

MEETING REPORT

CONSULTATION ON THE MEMORANDUM OF UNDERSTANDING TO REDUCE HIV VULNERABILITY ASSOCIATED WITH POPULATION MOVEMENT

11-13 JULY 2012

AMARI WATERGATE HOTEL

BANGKOK, THAILAND



*Empowered lives.
Resilient nations.*



TABLE OF CONTENTS

EXECUTIVE SUMMARY	3
SESSION 1: OPENING REMARKS	5
<i>Mr Craig Steffensen, Country Director, ADB Thailand Resident Office</i>	5
SESSION 2: HIV/AIDS AND MIGRATION IN THE REGION	7
<i>HIV/AIDS and Migration in the Region: What Do We Know?</i>	7
<i>2011 GMS MOU and Joint Action Program</i>	9
SESSION 3: COUNTRY PRESENTATIONS	12
<i>Cambodia</i>	13
<i>China</i>	16
<i>Lao PDR</i>	18
<i>Myanmar</i>	22
<i>Thailand</i>	26
<i>Vietnam</i>	28
SESSIONS 4-7 JAP COLLABORATION AREAS	31
JAP COLLABORATION AREA 1 – PROMOTE AN ENABLING ENVIRONMENT AND MECHANISMS	32
<i>Tripartite Action to Protect Migrants Within and From the GMS from Labour Exploitation (TRIANGLE)</i>	32
<i>Legally Binding: A Summary of Labour Laws in the Greater Mekong Subregion</i>	33
JAP COLLABORATION AREA 2 – PROMOTE COMMUNITY-BASED APPROACHES THAT REDUCE HIV VULNERABILITY	35
<i>Enhancing Mobile Population Access to HIV/AIDS Services, Information and Support (EMPHASIS)</i>	35
<i>Prevention of HIV/AIDS among Migrant Workers in Thailand (PHAMIT)</i>	37
JAP COLLABORATION AREA 3 – PROMOTE ACCESS TO HIV/AIDS PREVENTION, TREATMENT, CARE AND SUPPORT	40
<i>Access to Treatment – Medical Aspects</i>	40
<i>Access to Treatment – Legal Aspect</i>	41
JAP COLLABORATION AREA 4 – MONITORING AND EVALUATION FRAMEWORK	46
<i>Developing a Meaningful M&E framework</i>	46
SESSION 8: FINAL JOINT ACTION PLAN	50
SESSION 9: PROPOSED COUNTRY ACTIONS	55
CLOSING AND NEXT STEPS	57
ANNEX I: AGENDA	58
ANNEX II: PARTICIPANT LIST	60
ANNEX III: CONCEPT NOTE	64

EXECUTIVE SUMMARY

Investments in the infrastructure and transport sector in the Greater Mekong Subregion (GMS) have contributed significantly to improved connectivity and greater mobility. Driven by a combination of investment, economic growth and porous borders, more than three million citizens are now on the move within the GMS, a large percentage of whom are low- or semi-skilled migrant workers. These workers move primarily along three migration corridors: from Myanmar, Cambodia and Lao PDR to Thailand; from Vietnam to Lao PDR and Cambodia; and, from Yunnan and Guangxi in the People's Republic of China to Lao PDR and Myanmar.

While the construction of major economic corridors connecting countries in the region has facilitated the increased flow of goods and movement of populations, it has also contributed to an increased risk of transmission of communicable diseases, including sexually transmitted infections (STI), HIV and AIDS. Although migration per se is not a risk factor for HIV, challenges throughout the migration process for both documented and undocumented migrants can increase health-related vulnerabilities¹. For example, data from a recent IBBS study in the 6 provinces with the highest HIV prevalence rates in Thailand has shown staggering HIV prevalence rates among migrant workers: 2.5 % for Cambodian, 1.16 % for Myanmar and 0.5% for Laotian workers.

Within the GMS the need for joint action for HIV prevention and better access to treatment, care and support is increasingly articulated at national and provincial (border provinces) levels, especially in contexts where migrants and mobile populations face barriers to accessing services in destination countries. In 2004, the six countries in the GMS signed a *Memorandum of Understanding (MoU) for Joint Action to Reduce HIV Vulnerability Related to Population Movement* and, following the expiration of this MOU in 2009, an amended MoU was signed during the 4th GMS Summit in Myanmar in 2011. Accompanying the 2011 MOU is a draft Joint Action Program (JAP) that identifies priority areas for bilateral and multilateral cooperation.

Drawing guidance from both the MoU and its attached draft JAP, the Asian Development Bank (ADB) and the UNDP Asia-Pacific Regional Centre jointly convened this *2012 Consultation on the Memorandum of Understanding to Reduce HIV Vulnerability Associated with Population Movement*, in order to formulate concrete national, bilateral and subregional activities to address the challenges faced by migrants and mobile populations in this area. 25 government and CSO representatives working in the fields of health and HIV attended the event, along with representatives from key partner and donor organizations. Members of the Joint United Nations Initiative on Mobility and HIV in South East Asia (JUNIMA) provided technical support, while a strong group of expert presenters acted as resource persons for the event.

Working sessions of the Consultation were organized around the four collaboration areas of the GMS MoU's draft JAP. Guided by this framework, participants shared country progress and challenges and proposed concrete activities under three of the JAP's four collaboration areas: (1) promoting an enabling environment; (2) promoting community-based strategies that reduce HIV vulnerability; and (3) promoting access to HIV/AIDS prevention, treatment, care and support. The fourth collaboration area: (4) monitoring and evaluation, was also addressed during plenary sessions.

¹ UNDP, 2010, *HIV and Mobility in South Asia*; UNDP, 2009, *HIV Vulnerabilities Faced by Women Migrants: From Asia to the Arab States*

Throughout the three day consultation participants were able to articulate important next steps for operationalizing the draft JAP, by: identifying and agreeing on key activities, timeline and responsible actors; identifying potential sources of funding and funding mechanisms; and, developing country action plans. Participants identified a range of priority needs, including: (i) an improved knowledge base on migration and mobility patterns, for both documented and undocumented workers in the subregion; (ii) improved understanding of the continuum of treatment and care across borders, including treatment compatibilities across borders; (iii) increased joint implementation prevention and care programmes at source and destination by community and civil society groups; and, (iv) greater advocacy for migrants' inclusion in universal coverage schemes as the region moves toward one ASEAN community by 2015.

The key formal output of this meeting is an agreed Joint Action Plan (see Session 8 of this report), built from the draft JAP produced in September 2011, which will be presented for endorsement during the 11th Meeting of GMS Working Group on Human Resource Development, to be held in Myanmar on 4-5 October 2012. In addition, the joint priorities detailed in the JAP now provide a useful tool to assist participating government and civil society representatives from the GMS region to make a more coordinated effort to address HIV Vulnerability related to population movement. Participants' identification of key challenges and gaps in access and provision of health and HIV services for migrants in the region will also assist ADB and UNDP APRC, through JUNIMA, to identify priority areas for further collaboration.

SESSION 1: OPENING REMARKS

MR CRAIG STEFFENSEN, COUNTRY DIRECTOR, ADB THAILAND RESIDENT OFFICE

(Please check against delivery)

Opening Remarks

Mr. Craig M. Steffensen, Country Director, Thailand Resident Mission

Good morning. I would like to welcome you all to this important consultation meeting.

ADB investments in the transport sector in the Greater Mekong Subregion have contributed in opening new economic corridors which are offering local communities opportunities for an improved future. Transport plays a prominent role in ADB's poverty reduction and economic development efforts.

While infrastructure development promotes physical connectivity and regional economic integration, it can also bring increased risks of potential spread of communicable diseases, including HIV/AIDS. Hence, alongside the achievements made by the rapid economic development in the GMS, preemptive measures are necessary to mitigate and address possible negative side effects.

Such was the intent when six countries in the GMS decided in 2011 during the 4th GMS Summit in Myanmar to renew the Memorandum of Understanding (MOU) for Joint Action to Reduce HIV Vulnerability Related to Population Movement. The goal is to reduce HIV vulnerability and promote access to prevention, treatment, care and support among migrants and mobile population and affected communities in countries in the GMS.

ADB helped facilitate the renewal of the MOU. The initiative is part of ADB's continuing commitment to build and strengthen regional capacity to implement effective HIV and AIDS prevention and mitigation in the GMS, particularly among migrant and mobile population and other high-risk groups in cross-border provinces. And this commitment is shared by the UNDP- Joint United Nations Initiative on Mobility and HIV/AIDS (JUNIMA) which is ADB's partner in ensuring that the MOU and the Joint Action Plan become a platform for sustained action and cooperation.

As we convene today, we move forward from renewing the MOU to breathing life to it and ensure its implementation. We will seek to identify appropriate funding schemes and financing arrangements to sustain its activities. We will try to address any potential barrier to its implementation.

Let me thank, first and foremost our colleagues from the Cambodia's National AIDS Authority and the National Center for HIV/AIDS, our colleagues from Lao PDR's Center for HIV/AIDS and STIs, our colleagues from Myanmar's Department of Health, our colleagues from the Ministry of Health of the People's Republic of China, our colleagues from the Ministry of Public Health of Thailand, and our colleagues from the Viet Nam Authority of HIV/AIDS Control (VAAC), Ministry of Health.

Together with participants from the provincial health departments and provincial AIDS secretariats, their field perspective and direct involvement in prevention programs are expected to enrich the discussions over the next three days.

Allow me also to thank our esteemed partners from the civil society sector. Your insights and perspectives are indeed important to us. I am also pleased that we have with us today our partners from the Global Fund to Fight AIDS, TB and Malaria, World Health Organization (WHO), UNAIDS, and the World Bank, JICA, and the International Labour Organization.

I am grateful to have representatives from our long-term partners, AusAID and the Swedish International Development Agency for their funding support and partnerships. To Ms. Marta Vallejo and our friends from JUNIMA, thank you for co-organizing this event with us.

To all of you, I hope that we will leave here with a deepened understanding on how we can work together in implementing the GMS MOU-Joint Action Plan and build partnerships for securing maximum results.

On behalf of the ADB Thailand Resident Mission, I wish you a productive consultation meeting.

SESSION 2: HIV/AIDS AND MIGRATION IN THE REGION

HIV/AIDS AND MIGRATION IN THE REGION: WHAT DO WE KNOW?

Presenter Ms Marta Vallejo-Mestres, *HIV/AIDS Programme Specialist, UNDP Asia-Pacific Regional Centre*

Migration in the GMS

- There are more than 3 million people on the move in the region
- Movement is driven by economic growth, large investments in infrastructure and transport, and porous borders; and economic growth and investment increase the need for mobile workforces and low-skilled workers in labour-intensive jobs.
- There are three established migration patterns in the GMS:
 - *Low-skilled migrant workers* from Myanmar, Cambodia & Lao PDR → Thailand
 - *Low-skilled migrant workers* from Vietnam → Lao PDR and Cambodia
 - *Higher-skilled workers* from Yunnan and Guangxi → Lao PDR and Myanmar
- Labour migrants are mainly found in construction, fishing and seafood processing, agricultural industry, domestic and household sectors.

Migration and HIV in the GMS

- Migration is *not* a risk factor for HIV, however migration can increase vulnerability to HIV due to lack of access to health services and information; increased discrimination; and, lack of access to social support systems.
- A new IBBS study in the 6 provinces with the highest prevalence in Thailand has shown high figures for HIV prevalence among migrant workers: 2.15 % for Cambodian migrant workers; 1.16 for Myanmar migrant workers; and, 0.51% for Laotian migrant workers.
- Migrants - internal and/or cross border - are included as vulnerable populations in National AIDS Strategies in all countries in the Asian region, including 6 GMS countries, while current overarching UNAIDS Strategy, *Getting to Zero, 2011-2015*, involves three key aims: zero new infections; zero AIDS-related deaths; zero discrimination.
- There are a range of challenges in providing HIV/AIDS prevention, treatment, care and support services to cross-border labour migrants, including: policies on access for migrant workers; sensitivity and Suitability of Service Provision; differences in ART Treatment Regimens; and, sustainability of financing.

Improving Access to HIV services for Migrant Workers in the GMS

Report on Consultation on Migrant's Access to Anti-retroviral Treatment Continuum in Four GMS Countries, Bangkok, April 2012

- 30 central government policy makers, local health officials and civil society organizations working with migrants and/or people living with HIV addressed challenges of navigating different access policies, health systems, treatment regimens and modes of service provision and worked on creating a coordinated model of HIV service provision for migrants
- This coordinated model of HIV service provision for migrants involved the following key components:
 - **Service Providers**
 - Public/Private Hospitals, provincial and district
 - Community Health Centres
 - Community Drop-in Centres
 - CSOs/NGOs
 - Peer networks, Peer educators
 - Mobile services
 - Pre-departure information providers
 - **Services:**
 - VCT
 - ART
 - OI Treatment
 - ANC & PMTCT Services
 - Community Outreach and Information
 - Monitoring of treatment adherence
 - Emergency funds/support services for migrants
 - **Information & Awareness Activities**
 - Clinical and social research partnerships,
 - investigating difference in treatment regimens
 - reviewing access policies for migrant workers
 - mapping available models of service delivery
 - **Partnership Activities**
 - Bilateral consultations between sending and host countries
 - Joint policies and protocols on ART management

2011 GMS MOU AND JOINT ACTION PROGRAM

Presenters Mr Chris Lyttleton, *Technical Advisor-Consultant, Asian Development Bank*
Ms Emiko Masaki, *Social Sector Specialist, Southeast Asia Department, Asian Development Bank*

Historical Background of MoU

- First GMS MOU signed in September 2001 in Cambodia; second signed in 2004, expiring in 2009
- These MOU represented shared understanding among GMS countries that addressing HIV vulnerability caused by the greater mobility of populations, is a common concern requiring concerted action
- The 9th GMS ADB Meeting of WGHRD in Guilin, 6 GMS countries expressed the need to renew the MOU, further confirmed in the 3rd GMS Workshop on HIV Prevention and Infrastructure in Vientiane in September 2010. At this meeting ADB was asked to facilitate the process for renewing the 2004 MOU.
- ADB, ASEAN Task Force on AIDS and JUNIMA convened a workshop with GMS countries in Bangkok (April 2011) to review and revise the MOU, leading to a working draft MOU and Joint Action Plan and agreements on a 5-year timeframe for a new MOU

MOU for Cross-border collaboration

- Signed at GMS Summit in Myanmar in December 2011. Cross-border collaboration and Joint Action Program: to reduce HIV vulnerability; to promote access to prevention, treatment, care and support among migrants and mobile population and affected communities in countries in the GMS. Includes draft Joint Action Plan.

