizations (CBOs) will also be consulted and engaged in the planning and implementation of activities. The GAP will be tailored to gender-specific requirements within each township, based on research findings during baseline assessments. These local GAPs will contain timelines and responsibilities for action and monitoring during implementation. Implementation arrangements and estimated costs of the GAP are part of the overall project arrangements and total budget. The monitoring of the GAP will be part of the project's overall M&E framework. Quarterly and annual reports will include a specific summary of progress toward implementing the GAP. There is no dedicated gender or social development specialist attached to this project, but additional technical assistance (TA) from within the current regional TA working in the same project sites will be considered.

ETHNIC GROUPS' PLAN

1. The Greater Mekong Subregion (GMS) Capacity Building for HIV/AIDS Prevention Project in Myanmar includes a significant proportion of minority ethnic groups within its target groups in the targeted states. The ethnic groups' plan (EGP) ensures analyses of ethnic peoples' needs and their participation in and access to the project's benefits.

2. The project is classified as category B for indigenous peoples.

A. Background

3. Myanmar is one of the most ethnically diverse countries in the world. The country is geographically and administratively divided into seven regions, which are largely inhabited by the majority Burman population, and seven ethnic minority states named after the largest population group in them—the Chin, Kachin, Kayin, Kayah, Mon, Rakhine, and Shan. These states are not ethnically homogenous, and there are many smaller groups and subgroups with over 100 different dialects, on the basis of which the Myanmar government has officially classified 135 national races.[1] In general, the different ethnic groups in Myanmar have been loosely classified into four main language families: the Tibeto-Burmese, Mon-Khmer, Shan (or Tai), and Karen. Among the overall population, the majority Burman constitute 69%.[2] The largest minorities are the Shan, Karen, Mon, Rakhine, Chin, Kachin, Karenni, Danu, Akha, Kokang, Lahu, Naga, Palaung, Pao, Tavoyan, and Wa peoples.

4. The ethnic minority groups likely to benefit from or be affected by the project in the proposed sites include the Shan, Karen, and Mon peoples. These ethnic groups make up the majority populations in the project sites. A baseline survey, to include gathering and analysis of relevant and appropriate ethnic data and/or profile, will be conducted to strengthen ethnic community mapping in the project areas.

5. Most ethnic Shan live in the lowland valleys of Shan state, but large numbers are also found in Kachin state. A majority are Theravada Buddhists, with some elements of animist practices. The Shan language is part of the Tai-Kadai language family, and is closely related to Thai and Lao, which makes migration to Thailand particularly easy. Karen peoples comprise a number of subgroups who speak a number of distinct but related languages. A majority of Karen are Buddhists, although a significant number have converted to Christianity. Karen subgroups are also found in Thailand. The Mon language is from the Mon-Khmer group of Austro-Asiatic languages. The vast majority of Mon are Theravada Buddhists.[3]

6. Consultations will be conducted with representatives of ethnic minority groups who make up key affected populations in target areas during different stages of project implementation. This will initially take place during participatory needs assessment and demographic analysis of the provision of health services for STI/HIV and other infectious diseases, including malaria, reaching ethnic minority populations in target townships. Further consultations will be made during the design and delivery of culturally sensitive outreach strategies and the development and use of linguistically and culturally appropriate information, education, and communication (IEC) materials. Wherever appropriate, activities will be implemented in coordination with local ethnic-staffed community-based organizations (CBOs).

[1] Health in Myanmar Report 2009. p.7.
[2] UN Office for the Coordination of Humanitarian Affairs. Available: http://www.irinnews.org/report/95462/
[3] Ekeh, Chizom. 2007. *Minorities in Burma*. Minority Rights Group International. London.

