Technical Assistance Consultant's Report

Project Number: 48118-002
June 2016

Cambodia, Lao People's Democratic Republic, Myanmar, Viet Nam: Greater Mekong Subregion Health Security Project (Part 4/4)

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Clichy, France

For Asian Development Bank

Asian Development Bank

Greater Mekong Subregion Health Security Project

ADB PPTA 8842 - REG

ACTIVITY REPORT

June 2016

For
Asian Development Bank
by
Conseil Santé

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Acronyms

ADB	Asian Development Bank
ASPED	Asia Pacific Strategy for Emerging Diseases
CDC	Communicable disease control
CMLV	Cambodia-Myanmar-Lao-Vietnam
DMF	Design and monitoring framework
IHF	International health regulations
EIA	Environmental impact assessment
EID	Emerging infectious diseases
EGDP	Ethnic group development plan
FMA	Financial management assessment
GAP	Gender action plan
GDP	Gross domestic product
GMS	Greater Mekong Subregion
IEE	Initial environmental examination
IHR	International health regulation
IOM	International Organization for Migration
IP	Indigenous peoples
MEV	Migrant and mobile people, ethnic minorities, and other vulnerable groups
MOH	Ministry of Health
NGO	Non-governmental organization
PAM	Project administration manual
PMU	Project Management Unit
PPTA	Project preparatory technical assistance
PRA	Procurement risk assessment
RRP	Report and recommendation of the President
WHO	World Health Organization

Summary

The 4-country PPTA commenced on 13 July 2015. The inception report was submitted on 15 November 2015. The TA was closed on 30 June 2016. Submission of final accounts was made in August 2016.

The inception report provided the plan for the analytical and project planning work to be conducted during the PPTA for the GMS Health Security Project. Following inception, the PPTA team made three rounds in the four countries, for situation analysis, project planning, and final appraisal, to prepare and negotiate the project design with the four ministries of health. A total of 51 field trips for international experts were conducted, with different compositions. This included one regional workshop (led by ADB), six national workshops, and one regional meeting. For each country visit, the consultants prepared an aide memoire. The last round was with the ADB team for official loan fact-finding.

Due to time constraints on the part of ADB, the mission was requested to quickly proceed with project formulation, and was allowed more time for preparing the interim report - situation analysis. The consultants prepared the draft project proposal, cost estimates, administrative implementation arrangements, design and monitoring framework, implementation schedule, health sector summary analysis, coordination matrix, and terms of reference for consultants, while ADB prepared the project administration memorandum and finalized documentation. In Viet Nam, MOH was also assisted in preparing the project outline. Since then, MOH Viet Nam has obtained project clearance and ADB has proceeded with internal processing of the project.

For the situation analysis, the consultants prepared, for each country, the Financial Management Assessment (FMA), Procurement Risk Assessment (PRA), Ethnic Group Development Plan (EGDP), Gender Analysis, Initial Environment Examination (IEE), and also prepared summary gender analysis. While FMA and IEE were prepared in time, the other sets of reports were delayed due to time constraints and consulting problems. This report is much delayed due to a combination of priority being given to preparing the project proposal on request of ADB, and delay in completing the assessments. Conseil Santé had to make adjustments for the work of the Gender and Social Safeguard consultants, and limited availability of the Procurement and Laboratory Experts. Conseil Santé takes full responsibility for delays and quality issues of several reports caused accordingly, and hopes that the quality issues have been addressed. Conseil Santé engaged two additional experts to help edit reports.

A total of 95 documents had to be prepared. The complete list of documents is provided in the report. This large volume of work is also challenging. While the consultants supported the PPTA design, it was felt that the visits to each country were too short to do more extensive field visits and dialogue with government and partners. In particular for the Gender and Social Safeguard consultants, field time was inadequate to cover 4 countries. The inputs of these experts were increased from 1 month each to 1.756 months each to accommodate field visits of over 1.6 months. The four country visits had to be organized back-to-back for efficiency and field work but this was hard to manage and also took up precious time. Conseil Santé has learned that regional PPTAs are particularly challenging, and is pleased to have been able to partner with ADB for this important project.