ADB's Strategic Priorities for HIV prevention

- Mitigate HIV risk and vulnerability increased by infrastructure development
- Promoting regional cooperation in HIV prevention
- Knowledge development and sharing; and Policy dialogues

ADB's Strategic Response to HIV and AIDS in the Region

- 1) A Strategic Directions Paper (2005): *Development, Poverty, and HIV/AIDS: ADB's strategic response to a growing epidemic*
Established link of HIV and AIDS and Poverty and Development
- 2) A Regional Integration and Cooperation Strategy (2006)
Demonstrates ADB's commitment to regional cooperation and integration
- 3) Strategy 2020: The Long-Term Strategic Framework of the Asian Development Bank (2008)
Places Infrastructure development as a core operation of ADB
- 4) Strategic Direction on HIV Prevention and Mitigation in Asia and the Pacific (2011-2015)

ADB's GMS Portfolio on HIV and AIDS

- *Loans with HIV component:* 35 projects (31 of which are infrastructure projects (road development, irrigation, etc.) and 31 TA/grant projects on HIV and AIDS. The projects and TAs have expanded the knowledge base for actions in these areas and provided ADB with experience in effective regional and country-level HIV programming.

GMS MOU Joint Action Plan

Strategy	Key Activities
1. Promote Enabling Environment and Mechanisms	
1.1 Support enabling policy environment to reduce HIV vulnerability, stigma & discrimination, and promote access to prevention, treatment, care and support by improving systems of governance on development-related mobility.	<ul style="list-style-type: none"> • Collect evidence to support policy devt and share information from research and good practices. • Raise awareness and advocate among policy makers for supportive policies. • Disseminate and advocate for the implementation of the MOU and JAP at various levels and among relevant sectors.
1.2 Strengthen intra- and inter-country multi-sectoral collaboration, including public-private partnership, on HIV vulnerability related to migrants and mobile population at the local, national and regional levels.	<ul style="list-style-type: none"> • Facilitate multi-sectoral collaboration at intra- and inter-country levels relevant to mobility-related HIV issues <ol style="list-style-type: none"> i) <i>Organize regional forums to address issues and share information and experiences on mobility-related HIV issues among relevant stakeholders</i> ii) <i>Support existing or develop new cross-border collaboration, projects and programs</i> iii) <i>Encourage engagement of relevant stakeholders</i>
2. Promote community-based strategies that reduce HIV vulnerability	
2.1 Promote community-based development approaches using people-centered methodologies by empowering communities affected by development-related mobility to prevent HIV infection.	<ul style="list-style-type: none"> • Involve communities and key affected population and migrant workers in the planning, implementation and monitoring of interventions. • Develop activities for affected communities to understand, anticipate and adjust to development factors that contribute to HIV vulnerability resulting from mobility. • Strengthen collaboration amongst agencies, including the private sector, involved in and related to development planning and projects/programmes.
3. Promote access to HIV and AIDS Prevention, Treatment, Care and Support	
3.1 Promote leadership and political commitment at the community, national and regional levels to improve access to prevention, treatment, care and support.	<ul style="list-style-type: none"> • Conduct dialogues between sending and receiving countries on access to prevention, treatment, care and support services for migrants and mobile population.
3.2 Support strategies that ensure access to comprehensive HIV and AIDS prevention, treatment, care and support for migrant and mobile populations.	<ul style="list-style-type: none"> • Develop a joint mechanism for provision of quality care, including ART and referral system for migrants and mobile population.
4. Monitoring and Evaluation	
4.1 Use the annual meetings of the focal points for monitoring the progress of the implementation of the MOU Action Plan	<ul style="list-style-type: none"> • Review progress and identify follow up actions in annual meetings of focal points, held either independently or in conjunction with the annual meetings of ATFOA, JUNIMA, ADB, others
4.2 Establish an M&E framework to review progress in the implementation of the MOU	<ul style="list-style-type: none"> • Develop M&E tools in line with the activities of the Joint Action Plan • Conduct Joint Review of progress in implementing the MOU
4.3 Establish reporting mechanism to the signatories of the MOU	<ul style="list-style-type: none"> • Report to the biennial ASEAN Health Ministers Meeting plus China, or alternative meeting as required

ADB's Regional Initiatives on HIV and AIDS (ongoing)

- The 2nd GMS Regional CDC Project in Cambodia, Lao PDR and Viet Nam: \$47M (grants and loan), 2011-2015
- TA for Fighting HIV/AIDS in Asia and the Pacific: Subproject 3: HIV Prevention in the Infrastructure Sector in the GMS (\$1.7 million, 2008-2013)
- TA on HIV Prevention and Infrastructure: Mitigating Risk in the GMS (with 10 subprojects) – co-financed with AusAID, \$6M, 2008-2012

Regional Technical Assistance on HIV Prevention and Mitigation

Subprojects

- 1) LAO: Northern Economic Corridor
- 2) LAO/VIE: East-West Economic Corridor
- 3) VIE: Central Region Transport Network
- 4) GMS: Cross-Border Transport Agreement (CBTA)
- 5) CAM: Road Improvement Project
- 6) CAM/VIE: Southern Coastal Corridor
- 7) LAO: Northern GMS Transport Network Improvement Project
- 8) CAM/VIE: PP-HCMC Highway Project
- 9) CAM: NW Provincial Road Improvement
- 10) VIE/LAO: Second Northern GMS Transport Network



ADB's Regional Initiatives on HIV and AIDS (planned)

- GMS Regional Capacity Building for HIV/AIDS Prevention Project, Lao PDR and Viet Nam (grant and loan), 2013-2017
- TA on Enhancing Regional HIV Response in the GMS (co-financed by Sida), 2013-2014
- TA Labour Migration and Social Protection in ASEAN Communities (proposed 2015-)

ADB and the MOU-JAP

- Facilitation of MOU renewal and eventual signing of 6 countries in 2011
- Facilitation of detailing of Joint Actions and (for endorsement in the GMS HRDWG 2012)
- Regional knowledge management
- Link with other ADB projects focusing on migrants and mobile populations and cross-border issues

SESSION 3: COUNTRY PRESENTATIONS

During this session, representatives from each of the six GMS countries gave presentations providing a national situation assessment of the following, where available:

- cross border mobility and HIV/AIDS;
- policies and regulations on HIV/AIDS and migrant and mobile populations;
- access to medical interventions and ARV regimes for people living with HIV;
- current laws and policies affecting access to HIV medication.

Presenters also provided proposed joint actions, short and medium term, for effective health services support systems for migrant and mobile populations.

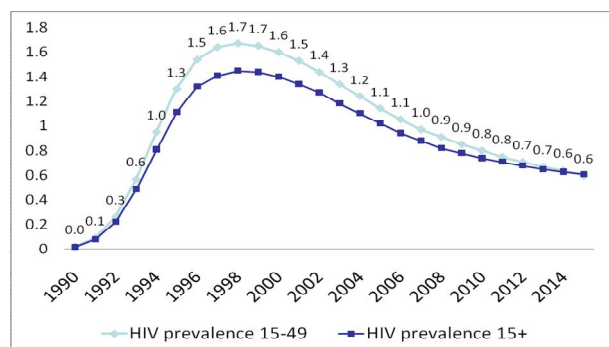
Following are highlights of these presentations. Pdf versions of complete PowerPoint presentations can be found on the JUNIMA website, www.junima.org.

CAMBODIA

Presenter Dr Ngauv Bora, *Vice Chief of AIDS Care Unit, National Center for HIV/AIDS, Dermatology and STDs, Ministry of Health*

Situation Assessment: HIV/AIDS

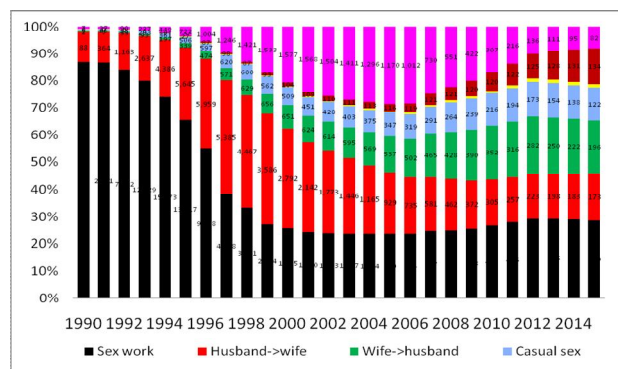
HIV Prevalence among population aged 15+ versus 15-49



Source: NCHADS and Partners, *HIV estimation and projection 2011*; Bros Khmer 2012.

- Entertainment Workers: 14.4% in 2010
- IDU/DU: 24%/1% in 2007
- MSM: 8.7% (2007 in Phnom Penh), 2.2% (in 2010, Bros Khmer Study)
- Mobile populations: no data

HIV/AIDS Situation, Modes of Transmission



Source: NCHADS and Partners, *HIV estimation and projection 2011*

- Almost 80% sexual transmission

- Foreign migrant workers in Cambodia: no data.
- Cambodian migrant workers to Asian countries (no clear data):
 - Thailand: 181.579 registered workers (2005, Thai Mol)
 - Estimated 180.000 other undocumented workers
 - Malaysia: around 20.000 workers (2010)
 - South Korea: 9.000 workers (2010)
 - Saudi Arabia, Qatar and Kuwait.
- Actual number currently may be much more than the above, but no updated data.
- No data on HIV prevalence or on sexual behavior among Cambodian migrant workers in nearby countries, neither data on HIV prevalence among migrant workers in Cambodia.
- Estimated 2-3% of PLHIV on ART were reported as migrants in nearby countries. There's report on HIV (+) migrants who misses their treatment follow up.

Situation Assessment: Current access to medical interventions and ARV regimes for people living with HIV

- All HIV positive people living in Cambodia including migrants are eligible for ARVs.
- HIV-VCCT exist at almost all health centers and referral hospitals all over the country, if tested positive, they will be referred to ART treatment.
- By the end of 2011: 57 ART sites; 46473 PLHIV are active patients on ART.
- ART coverage in 2010 is 92 % (UN MDG Award 2010)

ARV Regimen in Cambodia

- First Line regimen
 - Zidovudine + Lamivudine (AZT + 3TC)
 - Stavudine + Lamivudine (d4T + 3TC)
 - Zidovudine + Lamivudine + Nevirapine (AZT + 3TC + NVP)
 - Stavudine + Lamivudine + Nevirapine (d4T + 3TC + NVP)
- Second line regimen
 - TDF + 3TC + LPV/rvt
 - TDF + 3TC + ATV/rvt
- Alternative with
 - ABC + 3TC + LPV/rvt
 - ABC + 3TC + ATV/rvt

Cambodia cannot produce ARVs, ARVs are bought from WHO-pre-qualified pharmaceutical companies by Principle Recipient of GF.

Policies & Regulations on HIV/AIDS and Migrant & Mobile Populations (MMPs) at Cross-Border Areas

- Migrant & Mobile Population is a focus area in National Strategic Plan for Comprehensive and Multi-sectoral response to HIV/AIDS (III) , 2011-2015
- National Strategic Plan for Migrant & Mobile Population & HIV/AIDS 2010-2014 established that cross-border collaboration is encouraged, but lack of clear joint strategies and financial supports.
- Pre-departure policy for registered workers:
 - Enforces the pre-departure HIV education for registered migrants through the ministry of labor and vocational training.
 - Undocumented migrants are out of its coverage, some NGOs provide community forums.
- No policy to ban foreign workers from access to ART services in Cambodia

Proposed Joint Actions for effective health services support system for MMPs

Short-term Priority Actions (2011-2012)

Outcome	Strategies	Actions/Activities
Cross-border coordination body established and working	Strengthen bilateral and regional collaboration in the response to HIV/AIDS among MMPs	-cross border coordination mechanism established -regular meeting -develop joint plan and mobilize resource to provide HIV intervention among MMP at least preventive education and referral to existing health services -train healthcare providers
	Strengthen existing healthcare services esp. along the border to be ready to response to the MMP's or returnees' needs	

Medium-term Priority Actions (2011-2015)

Outcome	Strategies	Actions/Activities
Stigma and discrimination reduced	Reduce stigma and discrimination towards MMPs Receiving countries or NGOs develop HIV preventive and care program for migrant and mobile population	-Conduct campaign -Media -conduct regular HIV preventive education forums to migrant and mobile population -refer them to health services (VCT, STI, OI/ART...)
Risk and vulnerability of migration fully informed to population	Raising awareness at pre-departure	-mass media -community forums -facilitate pre-departure registration -pre-departure counseling

CHINA

Presenter Yi Lelai, *Ministry of Health*

Situation Assessment: HIV/AIDS (in internal migrant population)

- No. of rural labor migrants to cities/towns: 250 million, majority aged 18-49
- Cumulative no. of reported HIV/AIDS by the end of 2011: 351 709
- Reported HIV/AIDS in 2011: 92,940

Situation Assessment: Cross-border mobility and HIV/AIDS

- No specific information on HIV situation of cross-border migrant populations

Measures to prevent HIV spread between migrants

- Health education
- Surveillance and Testing
- Intervention among IDUs, FSWs and MSM
- ART Provision
- School for children of rural labour migrants

Situation Assessment: Current access to medical interventions and ARV regimes for people living with HIV

- You can get free ART: HIV+ & Cd4 < 350 /mm³, supported by Central Government
- Chinese Pharmaceutical factory produces most 1st line drugs. 2nd line drugs are imported.

List of 1 st line ART regimens used in adults ≥15 years old	List of 2 nd line ART regimens used in adults ≥15 years old
1.AZT+3TC+EFV	1.TDF+3TC+EFV
2.AZT+3TC+NVP	2.TDF+3TC+NVP
3.AZT+ddI+EFV	3.LPV/rLPV/r+AZT+3TC
4.AZT+ddI+NVP	4.LPV/r+AZT+ddI
5.d4T+3TC+EFV	5.LPV/r+d4T+3TC
6.d4T+3TC+NVP	6.LPV/r+ddI+3TC
7.d4T+ddI+EFV	7.LPV/r+TDF +3TC
8.d4T+ddI+NVP	
9.ddI+3TC+EFV	
10.ddI+3TC+NVP	
11.3TC+AZT+EFV	
12.3TC+AZT+NVP	
13.Other	

Policies & Regulations on HIV/AIDS and Migrant & Mobile Populations (MMPs)

- *Notice of the State Council on Further Strengthening HIV/AIDS Response by State Council 2010)*
 - Enhance HIV/AIDS health education targeting migrants;
 - Establish mechanism to ensure Free ART for migrants;
 - Establish mechanism to ensure MMT for drug users among migrants.
- *China's Action Plan for Reducing and Preventing the Spread of HIV/AIDS (2011-2015)*
 - by the general office of the state in 2012), with target of bringing HIV/AIDS knowledge awareness rate of migrants reaches above 85% by the end of 2015.
- *Rural Migrant Worker HIV Prevention Awareness "At Factory, At working field" Project*
 - launched on 21 Dec 2010, jointly implemented by All-China Federation of Industry and Commerce and State Council AIDS Working Committee Office. Supported by 5 ministries and covering 20 provinces.
- *Red Ribbon Health Package Project*
 - by China Red Ribbon Foundation (established by All-China Federation of Industry and Commerce), provides gift bag (15 080 given in 2010): health knowledge manual, towel, gloves, masks, knowledge poker, a band-aid, condoms, soap and so on.