B. Ethnicity and Disease Vulnerability

7. Ethnicity is directly related to HIV vulnerability for a number of reasons. Remoteness and language differences constrain effective HIV programs in areas populated by minority ethnic groups.[4] In addition, periods of internal and ethnic-based conflict have led to health threats due to resource constraints, displacement, and migration.[5] Surveys show a disproportionate disease burden in some minority and border areas stemming from multi-drug-resistant tuberculosis and drug-resistant malaria (*P. falciparum*). In the past, civil conflict and lack of opportunity fostered large-scale migration into neighboring Thailand, in particular of ethnic minorities from Shan, Mon, and Kayin states. It is estimated there are more than three million registered and unregistered migrants from Myanmar working or (temporarily) residing in Thailand.[6] Among these, migrant women (and men) enter voluntarily and involuntarily into the sex industry, where they often have higher levels of HIV infection than their Thai counterparts.[7] At the same time, mobile and migrant men also visit sex workers. Due to ongoing movement back and forth across the border, border zones show heightened levels of HIV prevalence. According to Kayin State medical data, surveys in Myawaddy at the Myanmar-Thai border show high levels of HIV prevalence: voluntary confidential counseling and testing (VCCT) done by the United Nations Population Fund (UNFPA) showed a 24.4% HIV prevalence and prevention of mother-to-child transmission (PMTCT) testing done by UNICEF and Global Fund (GF) showed 1.1% HIV prevalence among pregnant women.

8. Subsequent ceasefires have created an opportunity for the development of more effective health service delivery and allowed dialogues to begin with civil society groups and CBOs in previous conflict zones. An ongoing restraint, however, is the limited number of CBOs that have an official status. The recent rapprochement in many areas has also allowed a greater tolerance for use of minority languages in unofficial forms of education and can be potentially used in IEC materials developed by the project.

C. Ethnic Groups' Plan

9. A significant proportion of the population in the target provinces in Myanmar is from ethnic communities. The purpose of the ethnic groups' plan is to outline the potential impacts of the project on ethnic groups and specify actions to address the impacts and help improve the distribution of project benefits to the ethnic communities. Since the lands where the new health facilities will be constructed are owned by the Ministry of Health (MOH), no ethnic household will be physically or economically displaced.

10. The below actions will support integration of ethnic peoples' needs and interests into each of the project outputs, and ensure effective participation and access to the project's benefits. Where impacts on ethnic groups are positive, measures will be identified to enhance and ensure equitable sharing of benefits. Where impacts are potentially negative, appropriate mitigation measures will be identified. The below table outlines anticipated positive and negative effects and recommendations to enhance and/or mitigate impacts.

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[4] Mint Thwe. 2004. HIV/AIDS Education and Prevention in Myanmar. *AIDS Education and Prevention* 16 (Suppl. A). p. 176.

[5] National AIDS Program. *Myanmar National Strategic Plan and Operational Plan on HIV and AIDS 2011–2015.* p. 21.

[6] Hueget, J. et al. 2012. *Thailand at a Crossroads: Challenges and Opportunities in Leveraging Migration for Development.* IOM. Bangkok.

[7] Nigoon, J., Y. Siriporn, and B. Mandhana. 2010. *Migration and HIV/AIDS in Thailand: Triangulation of Biological, Behavioural and Programmatic Response Data in Selected Provinces*. International Organization for Migration. Bangkok.

Project Output	Anticipated Positive Effect	Anticipated Negative Effect	Proposed Measures to Mitigate Impact
Output 1: Strengthened planning and management capacity at the national, state or regional, and township level	Members of minority ethnic groups vulnerable to STI/HIV infection and malaria and ethnic group members living with HIV/AIDS benefitted by enhanced services	Possible exclusion of issues and needs of ethnic communities as a result of limited awareness among government staff	• Ensure key issues related to service delivery needs of ethnic groups are integrated into state and township plans and appropriate budgets are allocated • Needs assessment and demographic analysis of provision of health services for STI/HIV and other infectious diseases, including malaria, reaching ethnic minority populations in target townships • Ensure ethnic community leaders are identified, consulted, and targeted in preparation of STI/HIV and malaria response plans • Ensure the development of guidelines that address ethnic communities' needs and behavioral factors and social contexts that can support or hinder prevention efforts
Output 2: Enhanced capacity to provide quality and accessible services	Increased understanding and capacity of health staff to meet the needs of, and deliver appropriate services for, ethnic communities	No foreseen negative effects	• Training in needs assessment of health staff to include an assessment of their knowledge of minority ethnic groups' vulnerabilities • Ensure that all training and communication materials developed and/or adapted for service providers integrate needs of ethnic communities • Ensure that 100% of township and RHC-level ethnic health staff are appropriately trained
Output 3: Improved access to community outreach among target populations	Increased knowledge among the ethnic communities on STI/HIV and malaria prevention and increased ability to protect themselves		• Training and participatory mapping of risk behaviors of at-risk members of ethnic groups by gender and age • Integration of culturally sensitive approaches to ethnicity into all training and BCC materials, including appropriate language use, developed for service providers and target populations • Coordination with local ethnic-staffed CBOs in implementation of activities • Ensure that IEC/BCC and peer education materials present positive images and integrate issues and information and life-skills needs of ethnic groups • Ensure materials are produced in appropriate ethnic language as needed and disseminated through appropriate media and channels accessed by ethnic communities