Global Fund HIV/AIDS and Migration Project

- Launched on 1st January 2010, covered 7 provinces (municipalities) and 21 cities (districts), broadened in 2012 and now aims to provide comprehensive HIV/AIDS prevention services for over 2 million migrants in 5, 785 program sites (including factories, hotels, labour sites)
- 175,841 target migrants received HIV/AIDS intervention, care and support (end 2010).

Proposed Joint Actions for effective health services support system for MMPs

The goals for HIV/AIDS prevention and control in the 12th Five Year Plan (2011-2015) is to keep the number of PLWHA at about 1.2 million.

LAO PDR

Presenter Dr Bounpheng Philavong, *Director, Centre for HIV/AIDS and STIs*

Situation Assessment: Cross Border Mobility

- Long contiguous national borders (Thailand, Viet Nam, Cambodia, Myanmar and China)
- Rapid growth in regional economic, trade, tourism and manpower cooperation
- Increasing volume of domestic & trans- border population movement with resultant HIV vulnerability
- Lao PDR is both a source and destination country for migrant workers (infrastructure development projects, domestic and agricultural work, fishing industry, service sector, domestic and housework etc..)
- Destination countries: mainly Thailand and Malaysia
- A large number of Laotians have migrated through illegal channels
- No estimates have been found on the number of undocumented migrants to Malaysia and Thailand.
- The country is also a destination country for migrant workers, especially from Viet Nam, China and Thailand.
- The Lao population is vulnerable to trafficking due to high poverty levels and porous borders. Lao PDR is a source country for trafficked men, women and children to Thailand.

Situation Assessment: Cross Border Mobility and HIV/AIDS

- Limited information is available on HIV infection rates and risk behaviours among migrant workers and mobile populations
- According to a 2005 study: over 50 percent of people living with HIV and AIDS in Lao PDR had at one time migrated for work in another country; some of the males and females were involved in sexual activities outside marriage; condom use was very low for both regular and non-regular partners; almost half of the men used drugs and less than five percent of women.
- HIV prevalence among migrant workers was below one percent (0.37%) in 2005.

Situation Assessment: Current access to medical interventions and ARV regimes for people living with HIV

VCT Services in 2010

- At provincial level: 60 sites
- At district level: 83 sites
- Health Centres: 3 sites

Number of PLHIV using ongoing ART, 2003-2011

- Total Adults: 1855
- First Line Regimen: 1447 (72.79%)
- Alternative First Line Regimen: 379 (19.06%)
- Second Line Regimen: 29 (1.46%)

ARV Regimen trends for Adults, 2011

1st & al. 1st line	ARV Regimen for adults	Total patients on this regimen	Not Stratified %
1st	FDC (AZT-3TC-NVP)	00(	0(.0 %
1st	FDC1 (D4T-3TC-NVP)	00(	0(.0 %
1st	FDC5 (D4T-3TC) + NVP	4	0.0 %
1st	FDC7 (AZT-3TC) + NVP	00(	0.0 %
1st	FDC5 (D4T-3TC) + EFV600	00(	8.0 %
1st	FDC5(D4T-3TC) + EFV200	8	0.0 %
1st	FDC7 (AZT-3TC) + NVP	00(	0.0 %
1st	FDC7 (AZT-3TC) + EFV600	00(	0.0 %
1st	FDC7 (AZT-3TC) + EFV200	3	0.0 %
al.1st	ABC + 3TC + NVP	0(	3.0 %
al.1st	TDF + 3TC + EFV600	00(	7.0 %
al.1st	TDF + 3TC + NVP	0(	4.0 %
al.1st	ABC + 3TC + EFV600	0(	0.0 %
al.1st	ddI250 + AZT + EFV600	2	0.0 %
al.1st	FDC5 (D4T-3TC) + ABC	1	0.0 %
al.1st	ABC + TDF + EFV600	1	0.0 %
al.1st	ddI250 + 3TC + AZT	0	0.0 %
al.1st	TDF + 3TC + EFV200	2	0.0 %
al.1st	FDC7 (AZT-3TC) + LPV/r	0(	1.0 %
al.1st	FDC5 (D4T-3TC) + LPV/r	8	0.0 %
al.1st	ABC + 3TC + LPV/r	6	0.0 %
al.1st	FDC7(AZT-3TC) + TDF	1	0.0 %
al.1st	TDF + 3TC + LPV/r	8	0.0 %
al.1st	(TDF-FTC-EFV600)	9	0.0 %
al.1st	(TDF-FTC) + EFV	4	0.0 %
al.1st	(TDF-FTC) + NVP	1	0.0 %

ARV Regimen Trends on Second Line, 2011

2 nd Line Regimen for adults	Total patients on this regimen	Not Stratified %
TDF + 3TC + LPV/r	12	0.60%
ABC + ddI250 + LPV/r	1	0.05%
AZT + ddI250 + LPV/r	2	0.10%
ABC + TDF + 3TC+LPV/r	1	0.05%
FDC7 (AZT-3TC) + TDF + LPV/r	11	0.55%
FDC7 (AZT-3TC) + ddI250 + LPV/r	2	0.10%

Funding for ARV in Lao PDR

- Funding for ARV for Lao PDR: 100 % from the GFATM
- SSF 1st commitment: will last until end of 2012... Enough ARV
- SSF 2nd commitment: 2013-2015
- Enough funding for 2013 and 2014, however only enough for 6 months in 2015.
- Need additional fund of around 350,000 USD for 2015 for ARV
- After 2015 no funding secured, as GF round 11 cancelled. Waiting for announcement of next GF round, possibly end 2013.

Policies & Regulations on HIV/AIDS and Migrant & Mobile Populations (MMPs) at Cross-Border Areas

NSAP 2011-2015

- scale-up national capacity and responses towards universal access for prevention, treatment, care and support.
- expanding HIV VCT
- Strengthen M&E and surveillance
- increase condom use among target populations; strengthening data collection mechanisms for strategic information
- build capacity among implementing agencies.
- Focus on MARP: SW and clients, mobile populations, drug users, MSM and young people
- raise awareness among mobile populations and their families in rural and urban areas
- provide pre-departure and post-arrival information and counseling services at prioritized border crossing locations
- reach behavioural change
- increase the use of condoms
- provide STI confidential services
- establish and strengthen VCT services and referral systems
- build local authorities capacity to support mobile populations and their families.

Proposed Joint Actions for effective health services support system for MMPs

1. Strengthen/Establish Mobility Technical Working Groups (MTWG)
2. Cross-border meeting (bilateral) on HIV and AIDS – participated by all border provinces
3. Border province meetings on HIV and AIDS- participated by key sectors
4. Formulate a regional mechanism for the involvement of civil society including Mobile and Migrant People
5. Increase access to health care services for mobile and migrant workers

Medium-term Priority Actions (2011-2015)

Policy

- Harmonise policies on HIV and AIDS and Mobility and Migration
- Rationalise HIV VCT and referrals for migrant workers (not the same as standardizing, because countries have access to different resources and technologies)

Increase access

- Increase access to social support services for mobile and migrant workers
- Improve access to condom for Mobile and Migrant Populations

Capacity building

- Increase capacity building for health care providers and social welfare supporters.
- Capacity building and support for communities , especially those having direct impact by MMPs

Monitoring and Evaluation

- Set up a country monitoring and evaluation system for mobile and migrant populations;
- Include mobile and migrant populations in national surveillance, particularly sentinel surveillance (HIV, STI and behaviours).

Resource Mobilization

- Analyse situation analysis to provide evidence for use in advocacy and resource mobilization
- Estimate resource needs.

Behavioural Change Communication (BCC) for mobile and migrant populations

- Improve BCC access for Mobile and Migrant Populations; and
- Institutionalise pre-departure and post-arrival training programmes as standards for all countries (start with capacity building).

Share experiences and good practices

- Set up a system to share experiences and good practices – ASEAN (SOMHD, ATFOA, GMS, JUNIMA, ADB)
- Border meetings
- Regular forum - GMS

MYANMAR

Presenter Dr Myint Shwe, *Assistant Director (HIV/AIDS), Department of Health*

Situation Assessment: Cross-Border Mobility

- With Socioeconomic changes, infrastructure development, and improved physical connectivity among the GMS countries, population movement is increasing within and across borders.
- Cross- borders mobility between Myanmar, especially with China & Thailand, has been seen for many years.
- Not much research on migrant and mobile populations
 - High levels of migration: source, transit, destination and return especially in South-East Myanmar
 - Local populations travel across to Thailand and beyond
 - Internal migration also seen within country.
 - Health facilities at air ports, sea ports and ground crossing points were upgraded.

Situation Assessment: Cross-Border Mobility and HIV/AIDS

- *Activities along Myanmar-Thailand Border related to HIV/AIDS/STI*
 - HIV & AIDS Prevention and Control Activities including STI Management, Voluntary Confidential Counseling and HIV Testing, Prevention of Mother to Child Transmission.
 - Provision of Care and Support to the People living with HIV/AIDS and their families
 - Collaboration for increasing access to HIV Care and Support services
 - Myanmar-Thailand Joint Action Plan for cross border health development activities
- *Activities along Myanmar-China Border*
 - MOU for Capacity Building, Information Sharing and Networking, Strengthening Capacity in Disease Control between Health Ministries in 2001.
 - MOU for Reduction of HIV Vulnerability related to population movement, GMS Health Ministers, 2004
 - 1st ASEAN-China Health Ministers Meeting back to back with 8th ASEAN Health Ministers Meeting, 2006 (HIV Prevention & Control was decided Potential Area of Cooperation)

Situation Assessment: Current access to medical interventions and ARV regimes for people living with HIV

- 31 adult ART sites established between 2005 and 2010
- ART's provided by and through a range of international and national NGOs, including: MSF, MDM, AFXB, AMI, Save the Children, Care, MSI, MNA, IOM, Malteser, Alliance, AHRN, PSI, Burnet Institute, Pyigy Khin, Ratanamyitta, UNION

ART: What to Start?

- *HIV positive ARV naive adults and adolescents:* AZT or TDF + 3TC (or FTC-Emtricitabine) + EFV or NVP (d4T not preferred because of side effects, but if it is used initially, should not be for an extended period and should replace d4T with AZT or TDF).

- *HIV positive pregnant women*: same as above. AZT preferred but TDF acceptable. EFV preferred over NVP if CD4 count > 250 cells/mm³ because of risk of NVP toxicity; do not initiate EFV in first trimester. HIV positive women with prior exposure to MTCT - for details see text.
- *HIV/TB coinfection*: AZT or TDF + 3TC (or FTC) + EFV ; ART to be started 2 to 8 weeks after start of TB treatment ; NVP not recommended.
- *HIV/HBV coinfection*: NNRTI regimens that contain both TDF + 3TC (or FTC).

Recommended Second-Line ART

- *HIV positive adults and adolescents*:
 - a. If d4T or AZT used in first line therapy – TDF + 3TC (or FTC) + ATV/r (Atazanavir, ATZ) or LPV/r
 - b. If TDF used in first line therapy – AZT + 3TC (or FTC) + ATV/r or LPV/r
- *HIV positive pregnant women*: same as for adults and adolescents
- *HIV/TB coinfection*: substitute rifabutin (150 mg 3 times/week) for rifampicin if available; if not available same NRTI backbone plus LPV/r or SQV/r (Saquinavir) with adjusted dose of RTV (LPV/r 400mg/400 mg BD or LPV/r 800mg/200 mg BD or SQV/r 400 mg/400 mg BD
- *HIV/HBV coinfection*: AZT + TDF + 3 TC (or FTC) + ATV/r or LPV/r

Policies & Regulations on HIV/AIDS and Migrant & Mobile Populations (MMPs) at Cross-Border Areas

Policy

- Myanmar signed MOU for Joint Action to Reduce HIV Vulnerability Related to Population Movement between following other GMS countries in 2004.
- Heads of State from the six GMS countries including Myanmar signed a new MOU on Joint Action to reduce HIV vulnerability associated with population movement.

National Health Policy (1993) in Myanmar includes :

- To expand the health service activities not only to rural but also to *border areas* so as to meet the overall health need of the countries.
- To strengthen *collaboration with other countries* for national health development.
- To promulgate new rules and regulations in accord with the prevailing health and health related conditions as and when necessary.

National Strategic Plan II and Operational Plan 2011-2015

- Mobile and migrant populations and communities affected by population movement are included as a focus population.
- Strategic Priority I: Prevention of the transmission of HIV through unsafe behaviour in sexual contacts and injecting drug use
- Strategic Priority II: Comprehensive Continuum of Care for people living with HIV
- Strategic Priority III: Mitigation of the impact of HIV on people living with HIV and their families

Proposed Joint Actions for effective health services support system for MMPs

Short-term Priority Actions (2011-2012)

Outcome	Strategies	Actions/Activities
Authorities, decision-makers and all other related stakeholders at national and township levels become more aware about MOU and JAP so as to address more activities for MMPs.	Mobility thematic groups comprised of representatives from different related Govt ministries, UN,NGOs/CBOs are formed or revitalize existing coordinating bodies at national, regional and townships level.	Advocacy done .
Stronger partnerships established between HIV and anti-trafficking programmes (including law enforcement, general administration), and HIV prevention modules included in anti-trafficking programmes.	Prepare advocacy tools	Advocacy done
More resources made available	Find both internal and external funding sources. Prepare evidence based advocacy tools.	Advocacy done

Medium-term Priority Actions (2011-2015)

Outcome	Strategies	Actions/Activities
More mobile/migrant populations know their HIV status and gain access to health services including treatment.	Continuum from prevention to care, support and treatment programmes established at major hot spots/ mobility hubs with effective referral systems and networks.	Established migrant-friendly clinics or DICs. Provide VCCT and ARV, OI and STI drugs.
Behaviour change increases as education becomes more effective. Communities vulnerable to HIV because of their association with mobile/migrant populations become more resilient and able to make the most of mobility-related opportunities for development	More community-based prevention and care/treatment/support programmes are implemented in identified mobility-affected communities in a coordinated and participatory fashion using migrant-friendly methods linked to and supporting existing services.	Conduct community-based awareness campaigns.
Evidence based advocacy tools and programming developed.	Develop research protocols related to attitude towards mobile/migrant population in general and their associated risks and vulnerabilities to HIV along the migration routes led by	Conduct research followed by dissemination.

SESSION 3: COUNTRY PRESENTATIONS

	National AIDS Programme in collaboration with other related partners.	
Bilateral collaboration among neighbouring countries increased to facilitate referrals, transport, safe return, continuity of care for mobile/migrant persons	Expanded authority and mechanisms for actors on both sides of a border to meet and develop programme collaboratively	Conduct regular cross border meetings.
Improved analysis of migration patterns using common tools to facilitate regional sharing (common database, mapping at state level, collection instruments, early warning systems etc.) leads to improved programmes.	Establish database system on migrants	Capacity building for HRs and provide facilities.
Large companies and industries and workplace employing mobile/migrant populations implement more prevention and care/treatment/support programmes.	Develop or reinforce supportive instructions for employees.	Advocacy done.

THAILAND

Presenter Dr Pairoj Saonuam, *Medical Physician, National AIDS Management Centre, Department of Disease Control*

Situation Assessment: Cross-border Mobility

- Migrant workers are a necessary component of the workforce in Thailand
- There were 1,482,258 migrants in Feb, 2011 (78.6% Myanmar; 10.5% Lao PDR, 10.9% Cambodia)
- Source countries are mostly on Myanmar, Cambodia and Lao PDR
- Unskilled, and work in a variety of jobs: Daily Laborers, Factory workers, Fishermen and Seafood Processors, farm workers, Sex Worker, and Domestic Workers

Situation Assessment: Cross-border Mobility and HIV/AIDS

- The trends of HIV prevalence, represented by HIV sero-surveillance, indicated the continuous declination among fishing boat crew including Thais and migrants since 1997
- HIV prevalence is higher among migrants than Thais in many locations
- HIV prevalence among migrant FSW is higher than for Thai FSW
- HIV prevalence by nationality: Burmese – 0.67%, Cambodian – 2.53%, Lao PDR: 0.5% (Source: IBBS among 10 provinces, Thailand, July-August 2010)
- HIV prevalence by duration of stay in Thailand: 1-3 years -1.26%, 4-6 years – 1.45%, 7-9 years -1.44%, 10+ years – 1.92%
- HIV prevalence by occupation: fisherman – 1.96%, fishery workers – 2.34%, factory workers – 1.08%, farm workers – 0.74%

AIDS Cases in Border Areas

- Thai-Lao PDR border: 729 non-Thai (19.0%)
- Thai-Myanmar border: 2915 non-Thai (76.1%)
- Thai-Cambodia border: 113 non-Thai (2.95%)
- Thai-Malaysia border: 70 non-Thai (1.82%)

Policies & Regulations on HIV/AIDS and Migrant & Mobile Populations (MMPs) at Cross-Border Areas

- *Alien Working Act, 2008*
 - Government Policy on Registration includes Cabinet Resolutions, registration of migrant workers and dependents, registration of employers stating their needs for migrant workers
- *Migrant Healthcare Financing System*
 - Compulsory medical examination (fee:USD 17 USD)
 - Permitted to work if free from: tuberculosis; leprosy; filariasis; syphilis; malaria; and intestinal parasites
 - Unfit to work if: mental disorder/retardation; drug addiction; alcoholism; and the contagious stage of: tuberculosis; leprosy; filariasis; and syphilis

- health insurance premiums were 35 USD
- similar benefit package as Thai citizens enrolling in the National Universal Health Coverage Scheme
- Medical services provide in the same health facility at which they had their initial medical examination.
- exception of migrant fishermen who can access emergency services in the 22 coastal provinces
- ART limited only migrants in project "NAPHA-EXTENSION". However, Opportunistic Infection has been included.

Proposed Joint Actions for effective health services support system for MMPs

Existing Activities

- Capacity building for the health staffs along the border
- Promotion of STIs Clinic Services
- Develop practical guideline on HIV/AIDS surveillance and prevention for population along the border
- Develop the model of HIV/AIDS prevention for sex worker along the border

Proposed Actions

- Strengthening Information sharing system and network
- Capacity building: human resources (health staff/community and people) and health facilities)
- Strengthening of health service system in order to increase access to health services among migrants and cross-border population
- Strengthening collaborative mechanisms for border health collaboration, e.g. meetings of cross-border working group

VIETNAM

Presenter *Vietnam Authority of HIV/AIDS Control, Ministry of Health*

Situation Assessment: Cross-border Mobility

- Vietnam shares a 1,150 kilometer border with PRC (Lang Son, Lao Cai, Cao Bang, Ha Giang and Quang Ninh), a 1,650 kilometer border with Lao PDR (Lai Chau, Dien Bien, Son La, Nghe An and Kon Tum) and a 950 kilometer border with Cambodia (Mekong Delta provinces). Many official and unofficial border crossings have been opened to facilitate movement of people and goods.

Situation Assessment: Cross-border Mobility and HIV/AIDS

- *Cambodia-Vietnam border:* Vietnamese use Mekong waterways to go to Cambodia. In the Mekong Delta Provinces, there are many internal risk factors (eg commercial sex) for HIV transmission, but the risk situations are aggravated by return migrants from Cambodia who might have been exposed HIV/AIDS there.
- *Lao-Vietnam border:* Opium users in these areas may switch to injecting drugs if similar patterns occur as elsewhere, namely a scarcity of opium near trafficking routes leading to injecting of heroin. Further situational assessment is urgently needed to examine these areas and determine their potential for HIV/AIDS risk.
- *PRC-Vietnam border:* Cross-border mobility at the PRC-Vietnam border involves HIV risk situations.
- The two main threats of the AIDS epidemic in Vietnam are linked with mobile population
 - The first and the most severe one is through IDUs.
 - The second route of spread for HIV has been the link of the Vietnamese migrants with Cambodia. Intravenous drug use and commercial sex remain a dangerously important source of HIV transmission in the country but it is time now to look into many of these migrant and mobile population groups and their sexual networking.

Situation Assessment: Current access to medical interventions and ARV regimes for people living with HIV

ARV regimen: Base on update national guidelines

- 1st line regimen: TDF+ 3TC + EFV/NVP
- 2nd line regimen: TDF + 3TC + LPV/r; LPV/r + 3TC + EFV/NVP

Funding for ARVs:

Donors:

- PEPFAR (SCMS), Clinton (finished end 2011), Global Fund
- Procurement of ARV: Donors (bidding in international market);
- Importation of ARV: VAAC

National program:

- 5-10% total ARV budget
- Bidding process through HIV Treatment Committee, most ARVs are domestic pharmaceutical products (products of STADA Ltd.)

Policies & Regulations on HIV/AIDS and Migrant & Mobile Populations (MMPs) at Cross-Border Areas

- 2006 The Law on HIV/AIDS (article 16 and 14)
- 2008 Decision No 38/2008/QĐ-TTg by Prime Minister on 'Mechanism for Collaboration on Cross-border HIV/AIDS Prevention and Control'
- 2010 Decision No 4744/QĐ-BYT by Minister of Health on issuing "Guidelines for HIV/AIDS prevention at workplace"
- 2012 National Strategy on HIV Prevention and Control from 2011-2020 and the vision to 2030 (defining Migrant and Mobile populations being important objectives for HIV/AIDS prevention)
- 2012 Direction No 06/CT-BGTVT by Minister of Transportation on Strengthening HIV Prevention for the Transportation sector.

Proposed Joint Actions for effective health services support system for MMPs

Short-term Priority Actions (2011-2012)

Outcome	Strategies	Actions/Activities
HIV/AIDS prevention and control for mobile population being strengthened	develop and implement preventive intervention strategies for mobile populations in general and national highway travelers in particular	To reduce the vulnerability to HIV and AIDS of those who are working in the transport sector, with a focus on staff and workers of the sea ports, waterways and civil Construction sub-sectors in a period 2011-2013
Policy and regulation on HIV/AIDS is strengthened	National target 2011-2015 in response to HIV/AIDS	To develop comprehensive HIV/AIDS programs for migrant and mobile populations
The awareness of Authority body have been raised	MOU between Government, provincial and social civil	Advocacy the leadership involvement of Government, province, social civil and other International organizations in response to HIV/AIDS

Medium-term Priority Actions (2011-2015)

Outcome	Actions/Activities
The management role of border provinces in response to HIV/AIDS being strengthened	Encourage border provinces to support to implement interventions for mobile populations such as social marketing, communication, etc;
Capacity of staff of the health system and transportation have been improved	Exchange staff training and sharing experience on HIV/AIDS between regional countries

Cooperation with neighboring countries being improved

Planning Meeting of countries in Sub Mekong Region including Vietnam, Lao, Cambodia, Myanmar, Thailand, China. Interventions should be focused on education for behavior change, STI treatment and condom supply

Meeting between countries should be conducted annually /quarterly to overview the situation of population mobility and its effected to HIV/AIDS transmission

BCC and IEC is populated in border areas

Suitable Information, Education and Communications materials should be developed. Material distribution could be done by service providers at hot spots or managing authorities of mobile populations

SESSIONS 4-7 JAP COLLABORATION AREAS

Sessions 4-7 of the meeting each focused on one of the four Collaboration Areas of the Joint Action Plan, introduced in Session 2, as follows:

- JAP 1: Promoting an Enabling Environment and Mechanisms*
- JAP 2: Promote community-based approaches that reduce HIV vulnerability*
- JAP 3: Promote Access to HIV and AIDS prevention, treatment, care and support*
- JAP 4: Monitoring and Evaluation*

Each of the four sessions commenced with a presentation from an expert speaker on a topic related to the specific pillar under discussion. This was then followed by a short intervention by meeting facilitators, who briefly introduced the pillar under discussion and gave an overview of priorities under this pillar. Results of group discussions fed into the draft joint action plan, the key output from this 3 day meeting.

The following session summaries include highlights from session presentations. For complete PowerPoint presentations delivered by presenters, see the JUNIMA website, www.junima.org. For final draft joint action plan, see Session 8 in this report.

JAP COLLABORATION AREA 1 – PROMOTE AN ENABLING ENVIRONMENT AND MECHANISMS

Strategy	Key Activities
<p>1.1 Support enabling policy environment to reduce HIV vulnerability, stigma & discrimination, and promote access to prevention, treatment, care and support by improving systems of governance on development-related mobility.</p>	<ul style="list-style-type: none"> • Collect evidence to support policy development and share information from research and good practices. • Raise awareness and advocate among policy makers for supportive policies. • Disseminate and advocate for the implementation of the MOU and JAP at various levels and among relevant sectors.
<p>1.2 Strengthen intra- and inter-country multi-sectoral collaboration, including public-private partnership, on HIV vulnerability related to migrants and mobile population at the local, national and regional levels.</p>	<ul style="list-style-type: none"> • Facilitate multi-sectoral collaboration at intra- and inter-country levels relevant to mobility-related HIV issues <ol style="list-style-type: none"> i) <i>Organize regional forums to address issues and share information and experiences on mobility-related HIV issues among relevant stakeholders</i> ii) <i>Support existing or develop new cross-border collaboration, projects and programs</i> iii) <i>Encourage engagement of relevant stakeholders</i>

PRESENTATION: TRIPARTITE ACTION TO PROTECT MIGRANTS WITHIN AND FROM THE GMS FROM LABOUR EXPLOITATION (TRIANGLE PROJECT)

Presenter Max Tunon, *Senior Programme Office, International Labour Organization*

TRIANGLE Project: Aims and Approaches

- To increase labour rights protection and decent work opportunities for migrant workers in the GMS and Malaysia.
- Development of policy and legal framework; capacity building; support services
- Tripartite and CSOs
- Sector-based
- Bilateral and multilateral (ASEAN) cooperation
- Gender-responsive

Project Coverage

- Activities currently running in 19 sites in countries of origin and destination: Cambodia (3); Lao PDR (3); Viet Nam (5); Malaysia (3); Thailand (5).

Development of Policy and Legislation

- Drafting legislation on sending workers abroad in Cambodia, Lao PDR and Vietnam
- Strengthening legislation for workers in fishing and domestic work in Thailand
- Advocating for long-term and coherent policies on migration

Research and Advocacy on Attitudes to Migrants

Saphan Siang Campaign

Campaign objectives:

- To promote a positive image of migrant workers in line with their contribution to the Thai economy
- To promote greater understanding between Thais and migrant workers
- To draw attention to the often positive experience that migrants have in Thailand, to contrast the many negative stories that appear
- In line with the recommendations from the ASEAN Forum on Migrant Labour in October 2011
- Participation from tripartite constituents, university groups, NGOs, etc.

Building Capacity

- Training for labour inspectors
- Occupational safety and health training
- Promoting the role of trade unions in the protection of migrant workers' rights
- Promoting self-regulation in the recruitment industry
- Developing complaints mechanisms

Increased Access to Support Services

- *Migrant Worker Resource Centres (MRCs)*: providing information, counselling and legal assistance on safe migration and rights at work
- *Support services in countries of origin*: outreach to communities, schools, job fairs, etc; training of local leaders and community volunteers; pre-departure training;
- *Support services in countries of destination*: peer-leader training; organizing migrants and migrant associations; information dissemination

PRESENTATION: LEGALLY BINDING, A SUMMARY OF LABOUR LAWS IN THE GREATER MEKONG SUBREGION

Presenter Ms Pranom (Bee) Somwong, *MAP Foundation and Mekong Migration Network*

Legally Binding: A Summary of Labour Laws in the Greater Mekong Sub region

- This handbook on labour protection in the GMS is a concise guide to labour standards as contained in national labour laws in the GMS countries, and to get an understanding of existing labour standards in the region. It will also help migrant advocates to identify relevant labour laws that they can use in responding to labour rights abuses and/or violations.
- Includes sections on scope of application of labour laws, employment contracts, working hours and leave, wages, OHS, women and maternity protection, child labour, social security, etc.
- Includes sector specific articles on fishery industry, domestic work, informal sector, workers in special economic zones, sex workers.

Challenges

- While fairly comprehensive labour laws exist, this does not mean workers are protected, living and working comfortably. There is a major problem of implementation and this is increased many fold for migrant workers.
- Because a lack of information and awareness of rights, a lack of trained good personnel, corruption, and sometimes also a lack of political will or desire to ensure justice is done. Not having/belonging to unions and 'controlled' trade unions are also obstacles.
- Where migrant workers are concerned, the obstacles are greater – a sad case of labour rights 'blindness', with blatant abuses happening for all to see, but no one to acts to see it end.
- We need to take a more holistic approach to improve labour rights and conditions , reduce vulnerability including access to healthcare for workers
- Language is important, for things can be misinterpreted and misunderstood by reason of language skills and vocabulary used. The Mekong Migration Network has a project to produce a *Mekong Vocabulary on Labour Migration* to promote a common language understanding in the region and building a regional network for safe migration in the (GMS). This project aims to fill an information gap by increasing common understanding of vocabulary.