Project Output	Anticipated Positive Effect	Anticipated Negative Effect	Proposed Measures to Mitigate Impact
			• 100% of peer educators supporting an ethnic community from the same group • 80% of ethnic group people reached through the project, disaggregated by sex and ethnicity, correctly identify HIV transmission and means of prevention
Output 4: Monitoring and project management	Issues and priority needs of ethnic groups integrated in regional policy dialogue and interventions	No foreseen negative effects	• All joint studies include consultation with ethnic communities and report data by ethnicity and sex • Monitor the proportion of ethnic people accessing services relative to the total population of the ethnic community and report data by sex, age, and ethnicity as well as type of services accessed

BCC = behavioral change communication; CBO = community-based organization; IEC = information, education, and communication; RHC = rural health clinic; STI = sexually transmitted infection.
Source: Asian Development Bank.

D. Implementation Arrangements

11. The overall responsibility for the implementation of the EGP will rest with the Department of Health (DOH) at the national and township medical offices at the subnational levels. Nongovernment organizations (NGOs) and CBOs will be consulted and engaged in the planning and implementation of activities. The EGPs will be tailored to township contexts, based on research findings during baseline assessments. These specific local-level EGPs will contain timelines and responsibilities for action and monitoring during implementation periods. Implementation arrangements and estimated costs of the EGPs are part of the overall project arrangements and total budget. The monitoring of the EGPs will be part of the project's overall M&E framework. Quarterly and annual reports will include a specific summary of progress toward implementing the EGPs.

Table 1. Summary of Target Beneficiaries in Five Target Townships

Location	Ethnic Group	Target Population			Target Ethnic Population	Returnees from Thailand	Target Mobile Population (Residents)	Target PLWHIV	Target MSM	Target FSW
		Male	Female	Total						
Kawkareik	Kayin	146,112	160,562	306,675	2,640	200	1,400	50	10	40
Myawaddy	Kayin	45,306	48,717	94,023	1,320	500	2,000	250	75	150
Hpa-an	Kayin	217,196	235,296	452,492	2,640	500	14,000	100	10	100
Tachilek	Shan	60,669	62,031	122,700	2,640	500	1,440	180	60	100
Mawlamyine	Mon	273,784	131,542	405,326	1,320	50	700	500	150	200
TOTAL		**743,067**	**638,148**	**1,381,216**	**10,560**	**1,750**	**19,540**	**1,080**	**305**	**590**

FSW = female sex workers; MSM = men who have sex with men; PLWHIV = people living with HIV.
Source: National AIDS Program, Ministry of Health, Myanmar. 2013.

Table 2. Number of Health Staff and Facilities Participating in Training

Location	State Level	Township Hospital		Station Hospital		Rural Health Center		Subrural Health Center		Urban Health Center		Subtotals	
	No. trainees (management)	No. trainees	No. facilities	No. trainees	No. facilities	No. trainees	No. facilities	No. trainees	No. facilities	No. trainees	No. facilities	No. trainees	No. facilities
Shan State	30											30	
Tachilek		49	1	14	1	20	4	44	22	0	0	127	28
Kayin State	30											30	
Hpa-An		49	1	56	4	60	12	146	73	2	1	313	91
Myawaddy		49	1	14	1	15	3	36	18	2	1	116	24
Kawkereik		49	1	42	3	20	4	56	28	2	1	169	37
Mon State	30											30	
Mawlamyaing		49	1	14	1	10	2	24	12	4	2	101	18
TOTAL	90	245	5	140	10	125	25	306	153	10	5	916	198

Source: National AIDS Program, Ministry of Health, Myanmar, 2013.