Sub-regional Responses

- There is a need for sub regional standards, improved understanding of the needs and mechanisms to protect workers in the GMS
- NOW is a critical time to step up collaboration between the countries to better increase workers', including migrant workers', social protection as our neighbor is drafting a new social protection legislation, and Thailand is increasing the coverage of its social security system.
- The new challenge is how to link these various systems so that people who move across borders for work do not find themselves excluded from systems in different countries, but would be able to contribute to and benefit from either one of these systems, or even better still that the systems are so linked that migrant workers can take their benefits with them to the next country (the portable approach).

JAP COLLABORATION AREA 2 – PROMOTE COMMUNITY-BASED APPROACHES THAT REDUCE HIV VULNERABILITY

Strategy	Key Activities
<p>2.1 Promote community-based development approaches using people-centered methodologies by empowering communities affected by development-related mobility to prevent HIV infection.</p>	<ul style="list-style-type: none"> • Involve communities and key affected population and migrant workers in the planning, implementation and monitoring of interventions. • Develop activities for affected communities to understand, anticipate and adjust to development factors that contribute to HIV vulnerability resulting from mobility. • Strengthen collaboration amongst agencies, including the private sector, involved in and related to development planning and projects/programmes.

PRESENTATION: ENHANCING MOBILE POPULATION ACCESS TO HIV/AIDS SERVICES, INFORMATION AND SUPPORT (EMPHASIS)

Presenter Shantamay Chatterjee, *Regional Advocacy Manager, Care International*

Background

- High mobility exists between Bangladesh, Nepal and India
- Conditions under which migration takes place increase vulnerability of mobile community towards HIV
- Vulnerable mobile populations form a bridge with high prevalence areas of India
- Women are particularly vulnerable at source, transit and destinations

Project Background

- *Goal:* Contribute to reduce vulnerability of mobile populations (particularly women) to HIV infection across selected cross border regions within India, Bangladesh and Nepal.
- *Donor:* Big Lottery Fund (BIG), U.K.
- *Duration:* 5 years (3 Aug 2009 to 2 August 2014)
- *Direct Beneficiaries:* 141,000 persons
- *Impact Population:* Mobile workers (men and women) from Nepal and Bangladesh travelling to India; Spouses and families of migrants in source communities
- *Location:* source countries (Nepal and Bangladesh); destination countries (India); transit locations (India-Nepal border, India-Bangla border)
- *Implemented by:* CARE offices in Bangladesh, India and Nepal with management oversight by a Regional Secretariat based at Kathmandu
- *Key Stakeholders:* SAARC, government agencies, regional research institute, other NGOs, regional advocacy networks and impact population

Project Objectives

- **Objective 1 : Provision of Service:** establish service centres, referral networks, increased access to Voluntary Counseling and Testing, condom provision & information and foster behaviour change

Activities: Social & Behaviour Change Communication; Drop-in-centres and Community resource centres; Media; Referrals and Linkages

- **Objective 2 : Enhancing Capacities:** Key Targets: government agencies and border forces, health service providers, PLWHA networks, partner NGOs and local organisations
Activities: Ensuring service provision; Creating enabling environment; Supporting solidarity groups/CBOs; Learning sites
- **Objective 3: Evidence Based Advocacy:** In collaboration with ODI, generating evidence on HIV and mobility to contribute in national and regional policy-making
Activities: Baseline dissemination workshop; Research studies; Advocacy

Project Achievements

- **Service Provision** (at 31/5/2012)
 - 35 Service Centers established across three countries
 - 144, 820 persons visited the service centers
 - 335, 691 persons reached through various outreach activities
 - 4,088 persons have been referred to different service providers (STI, VCT, etc.)
 - 66 outreach workers & 611 peer educators mobilized
- **Enhancing capacities**
 - Sensitisation of security forces
 - Training /orientation to service providers on STI treatment, infection prevention, universal precautions etc. at source
 - Training to NGOs & CBOs on HIV and mobility
 - Training to country teams and NGO partners on qualitative data analysis
- **Research**
 - Qualitative and quantitative baseline study
 - Mapping of the impact population in the three countries
 - Review of laws and policies
 - Publication of briefing papers
 - Study on barriers to access HIV & AIDS support, care and treatment services
- **Advocacy**
 - Development of advocacy frameworks
 - Signature of a MoU with Women Power Connect in India and National Federation of Women Living with HIV & AIDS in Nepal
 - Development of a scope of collaboration with STAC (being finalized)
 - Participation in the revision of the SAARC HIV/ AIDS Regional Strategy for 2012-16
 - Convergence of EMPHASIS under national programme in India and mainstreaming in Bangladesh proposed

Key Lessons Learned

- Regional cooperation and acceptance of cross border mobility is crucial
- Peer/ community led outreach are effective and sustainable models
- Advocacy at national/state level needs to be initiated from inception
- Undocumented and stigmatized migrants will prefer not to be identified, thus need for proper 'do no harm policy'

Major Challenges

- Mapping mobility & volume estimation
- Source to destination linkage & referral including LFU tracking
- Limited Regional Cooperation
- Bilateral government & stakeholders' involvement /support hinges on evidence base
- HIV & AIDS is not a priority for the impact population
- Stigma leading to discrimination, violence and harassment

PRESENTATION: PREVENTION OF HIV/AIDS AMONG MIGRANT WORKERS IN THAILAND PROJECT (PHAMIT)

Presenter Dr Promboon Panitchpakdi, *Executive Director, Raksthai Foundation*

PHAMIT Project Background

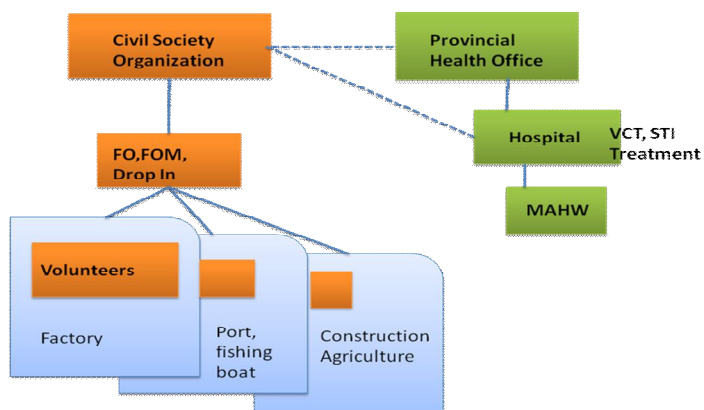
- Funded by Global Fund Rounds 2, 8 (since 2003)
- RCC ARV Treatment + follow up
- 450,000-650,000 migrants reached
- 3,000 provided with ART

Key Components

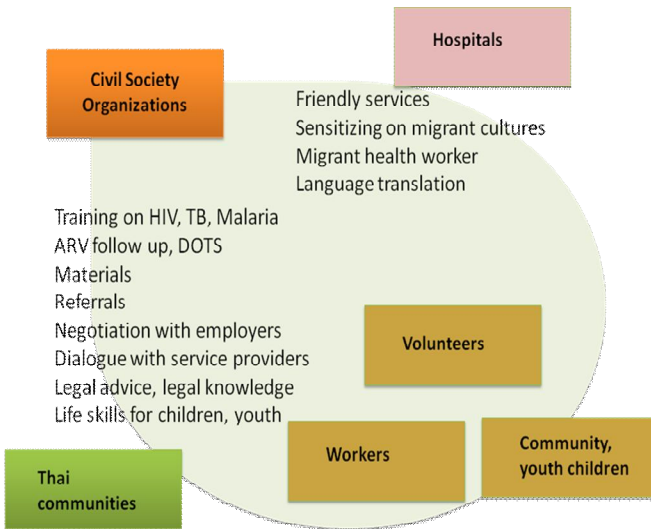
- Outreach, BCC, condoms
- STI/VCT Referrals
- Home-based care
- Health Systems
- Enabling environment
- Policy

PHAMIT Project Overview

Migrant Health: A Simplified Model



Outreach



Social and Political Advocacy



Why is outreach critical for migrant workers and their dependents?

- Government health program is static with only village health volunteers that cannot reach migrants.
- Health centers do not have training or staff to reach migrant workers.
- Language is a barrier in receiving health information or information of social benefits.
- Migrant usually work long hours and cannot take leave to medical treatment unless critical.
- Working locations of migrants are relatively extreme – e.g. fishing boats, remote rubber plantations, construction sites.
- Undocumented workers are at risk of being arrested.
- Civil society organizations and their staff gain acceptance and trust easier than government.

What are some options for long-term services?

- Government develops mechanisms for undocumented migrants (including children) to be covered in insurance.
- Migrants included in National Health Insurance Program

- Special fund for migrant health or for excluded services/populations set up.
- Develop health systems that incorporate role of civil society as part of the outreach mechanisms
- Strengthen role of migrants in community health

Future Challenges

- Need for health systems and health financing model development and expansion.
- Building bilingual services at hospitals
- Cadre of migrant health workers
- Outreach role of non-profit organizations
- Community engagement
- Finance system
- Monitoring for quality of “friendly services.”

JAP COLLABORATION AREA 3 – PROMOTE ACCESS TO HIV/AIDS PREVENTION, TREATMENT, CARE AND SUPPORT

Strategy	Key Activities
<p>3.1 Promote leadership and political commitment at the community, national and regional levels to improve access to prevention, treatment, care and support.</p> <p>3.2 Support strategies that ensure access to comprehensive HIV and AIDS prevention, treatment, care and support for migrant and mobile populations.</p>	<ul style="list-style-type: none"> • Conduct dialogues between sending and receiving countries on access to prevention, treatment, care and support services for migrants and mobile population. • Develop a joint mechanism for provision of quality care, including ART and referral system for migrants and mobile population.

PRESENTATION: ACCESS TO TREATMENT –MEDICAL ASPECT

Presenter Dr Anchalee Avihingsanon, HIV-NAT

Key Challenges: Cross border mobility & ART Treatment

- language barrier
- cultural background of home and host country
- Delay diagnosis, increased transmission, tuberculosis esp MDR/XDR
- STIs management
- adherence
- Referral system/transportation
- financial issues

Issues to consider when migrants on ART cross borders

Are different treatment regimens compatible?

- Yes, for efficacy outcome but toxicity may differ
- Host country : AZT/3TC/NVP (GPOvir-z 250) : anemia, hyperpigmentation
- Home country : TDF/3TC/ EFV or NVP : TDF related renal/bone toxicity, EFV toxicity : CNS, lipid

Are there issues when migrants' switch regimens when they move to host country, and then switch back if they return to home country?

- Toxicity
- Resistance
- Hepatitis B co-infection

What are the main challenges in switching regimens, what are the clinical monitoring and follow-up requirements?

- CD4
- HIV RNA** (every 6 months if possible) if > 1000 copies/mL drug resistance should be performed
- Lipid abnormality, FBS

- eGFR monitoring for TDF user to avoid chronic renal failure, especially in high risk : DM, HT, low BW, previously IDV user, older population
- UA, urine protein/creatinine ratio for TDF user
- AST/ALT
- Pap smear

Recommendations: Improving ART access for mobile populations

Host and home country collaboration

- Staff training
- Friendly clinic, one stop service, translators
- Mobile clinic to community
- Good referral system between the country
- Sharing ART/monitoring expense ie health insurance to cover standard ART treatment
- Peer group education, consultation, NGOs network
- Treatment of special groups ie early TB diagnosis/treatment, syphilis, HCV, HBV coinfection
- High genetic barrier ARV
- Once daily ARV
- Less toxicity
- TDF/3TC/EFV, TDF/FTC/EFV, TDF/3TC/NVP (QD, VL suppressed patients)
- TDF/3TC + LPV/r QD, TDF/3TC+ ATV/r (generic fixed dose)

PRESENTATION: ACCESS TO TREATMENT – LEGAL ASPECT

Presenter Ms Cecilia Oh, *Duke Global Health Institute, Duke University*

Challenges to Migrants' Access to HIV Treatment and Services

- *Lack of national and regional legal frameworks guaranteeing rights of migrants*
 - Discrimination and stigmatization
 - Lack of access to health and HIV services in host countries
- *Migrants not defined or targeted as a HIV-vulnerable group*
 - Lack of epidemiological and health needs data
 - Absent/inadequate coverage for migrants under national health and HIV programmes
- *Policy and implementation inconsistencies*
 - Need for cross-border policy coordination on migration and HIV responses

International Rights and Obligations

- *Right to health and right to work*
 - Universal Declaration of Human Rights
 - ILO Conventions
 - International Covenant on Economic, Social and Cultural Rights
 - Political Declaration on HIV/AIDS, 2006

- *Access to HIV treatment and services*
 - World Health Assembly Resolution on the Health of Migrants, 2008
 - UNGASS Declaration of Commitment on HIV/AIDS, 2001
 - UN General Assembly High Level Meeting on AIDS, 2011
 - Global Commission on HIV and the Law, 2012

Countries should offer the same standards of protection to migrants, visitors and residents who are not citizens, as those offered to its citizens

A core minimum of health services for migrants without discrimination

- Elimination of barriers to health service access - regulatory reform to allow legal registration of migrants with national health services
- Access to the same quality of HIV prevention, treatment and care services and commodities that are available to citizens – coverage under national HIV programmes
- Cross-border policy coordination between home and host countries and mechanisms for continuity of care
- Funding and human resources?

Recognition of economic contributions of migrants – by home and host countries

- Financial investments and allocation of human resources targeted towards protection of migrant rights and provision of health and HIV services

Challenges to provision of healthcare and HIV services at national level

- Political will and public awareness
- Capacity and human resources
- Implementation challenges
- Costs and sustainability concerns
 - Costs of HIV treatment and continuing care
 - Drug resistance and need for new treatments (2nd and 3rd line treatments)
 - ARVs as prophylaxis and prevention (HPTN 052 trial: 96% reduced risk of transmission; Partners PrEP study: 62-73% reduced risk)
 - Continued access to donor funding?
 - Continued access to generic ARVs?

Intellectual property rights, patents and access to drugs

- Global ARV scale up effort – introduction of generic ARVs has been key contributing factor to increased access coverage
- Generic ARVs are the mainstay of many national HIV treatment programmes
- Massive reduction in costs for first-generation, first-line treatments – >99% reduction in prices
- Generic ARVs from India account for 87% of volume in donor funded ARV purchases

Trade, TRIPS & access to medicines

- Patents affect access to medicines because patent monopoly allows patent holders to control production, supply and pricing of medicines
- Market competition and generic introduction are key factors in driving, and keeping, drug prices down

- All WTO Members required by the TRIPS Agreement to provide patent protection for pharmaceutical products for a minimum 20-year period
- What are the implications for pharmaceutical production, prices and access to medicines?

Doha Declaration on TRIPS Agreement and Public Health, 2001

- Debate over impact of patents on medicines and access to ARVs from 1990s
- Arose out of developing countries' proposal to examine impact of TRIPS Agreement on access to medicines
- Clarification that TRIPS Agreement does not prevent WTO Members from taking measures to protect public health
 - Interpretative guide to TRIPS Agreement provisions
 - Affirmation of right to use "flexibilities" in TRIPS
 - August 30 Decision – an "expeditious" solution for countries with insufficient or no manufacturing capacities
 - Extension of transition period for least-developed countries to 2016

Types of flexibilities in TRIPS

- *Time-based provisions*
 - Transition periods for developing countries and LDCs
 - Deadlines: 2013, 2016
- Substantive provisions
 - Flexibilities specifically recognised in Doha Declaration
 - E.g., compulsory licences, exhaustion of rights
 - Public health interpretation of other TRIPS provisions
 - E.g., exceptions, patentability criteria, test data protection

Using TRIPS flexibilities to improve access to medicines

- *Compulsory licences (Article 31 of TRIPS)*
 - Permits pharmaceutical company/distributor to import and/or produce of generic versions of patented drugs
 - Permits government/public agency to import and/or produce generic versions of patented drugs, usually through "fast-track" procedures
- *Parallel importation (Article 6)*
 - Allows import of patented medicines that are sold cheaper in another country
- *Bolar or early-working exception (Article 30)*
 - Allows generic company to conduct R&D for production of generic and to make preparations for marketing approval prior to expiry of patent, to enable prompt marketing of generic drug

GMS Joint Action

- *Efforts to reduce HIV vulnerabilities of migrant populations require coordinated action by host and home countries*
 - Research and exchange of information on migration patterns, HIV trends, etc. to identify and determine health/HIV needs of migrant populations

- Joint design, planning, funding and implementation of programmes
- *Host country measures*
 - Assessment of legal and policy environment to determine reforms needed
 - Financial investment and human resource allocation
 - Implementation of programme/measures in host country
- *Home country measures*
 - Resource and technical support to implementation efforts in host country
 - Assessment of reforms needed to ensure continuum of care in home countries

Case Study: Thailand as host country

- *Legal and policy environment for health & HIV services*
 - Universal health coverage scheme in Thailand
 - National HIV treatment programme and universal access to ARVs policy
 - Assessment of standard of care for migrant populations vs. citizens – elimination of barriers to access
 - Determination of contributions from home countries – financial, human resource and technical
- *Key implementation issues*
 - Increased capacity needs for service delivery
 - Treatment compatibility issues
 - Increased costs for implementation and treatment provision
 - Use of CL for import/production of generics
 - Use of generic medicines imported/produced under CL for migrant populations
 - Can Thailand provide the generic ARVs imported under CL to migrants not covered under the UCS?
 - Are there restrictions to such use?
 - Import/export of generics within GMS
 - Can generic ARVs produced in Thailand be exported to other GMS countries?
 - Could there be joint procurement of ARVs by GMS countries?
- *Use of generic ARVs imported/produced under CL for migrant populations*
 - Compulsory licences granted in 2006 for efavirenz and lopinavir+ritonavir combination
 - "... exercise of the right limited to annual provision of drug ... to not exceeding 200,000 patients who are entitled persons under the National Health Security Act ..., insured persons under the Social Security Act and persons entitled to medical benefits for civil servants and government employees scheme ..."
- *Import/export of generics within GMS*
 - What is the patent status of medicine? Determination of patent status in both exporting and importing countries
 - What does the national law state? State of TRIPS implementation in national law

Recommendations for Joint Action Program

1. Assessment of national health systems and HIV treatment programmes

- Inclusive health and HIV services targeted at migrant populations
- Which policy and legal reforms are required?

2. Evaluation of capacity and resource needs

- Allocation human resources for service delivery
- Increased funding for drug procurement, incorporation of migrant HIV needs in funding proposals

3. Coordination on IPR and TRIPS issues

- Survey of IPR legislation in GMS countries and assessment of status of TRIPS implementation
- Determine status of key ARVs in use in GMS countries
- Promote use of 2016 deadlines by LDCs – no patent protection for pharmaceuticals until at least 2016
- Promote incorporation of all TRIPS flexibilities in national legislation
- Sub-regional coordination on IPR and TRIPS issues, including use of TRIPS flexibilities
- Coordination on ARV procurement – option of joint procurement for GMS countries?

JAP COLLABORATION AREA 4 – MONITORING AND EVALUATION FRAMEWORK

Strategy	Key Activities
4.1 Use the annual meetings of the focal points for monitoring the progress of the implementation of the MOU Action Plan	<ul style="list-style-type: none">Review progress and identify follow up actions in annual meetings of focal points, held either independently or in conjunction with the annual meetings of ATFOA, JUNIMA, ADB, others
4.2 Establish an M&E framework to review progress in the implementation of the MOU	<ul style="list-style-type: none">Develop M&E tools in line with the activities of the Joint Action PlanConduct Joint Review of progress in implementing the MOU
4.3 Establish reporting mechanism to the signatories of the MOU	<ul style="list-style-type: none">Report to the biennial ASEAN Health Ministers Meeting plus China, or alternative meeting as required

PRESENTATION: DEVELOPING A MEANINGFUL M&E FRAMEWORK

Presenter Mr Sushil Koirala, *M&E Consultant, UNDP*

Definitions of Monitoring and Evaluation

Monitoring

- Is *routine* tracking
- Usually looks at key elements of program performance (inputs, process and outputs)
- Conducted through regular reporting
- To take corrective measures

Evaluation

- Is *episodic* assessment
- Usually looks at the change in targeted results that can be attributed to the program
- Measures how well the program activities have met expected objectives
- Helps understanding the effectiveness, relevance and impact

Frameworks in Project Design

Logic Model Framework

- It is a framework that logically summarizes the intended outcomes of a program and the steps to attain those
- It describes the inputs, activities or processes, outputs, outcomes, and impacts of a program and how these elements work together to reach a particular goal
- It helps to identify key processes and can point to potential problems if goals are not achieved

Constructing a Logic Model Framework

- **Step 1:** State the problem that the program intends to address
- **Step 2:** Consider the related inputs that are necessary to address the problem
- **Step 3:** Add activities and indicate relationships between activities, and inputs and activities, as applicable
- **Step 4:** Add outputs that are expected from the activities and indicate applicable relationships between activities and outputs
- **Step 5:** Add expected outcomes and indicate applicable relationships within outcomes and with impact
- **Step 6:** Add expected impact

Components of a Logic Model Framework

- **Inputs:** Resources used in a program, such as money, staff, guidelines, materials etc.
- **Activities:** Services that the program provides to accomplish its objectives, such as outreach, materials distribution, counseling sessions, workshops, and training sessions for counseling/testing (C/T) counselors
- **Outputs:** Direct products or deliverables of the program, such as intervention sessions completed, people reached, materials distributed, or number of people who received HIV test results
- **Outcomes:** Program results that occur both immediately and some time after the activities are completed, such as changes in knowledge, attitudes, beliefs, skills, access, or behaviors
- **Impacts:** Long-term results of one or more programs over time, such as changes in HIV infection, morbidity, and mortality etc.

Conclusion

- It is essential that all components are clearly stated since the design of the program. Vague activities are hard to implement and to monitor
- Different frameworks are used for M&E with its own strengths and limitations. Logical Model Framework is widely used to monitor and evaluate HIV programs
- Developing a M&E plan while designing a program provides better opportunity to think out potential problems and identify possible solutions early-on
- Early attention to M&E also helps in building a program that has an increased chance to succeed
- Properly evaluated successful programs provide opportunities to replicate strategies in similar setting elsewhere

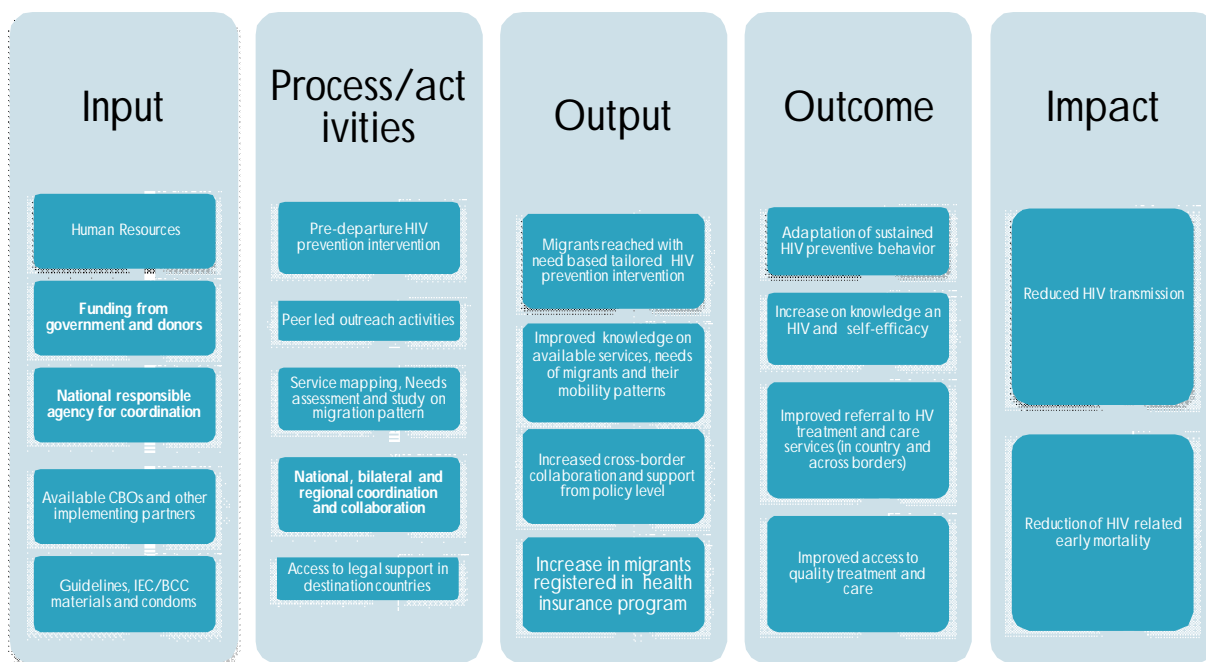
PRESENTATION: RECAP, DEVELOPING A MEANINGFUL M&E FRAMEWORK

Review of Example of Logical Model Framework

JAP Collaboration Area 2: To Promote Community-based approaches that reduce HIV vulnerability

- **Goal:** To reduce vulnerability and promote access to HIV prevention, treatment, care and support among migrants, mobile population, and affected communities in GMS countries.
- **Strategic Objective 2.2:** To provide awareness and information on HIV prevention and HIV care services to migrants, mobile population, and affected communities (hereinafter referred as migrants)

- **Problem Statement:** Migrants are in increased risk of acquiring HIV and often face difficulties accessing basic HIV prevention, care and support services. A peer led intervention with proper access to quality care is proven to be an effective intervention



Monitoring Questions

- What are the key success factors? (priority)
- Can we quantify the output? (measureable)
- How are we going to measure it? (feasible)
- How often and when we are going to measure it? (time-bound)
- Is it possible to get this information from the existing sources? (cost effective)
- How are we going to use the information? (use)
- How expensive it is to measure it? (affordable)

Sample Indicators

- Indicators are measurable characteristic or variable, which represent project progress
- Monitoring and evaluation requires indicators that are specific, measurable, attainable, relevant, and time-bound (SMART)
- For example:
 - *Inputs:*
 - Amount in USD made available for the implementation of HIV prevention, care and support program among on migrants (financial commitment)
 - Number of BCC materials (posters, brochures) made available for the program (use of existing recourses/saving)
 - *Activities:*
 - Number of migrants reached through pre-departure orientation program (improved coverage)

- Number of migrants reached through peer led outreach based interventions (improved coverage)
- Output:
 - Number of migrants reached with need based tailored HIV prevention intervention (improved coverage)
 - Percentage of migrants registered in health insurance program (improved access)
 - Percentage of migrants correctly identifying at-least three methods of HIV transmission (improved knowledge)
- Outcome:
 - Anti Retroviral Therapy coverage among migrants (Improved access)
 - Percentage of migrants reporting the use of a condom their most recent sexual encounter (Improved HIV preventive behavior)
- Impact:
 - Number of new reported HIV infection among migrants (Reduced incidence)

Monitoring and Evaluation Design Process

- Define M&E process and Information flow for the program
- Recording and reporting tools
- Reporting timeline and cycles
- Recording and reporting responsibilities (country level and regional level)
- Validation of data and data quality assurance
- Feedback process (regular, coordination sharing meetings, annual reviews)
- M&E capacity building and supportive supervision
- Dissemination of information
- Data protection and confidentiality issues
- Evaluation through Internal and external review

Conclusion

- SMART indicators makes it easy to measure and interpret
- Using standard indicators and adopting pre-devolved/tested tools ensures consistency and comparability across the member countries
- It is important to distinguish between program M&E and information collection functions like active surveillance, mapping, outreach based information collection etc. These form basis for M&E but are activities under regular implementation.
- It is possible that a lot of program information are already inside existing national M&E system, IBBS etc. Using existing data sources saves money, time and mostly importantly reduces reporting burden to already overburdened people.
- Defining roles, timeline and process very clearly early-on helps in smooth implementation of M&E functions
- Choosing only optimal number of indicators makes the system light and practical
- Ensuring participation of all stakeholders in planning process develops ownership of the M&E system and the program as a whole

SESSION 8: FINAL JOINT ACTION PLAN

COLLABORATION AREA 1: TO PROMOTE ENABLING ENVIRONMENT and MECHANISMS

- (i) Support enabling policy environment to reduce HIV vulnerability, stigma & discrimination, and promote access to prevention, treatment, care and support by improving systems of governance on development-related mobility.
1. Collect evidence to support policy development and share information from research and good practices.
 - 1.1 Establish/strengthen of information exchange on HIV and migrant and mobile population through effective and efficient repository/database mechanism
 - Provide support for existing databases (eg. HIVAIDS Datahub, JUNIMA) to act as online information exchange of research, publications, latest news and meetings related to migration, mobility and HIV vulnerability in the region
 - 1.2 Develop common analysis and understanding of migrant needs across the region and generate new data to support it

Mapping exercises to identify:

 - 1) Migration patterns and profiles and mobility route with vulnerability assessment
 - using established/tested methodologies, , i.e. EMPHASIS study on Nepal- India & Bangladesh
 - 2) Socio-economic determinants of health and HIV vulnerabilities for migrants
 - gender, legal status, stigma and discrimination, barriers to health access, travel restrictions, etc
 - 3) Linkages between HIV vulnerability and migration and mobility
 - 4) Economics implications of providing health access
 - highlighting 'hidden' cost to health system to demonstrate savings if migrants are provided access to health services;
 - proving investment in HIV prevention is good business; understanding costs of prevention vs care.
 - cost-benefit analysis of HIV/AIDS prevention and treatment programs for migrants, analysis of how to make interventions cost-effective
 - 1.3 Harmonize country policies and development initiatives on migrants and migrants' health
 - Mapping exercise to identify: key stakeholders. existing national policies, identify policy incoherence and gaps; include initiatives of development partners such as UN agencies and ASEAN
-

-
- (i) *Support enabling policy environment to reduce HIV vulnerability, stigma & discrimination, and promote access to prevention, treatment, care and support by improving systems of governance on development-related mobility (cont.)*
- 2. Raise awareness and advocate with policy makers**
- 2.1. Develop advocacy materials and information briefs for policymakers**
- *Create information briefs/advocacy materials in key GMS languages*
 - *Advocate for mainstreaming of HIV prevention and promotion programs as part of contracting for new infrastructure*
- 2.2 Establish a forum as venue for engaging policymakers on issues such as HIV, migrants' access to health care, and cross-border cooperation**
- *Forum for Parliamentarians where proposed evidence-based policies and corresponding budget can be presented and agreed on to strengthen a mainstreamed approach on migration & HIV*
- 2.3 Engage media as partner in promoting supportive policy environment for HIV, migrant health and cross-border cooperation**
- No agreed activity*
- 3. Disseminate and advocate for the implementation of the MOU and JAP at various levels and among relevant sectors.**
- 3.1 Develop advocacy plan with key messages to ensure implementation of the MOU and JAP at various levels targeting relevant sectors**
- *Each country to include advocacy plan in their Country Action Plan*
- 3.2 Develop communication materials on the MOU and JAP in key GMS languages**
- *translation of the MOU and JAP in key GMS languages and dissemination to relevant stakeholders including development partners and NGOs/CBOs*
- (ii) **Strengthen intra- and inter-country multi-sectoral collaboration, including public-private partnership, on HIV vulnerability related to migrants and mobile population at the local, national and regional levels.**
- 4. Facilitate multi-sectoral collaboration at intra- and inter-country levels relevant to mobility-related HIV issues.**
- 4.1 Conduct/organize yearly regional forum among relevant sectors and practitioners to share information, advocacy and best practices**
- *formation of a technical group of experts from diverse background including country representatives for review & assessment of progress and technical suggestion to countries to strengthen intervention*
- 4.2 Optimize existing regional meetings such as ASEAN Summit, ASEAN People's Forum, etc. to include HIV and migrant health issues**
- *provide research/information/advocacy materials to support Cambodia to advocate for inclusion of HIV/Health issues in the agenda of the 5th ASEAN forum on migrant labour*
-

COLLABORATION AREA 2: TO PROMOTE COMMUNITY-BASED STRATEGIES THAT REDUCE HIV VULNERABILITY

- (i) **Promote community-based development approaches using people-centered methodologies by empowering communities affected by development-related mobility to prevent HIV infection.**
1. **Involve communities and key affected population and migrant workers in the planning, implementation and monitoring of interventions.**
 - 1.1 **Undertake participatory studies of source and host communities (to include gender and social networks specific to occupational sites)**

No agreed activity
 - 1.2 **Identify/Map CBOs/NGOs working in affected populations and services available in local communities (host and sending)**
 - *for sustainable engagement capacity building of CBOs and support through country mechanisms, existing support schemes for NGOs could be used*
 2. **Develop and implement activities for affected communities to understand, anticipate and adjust to development factors that contribute to HIV vulnerability resulting from mobility.**
 - 2.1 **Design/Develop sustained community-managed/based interventions on HIV prevention, health and migrant population that would also provide link between source and host countries**
 - *conduct training for migrant volunteers, village health workers, community leaders (using Thai example);*
 - *establish drop-in service centers for migrants;*
provision of pre-departure and post-arrival information jointly developed by source and host countries (including information on accessing HIV/AIDS and health services and potential risks for each occupation and risk mitigation measures);
 - 2.2 **Engage CSOs/NGOs in developing/piloting cross-border activities on HIV, health and migrant population**
 - *develop mechanisms for collaboration and coordination among CSOs between receiving and sending countries; develop mechanisms for multisectoral coordination between CSOs and governments across borders*
 - 2.3 **Conduct of participatory researches and studies on migrant and mobile population that would inform community-based and cross-border activities, interventions and strategies**
 - *conduct regional research to map and understand migrants' vulnerabilities, including analysis of motivations for migration, analysis of specific vulnerability linked to mobility and migration; specific understanding of occupational contexts and their link to mobility*
 3. **Strengthen collaboration amongst agencies, including the private sector, involved in and related to development planning and projects/programmes.**
 - 3.1 **Develop mechanism for public-private partnerships to address HIV and migrant health**
 - *develop multi-level private sector engagement in PPP initiatives (i.e. project, campaigns, etc.)*

- 3.2 Engage ministries dealing with private corporations hiring migrant workers to integrate HIV and migrant health in the cooperative agreement**
- *review workplace program with a specific approach for gender based intervention*
- (ii) Enhance information dissemination, education and behavior change communication in HIV/AIDS prevention for the community of migrants and mobile populations.**
- 4.1 Develop and implement localized, culturally-appropriate, target-specific behaviour change framework and plan**
- *conduct outreach education for specific target groups (i.e. spouses of migrants, returning and circular migrants, host communities);*
 - *conduct of awareness-raising activities for local authorities/police;*
 - *conduct of pre-departure information (on health access rights, available services, etc.), particularly for women migrants*
- 4.2 Based on the results of regional and local studies, develop and disseminate appropriate IEC materials targeting local communities and risk groups**
- No agreed activities*

COLLABORATION AREA 3: PROMOTE ACCESS TO HIV AND AIDS PREVENTION, TREATMENT, CARE AND SUPPORT

- (i) Promote leadership and political commitment at the community, national and regional levels to improve access to prevention, treatment, care and support.**
- 1. Conduct dialogues between sending and receiving countries on access to prevention, treatment, care and support services for migrants and mobile population.**
- 1.1 Establish bilateral and/or subregional coordination and cooperation at cross-border for prevention and treatment programs for migrant population**
- *convene bilateral and/or subregional meetings to set policy/protocol/direction on prevention, treatment, care and support for migrants;*
 - *convene meetings between individual border provinces to develop action plans based on strategy produced in bilateral/subregional meetings;*
 - *cross-border networks between border provinces/districts to ensure provision of information and services at the district level*
- 1.2 Establish bilateral prevention systems**
- *training of peer educators/volunteers with NGOs on prevention services for migrants and mobile people in sending and host countries*

- (ii) **Support Strategies that ensure access to comprehensive HIV and AIDS prevention, treatment, care and support for migrant and mobile populations**
2. **Develop a joint mechanism for provision of quality care, including ART and referral system for migrants and mobile population.**
- 2.1 **Conduct bilateral and subregional technical meetings to develop a joint mechanism to propose a draft protocol of a referral system for HIV quality care**
No agreed activities
- 2.2 **Bilateral coordination regarding treatment regimes for migrants**
- *create format for information that needs to be exchanged when migrants and mobile populations move across borders;*
 - *develop effective referral system (MW brings hospital/medical record history back to sending countries);*
 - *MW informed/conscious of hospital protocol re medical information*
 - *study on standard service packages for migrants and mobile population at sending and hosting country*
3. **Develop joint programs for provision of prevention, care and support services for migrants and mobile population.**
- 3.1 **Develop innovative collaborative country-country initiatives to promote access to HIV and AIDS prevention and treatment for mobile and migrant population**
- *services providers aware and trained to provide services*
-

SESSION 9: PROPOSED COUNTRY ACTIONS

Following agreement on Joint Action Plan Draft, Country Groups worked together to identify suggested national or bilateral actions that could be implemented, based on this Joint Action Plan. Proposed activities are summarized below, with the proposing country noted in parentheses.

JAP COLLABORATION AREA 1: PROMOTE AN ENABLING ENVIRONMENT AND MECHANISMS	
JAP Strategy	JAP Activity Guidelines
<p>1.1 Support enabling policy environment to reduce HIV vulnerability, stigma & discrimination, and promote access to prevention, treatment, care and support by improving systems of governance on development-related mobility.</p>	<ul style="list-style-type: none"> Collect evidence to support policy development and share information from research and good practices. Raise awareness and advocate among policy makers for supportive policies. Disseminate and advocate for the implementation of the MOU and JAP at various levels and among relevant sectors.
<p>1.2 Strengthen intra- and inter-country multi-sectoral collaboration, including public-private partnership, on HIV vulnerability related to migrants and mobile population at the local, national and regional levels.</p>	<ul style="list-style-type: none"> Facilitate multi-sectoral collaboration at intra- and inter-country levels relevant to mobility-related HIV issues <ol style="list-style-type: none"> Organize regional forums to address issues and share information and experiences on mobility-related HIV issues among relevant stakeholders Support existing or develop new cross-border collaboration, projects and programs Encourage engagement of relevant stakeholders
Country's Proposed Activities	
<p>(1) Produce a report mapping migration patterns (Myanmar/Thailand/Lao PDR/Vietnam)</p> <ul style="list-style-type: none"> Government partners: Involving Ministry of Immigration, Ministry of Labour, Ministry of Railway, Ministry of Home Affairs, Ministry of Social Welfare, Ministry of Education Non-Government partners: IOM, WVI, CARE, SCF, PSI, MSI, AZG/MSF and MRCs, MMA, CSOs Funded by ADB, government and other donor agencies Proposed timeframe for Myanmar/Thailand April-September 2013 	
<p>(2) Harmonization of country policies on migrants and migrants' health (Myanmar/Thailand)</p> <ul style="list-style-type: none"> Leading to publication of revised policy on migrants/migrants' health Government partners: Involving Ministry of Immigration, Ministry of Labour, Ministry of Railway, Ministry of Home Affairs, Ministry of Social Welfare, Ministry of Education Non-Government partners: IOM, WVI, CARE, SCF, PSI, MSI, AZG/MSF and MRCs, MMA, CSOs Funded by ADB, government and other donor agencies Proposed timeframe for Myanmar/Thailand January – March 2013 	
<p>(3) Develop a joint advocacy plan to raise awareness and advocate with policy makers (Myanmar/Thailand)</p> <ul style="list-style-type: none"> Government partners: Involving Ministry of Immigration, Ministry of Labour, Ministry of Railway, Ministry of Home Affairs, Ministry of Social Welfare, Ministry of Education Non-Government partners: IOM, WVI, CARE, SCF, PSI, MSI, AZG/MSF and MRCs, MMA, CSOs Proposed timeframe for Myanmar/Thailand October – December 2013 	
<p>(4) Share information and research results bilaterally and regionally (China)</p> <ul style="list-style-type: none"> For example, share research between Vietnam and Guangxi province – on migrants, employment sector, level of documentation, HIV prevalence) 	
<p>(5) Conduct research on push-pull factors for migrants crossing borders (China)</p> <ul style="list-style-type: none"> Leading to improved understanding of undocumented workers and why they are not going through registration processes 	
<p>(6) Establish/strengthen cross-border committees for health (Lao PDR/Vietnam)</p>	

JAP COLLABORATION AREA 2: PROMOTE COMMUNITY-BASED APPROACHES THAT REDUCE HIV VULNERABILITY

JAP Strategy	JAP Activity Guidelines
2.1 Promote community-based development approaches using people-centered methodologies by empowering communities affected by development-related mobility to prevent HIV infection.	<ul style="list-style-type: none"> • Involve communities and key affected population and migrant workers in the planning, implementation and monitoring of interventions. • Develop activities for affected communities to understand, anticipate and adjust to development factors that contribute to HIV vulnerability resulting from mobility. • Strengthen collaboration amongst agencies, including the private sector, involved in and related to development planning and projects/programmes.

Country's Proposed Activities

- (1) Mapping of services currently available (Myanmar/Thailand)**
- (2) Joint training for community-based organizations and community authorities (Myanmar/Thailand)**
 - Include entertainment establishments, employers, construction companies
- (3) Develop cross-border activities to link migrants with health services and legal support (Myanmar/Thailand)**
- (4) Bilateral technical meetings on community approaches (Lao PDR/Vietnam)**
 - Leading to develop of bilateral community approaches
- (5) Establish community drop in centres to provide services to migrant workers from host and source countries (Lao PDR/Vietnam)**
- (6) Create links with NGOs and CSOs for referral of cases (Thailand)**

JAP COLLABORATION AREA 3: PROMOTE ACCESS TO HIV/AIDS PREVENTION, TREATMENT, CARE AND SUPPORT

JAP Strategy	JAP Activity Guidelines
3.1 Promote leadership and political commitment at the community, national and regional levels to improve access to prevention, treatment, care and support.	<ul style="list-style-type: none"> • Conduct dialogues between sending and receiving countries on access to prevention, treatment, care and support services for migrants and mobile population.
3.2 Support strategies that ensure access to comprehensive HIV and AIDS prevention, treatment, care and support for migrant and mobile populations.	<ul style="list-style-type: none"> • Develop a joint mechanism for provision of quality care, including ART and referral system for migrants and mobile population.

Country's Proposed Activities

- (1) Workshop on standardizing ARV regimens (Thailand)**
 - Leading to draft agreement on standardized sub-regional regimen, presented to ASEAN, GFATM, WHO, etc
 - Involve MOPH/DDC, cover source of procurement, issues of costs and funding
 - (2) Develop bilateral/regional strategies and action plans (Myanmar/Thailand)**
 - Convene meetings between individual border provinces/districts
 - Conduct bilateral technical meetings to standardize referral system for HIV quality care and referral
 - (3) Training of peer education/volunteers through NGOs on prevention services for migrants and mobile populations (Myanmar/Thailand/Lao PDR/Vietnam)**
 - Target worksites, involve companies/employers at different worksites
 - (4) Develop protocol for information sharing and referral (Myanmar/Thailand/Lao PDR/Vietnam)**
 - Involve provincial health offices, hospitals, non-government organizations
 - (5) Develop an integrated information and registration system for the sub-region (Thailand)**
 - Involve DDC, other stakeholders (MOI, MOL), non-government organizations
 - (6) Create a sub-regional platform to discussion social protection across countries (Thailand)**
-

CLOSING AND NEXT STEPS

On behalf of UNDP, Ms Marta Vallejo thanked all country representatives and partner organizations for their participation in this consultation. She noted that the task of addressing HIV vulnerabilities of migrant and mobile populations in the GMS was complex and difficult. However this consultation, with a strong draft Joint Action Plan as a key output, constituted an important step toward identifying opportunities and challenges in providing access to HIV prevention, treatment, care and support for vulnerable migrant and mobile populations. Ms Vallejo thanked the very strong group of presenters who acted as resource persons for this meeting, highlighting important knowledge, lessons and practices related to medical, legal and rights-based approaches to addressing mobility-related HIV vulnerabilities.

In closing, Ms Vallejo expressed the hope that UNDP and ADB could continue to work together with GMS countries to help implement components of the final Joint Action Plan. She noted that the JUNIMA network, for which UNDP is the Secretariat, was committed to promoting universal access to HIV prevention, treatment, care and support for mobile and migrant populations in this region, and would continue to engage governments, non-government organizations and UN agencies in this work.

On behalf of ADB, Ms Emi Masaki reiterated UNDP's thanks to both participants and presenters. She noted that the commitment of participants was evident in their participation in group and plenary sessions. In closing the meeting she assured participants that the outcomes of this meeting would help define the MoU's final Joint Action Plan, to be presented at the 11th Meeting of GMS Working Group on Human Resource Development convened by ADB in Myanmar, in October 2012, with the overall aim of finding financial resources for its implementation with the donors.

ANNEX I: AGENDA

DAY 1: Wednesday 11 July 2012

08:30 – 09:00	Registration
09:00 – 09:20	Session 1: Opening Remarks <i>Mr. Craig Steffensen, Country Director, ADB Thailand Resident Office</i> Consultation Objectives, Agenda and Introduction of Participants <i>Ms. Marta Vallejo-Mestres, UNDP</i>
09:20 – 10:00	Session 2: HIV/AIDS and Migration in the GMS: What's at Stake? What do we know about HIV/AIDS and Migration in the GMS? <i>Ms. Marta Vallejo-Mestres, UNDP</i> The 2011 GMS Memorandum of Understanding and Joint Action Programme <i>Ms. Emiko Masaki and Chris Lyttleton, ADB</i>
10:00 – 10:30	Session 3: Country Presentations Cambodia, Vietnam, China
10:30 - 11:00	Coffee break
11:00 – 11:45	Session 3: Country Presentations Continued Thailand, Lao PDR, Myanmar
11:45 – 12:30	Session 4: JAP Collaboration Area 4 – <i>Monitoring and Evaluation Framework</i> Developing a Meaningful M&E Framework <i>Ms. Sushil Koirala, M&E Consultant, UNDP</i>
12:30 – 13:30	Lunch break
13:30 – 14:15	Session 5: JAP Collaboration Area 3 – <i>Promote access to HIV and AIDS prevention, treatment, care and support</i> Access to treatment – Medical aspect <i>Dr Anchalee Avihingsanon, HIV-NAT</i> Access to treatment – Legal Aspect <i>Ms. Cecilia Oh, Duke Global Health Institute, Duke University</i>
14:15 – 17:00	Session 5: Group work on Detailing the 2012-2014 JAP Collaboration Area 3
18:00 – 20:00	Welcome Reception

DAY 2: Thursday 12 July 2012

09:00 – 10:00	Session 6: JAP Collaboration Area 2 – <i>Promote community-based approaches that reduce HIV vulnerability</i> Enhancing Mobile Population Access to HIV/AIDS Services, Information and Support (EMPHASIS) <i>Mr. Shantamay Chatterjee, Regional Advocacy Manager, Care International</i> Prevention of HIV/AIDS among Migrant Workers in Thailand Project (PHAMIT) <i>Dr. Promboon Panitchpakdi, Executive Director, Raks Thai Foundation</i>
10:00 – 12:30	Session 6: Group work on Detailing the 2012-2014 JAP Collaboration Area 2

12:30 – 13:30	Lunch
13:30 – 14:30	<p><u>Session 7: JAP Collaboration Area 1 – Promote an enabling environment and mechanisms</u></p> <p>Tripartite Action to Protect Migrants within and from the GMS from Labour Exploitation (TRIANGLE Project) <i>Mr Max Tunon, Senior Programme Officer, International Labour Organisation (ILO)</i></p> <p>Legally Binding: A Summary of Labour Laws in the Greater Mekong Subregion - <i>Ms. Pranom (Bee) Somwong, MAP Foundation and Mekong Migration Network</i></p>
14:30 – 17:00	<u>Session 7: Group work on Detailing the 2012-2014 JAP Collaboration Area 1</u>
13:30 – 14:30	<u>Session 8: Draft JAP Presentation of Overall JAP Developed</u>
DAY 3: Friday 13 July 2012	
08:45 – 09:10	<p>Recap of the JAP developed and final comments <i>Mr. Chris Lyttleton, ADB</i></p>
09:10 – 09:40	<p><u>Session 9: Recap Developing a Meaningful M&E Framework (JAP – Collaboration Area 4)</u> <i>Ms. Sushil Koirala, M&E Consultant, UNDP</i></p>
09:40 – 11:00	<p><u>Session 10: Development of Country Action Plans and Teams</u> Group Work</p>
11:00 – 12:00	<u>Session 10: Country Presentations</u>
12:00 – 12:30	<p>Key Agreements on the Next Steps and Timeline <i>Facilitators: Ms. Emiko Masaki, ADB and Ms. Marta Vallejo-Mestres, UNDP</i></p> <p>Closing Remarks <i>Ms. Emiko Masaki, ADB and Ms. Marta Vallejo-Mestres, UNDP</i></p>
12:30 – 13:30	Lunch

ANNEX II: PARTICIPANT LIST

COUNTRY REPRESENTATIVES

	Country	Name	Job Title	Organization
1	Cambodia	HE Teng Kunthy	Secretary General	National AIDS Authority
2	Cambodia	Dr. Ros Seilavath	Deputy Secretary General	National AIDS Authority
3	Cambodia	Dr. Ngauv Bora	Vice Chief	National Center for HIV/AIDS, Dermatology and STDs
4	Peoples Republic of China	Ms. Yi Lelai		Ministry of Health
5	Peoples Republic of China	Ms. Li Jia		Department of Disease Prevention and Control, Ministry of Health
6	Peoples Republic of China	Mr. Wu Xinhua		Department of Disease Prevention and Control, Ministry of Health
7	Lao PDR	Dr. Bounpheng Philavong	Director	Center for HIV/AIDS and STIs
8	Lao PDR	Dr. Lavanh Vongsavanhong	Head	Vientiane Capital Committee for Control of HIV/AIDS, Ministry of Health
9	Lao PDR	Dr. Niramonh Chanlivong		Burnet Institute
10	Myanmar	Dr. Myint Shwe	Asst. Director (HIV/AIDS)	Department of Health
11	Myanmar	Dr. Khin Maung	State Health Officer (HIV/AIDS)	Shan State, Taunggyi
12	Myanmar	Dr. Than Tun	Regional Health Officer (HIV/AIDS)	Sagaing Region
13	Thailand	Dr. Sumet Ongwandee	Director, Bureau of AIDS, TB and STI	Ministry of Public Health
14	Thailand	Dr. Petchrsi Srinirund	Director, National AIDS Management Centre, Department Disease Control	Ministry of Public Health

	Country	Name	Job Title	Organization
15	Thailand	Dr. Chanvit Tharathep	Senior Advisor for Health Services System Development	Ministry of Public Health
16	Thailand	Dr. Surasak Thanaisawanyangkoon	Chief, International Collaboration	Ministry of Public Health
17	Thailand	Dr. Pairoj Saonuam	Medical Physician, Senior Professional Level, National AIDS Management Center, Department of Disease Control	Ministry of Public Health
18	Thailand	Promboon Panitchpakdi	Executive Director	Raks Thai Foundation
19	Thailand	Thongphit Pinyosinwat		Raks Thai Foundation
20	Thailand	Brahm Press		Raks Thai Foundation
21	Thailand	Dr. Kyi Minn	Regional Advisor	World Vision Foundation
22	Thailand	Dr. Sri Chander	HIV/AIDS Manager	World Vision Foundation
23	Vietnam	Cao Thi Hue Chi	Vice Chief of VAAC's Office	Viet Nam Authority of HIV/AIDS Control (VAAC), Ministry of Health
24	Vietnam	Dr. Tran Thi Bich Tra	Vice Head of International Cooperation	Viet Nam Authority of HIV/AIDS Control (VAAC), Ministry of Health
25	Vietnam	Dr. Pham Thi Ngoc Bich	Lecturer	Hanoi Medical University

PARTNER AGENCIES, RESOURCE PEOPLE

	Name	Job Title	Organization
1	Royce Escolar		AusAID, Mekong Subregion
2	Dr. Philippe Creac'H	Global Manager	The Global Fund to Fight AIDS Tuberculosis and Malaria
3	Dawn Foderingham		UNAIDS
4	Mukta Sharma	Technical Officer, HIV/AIDS and TB	World Health Organization
5	Dr. Brent Burkholder	Border and Migrant Health Programme Coordinator	World Health Organization
6	Ray Serrano	HIV Focal Point	World Health Organization
7	Ms. Shravya Kidambi	Migrant Health and Financing	World Health Organization
8	Jaime Calderon	Regional Health Migration Manager	IOM Regional Office
9	Dr Anchalee Avihingsanon	Senior Clinical Trials Physician	HIV-NAT
10	Pranom Somwong		Mekong Migration Network
11	Shantamay Chatterjee	Regional Advocacy Manager	EMPHASIS, Care International
12	Cecilia Oh	Independent Consultant	
13	Max Tunon	Technical Officer, ILO Triangle Project	ILO Regional Office for Asia and the Pacific
14	Sushil Koirala	M&E Consultant	Independent consultant
15	Dr Anchalee Avihingsanon	Senior Clinical Trials Physician	HIV-NAT
16	Emiko Masaki	Social Sector Economist	Asian Development Bank

	Name	Job Title	Organization
17	Randy Dacanay	Program Coordinator	Asian Development Bank
18	Ferdinand Reclamado	Program Admin Support	Asian Development Bank
19	Chris Lyttleton	Regional Program Advisor	Asian Development Bank
20	Nguyen Nhat Tuyen	Social Development Officer	ADB Viet Nam Resident Mission
21	Phoxay Xayyavong	Project Officer	ADB Lao PDR Resident Mission
22	Craig Steffensen	Country Director	ADB Thailand Resident Mission
23	Marta Vallejo	HIV Programme Specialist	UNDP APRC
24	Sangita Singh	HIV Programme Officer	UNDP APRC
25	Jennifer Branscombe	Consultant	UNDP APRC

ANNEX III: CONCEPT NOTE

SIX-COUNTRY CONSULTATION ON THE 2011 Greater Mekong Subregion (GMS) Memorandum of Understanding (MOU)-Joint Action Plan (JAP)

A. Background

1. Investments in the infrastructure and transport sector in the Greater Mekong Subregion (GMS) have contributed significantly to improved connectivity and greater mobility. The construction of major economic corridors connecting countries in the region have facilitated the flow of goods and movement of populations but also contributed to increased risk of transmission of communicable diseases, including sexually transmitted infections (STI), HIV and AIDS. Between countries, the need for joint action for HIV prevention and better access to treatment, care and support is increasingly being articulated at the national and provincial (border provinces) levels, especially in contexts where migrants and mobile populations face barriers to accessing services in destination countries.

2. In 2004, the six countries in the GMS signed the *Memorandum of Understanding (MOU) for Joint Action to Reduce HIV Vulnerability Related to Population Movement*. The MOU represented a shared understanding among GMS countries that addressing HIV vulnerability, caused by greater mobility of populations in the region, is a common concern requiring concerted action. The MOU expired in 2009 and the GMS countries indicated their intention to amend and renew the MOU. After a series of meetings organized by ADB to facilitate discussion and agreement on the renewal of the MOU, an amended MOU was signed on 20 December 2011 during the 4th GMS Summit in Myanmar. Accompanying the MOU is a Joint Action Program (JAP) that identifies priority areas for bilateral and multilateral cooperation. With the amended MOU, there is now a clear and enabling policy that can be invoked in pursuing or advocating joint action.

3. The 2011 MOU will help GMS countries achieve the Millennium Development Goal (MDG) 6, Target 7: “to have halted and begun to reverse the spread of HIV and AIDS by 2015” and is expected to reduce HIV vulnerability and promote access to prevention, treatment, care and support among migrants and mobile population and affected communities in countries in the GMS. The 2011 MOU agreed to the following areas of collaboration among the six GMS countries: (i) promoting enabling environment and mechanisms; (ii) promoting community-based strategies that reduce HIV vulnerability; (iii) promoting access to HIV and AIDS prevention, treatment, care and support and (iv) developing a monitoring and evaluation framework.

B. Proposed Consultation on the 2011 GMS MOU-JAP

4. The proposed consultation on the 2011 GMS MOU-JAP is a follow up meeting with the MOU focal points and other key stakeholders in the six GMS countries to facilitate discussion on the priority areas of collaboration among the countries and agree on concrete activities/ initiatives to be implemented in 2012–2014. The consultation will also be designed to address potential barriers in the implementation of the MOU and identify potential fund sources and appropriate funding schemes. It will be jointly organized by the Joint United Nations Initiative on Mobility and HIV/AIDS (JUNIMA), and the Asian Development Bank (ADB).

5. The results of GMS MOU-JAP consultation will be presented during the 11th Meeting of GMS Working Group on Human Resource Development, tentatively scheduled in September 2012, for its endorsement.

6. The consultation will have the following objectives: (i) identify and agree on key activities, timeline and responsible actors for each of the three areas of collaboration; (ii) discuss and propose measures to address potential problems and setbacks in the implementation of the MOU-JAP; (iii) identify potential sources of funding and funding mechanisms and agree on set of guidelines to harmonize funding for HIV and migrant/mobile populations in the GMS; (iv) develop indicative country action plans, identify country focal persons and country action teams; (v) articulate immediate next steps to operationalize the JAP (i.e. country consultations to finalize country action plans, setting up of GMM MOU-JAP secretariat, next regional consultative meetings, etc.); (v) immediate next steps (i.e. country consultations to finalize country action plans, setting up of GMS MOU-JAP secretariat, next regional consultative meetings etc.).

7. The expected outputs from the consultations will include: (i) detailed JAP for 2012–2014 with key activities and outputs, timeline responsible actors, and sources of funding; (ii) funding commitments from governments and (iii) indicative country action plans with specific cross border activities (iv) list of country focal persons and country action teams; (v) list of immediate next steps.

8. The tentative schedule of three day consultation is 11-13th of July 2012 at the Amari Watergate Hotel in Bangkok, Thailand. Invitees to the workshop include 2-3 representatives from each of the six countries (including country-level and regional CSOs), representatives from regional and international donors and bilateral aid agencies, and representatives from the ASEAN, JUNIMA, and ADB. Participants are expected to be involved in the management and/or implementation of programs and projects on HIV, cross-border activities, and migrant and mobile populations.