Part 1: PPTA Implementation

1.1 Background

1. The Greater Mekong Subregion (GMS) presents a major global health security concern of emerging infectious diseases and communicable diseases like dengue, malaria, tuberculosis, HIV/AIDS, cholera and other diarrheal diseases, drug resistant and hospital acquired infections, and others. As management of non-communicable diseases is advancing, infectious diseases will resurge due to a combination of new agents, increased communication and exposure, declining immunity, and lack of new medicines. Governments recognize the need for government support for regional public goods and goods with major externalities, and with limited treatment options and possibly major health and economic impact of outbreaks push for prevention, early recognition, and quick control.

2. WHO's International Health Regulations (IHR) of 2005 identifies key strategic areas and within that specific services that each country has to comply with. To further guide South-east Asia in implementing IHR, WHO issued a bi-regional Asia Pacific Strategy for Emerging Diseases (APSED) in 2005, updated in 2010, and to be updated in 2016 incorporating Ebola hemorrhagic fever (EHF) and other emerging challenges and responses.

3. All GMS countries have built up a bottom-up surveillance system that is functioning from fair to excellent. However, response to outbreaks may be delayed, and hospitals lack in infection control and surge capacity. Public and private laboratories in Cambodia, Lao and Myanmar lack in resources, quality, and networking. Cross-border and inter-sectoral coordination of prevention and control measures are often delayed, informal, and ad hoc. Community preparedness and APSED monitoring also need more attention.

4. As part of the GMS economic development program, ADB has been supporting CDC in the GMS for the past 20 years. This included support for HIV prevention and the first and second communicable diseases control projects for Cambodia, Lao and Viet Nam, and targeted support for severe acute respiratory syndrome (SARS), highly pathogenic avian influenza (HPAI), malaria, and dengue control. ADB also supported studies targeting migrants, ethnic minorities, and remote rural communities.

5. ADB's engagement in the CDC projects has focused on (i) strengthening national surveillance and response systems, (ii) regional and cross-border cooperation and knowledge management for CDC, (iii) improving laboratory services, (iv) control of dengue and neglected tropical diseases, (v) model-healthy villages, and (vi) strengthening provincial training capacity building. ADB and Japan have supported rolling out the model healthy village. ADB also supported improving sanitary and phytosanitary standards for processed food for export in the GMS (including a forum in Myanmar in 2014), and a cold chain project in PR China.

6. WHO, ADB, EU, France, Japan, USAID and other partners have supported the implementation of APSED and IHR compliance and more broadly building up CDC capacity, including for laboratory capacity. Coordination of support is typically done by strategic area or subsector, under leadership of WHO. ADB played a major complementary role in terms of financing and organizing regional activities. The Global Fund is the major supporter of HIV, malaria, and TB control in the GMS.

7. The focus of the project is to help avert any major outbreak of communicable diseases in the GMS, in particular emerging infectious diseases (EIDs) but also other diseases of regional importance, by basically system strengthening based on APSED. While APSED provides a

strong strategic framework, there is no cohesive APSED implementation program. It is important to develop one strategic approach in the GMS, which will help strengthen each country's efforts.

8. The Project scope is directed by gaps in APSED implementation. Based on APSED evaluation, major gaps are in surveillance and response in groups out of reach of regular services, risk analysis and communication, laboratory services and biosafety, infection prevention and control in hospitals, and particular in inter-sectoral and cross-border and regional cooperation.

9. Information on risks and risk groups for EIDs and common and less common infections is lacking. Migrants, mobile people, and isolated ethnic minority communities are basically off the radar screen of MOH. Provincial health officers may even not know the actual population in their province including migrant laborers, as a basis for budgeting and services. Migrant workers in factories and casinos are supervised by other ministries, and receive some work place care but not particularly for disease control (or even mother and child health). Mainly for physical but also social obstacles, there are still isolated ethnic groups in the GMS that need to be reached. Specific gender issues affecting access and responsiveness will also need to be considered, in particular regarding women's empowerment to take decisions as the common caretaker in case of illness.

10. While a large number of HIV/AIDS and tuberculosis cases are still not detected, even for currently known cases there is not enough budget to treat all, despite major Global Fund support. As the Global Fund is planning to scale down, countries have started to increase domestic budgets, but not enough. Minimum targets have to be met, such as ensuring that all pregnant women receive HIV treatment so that their children are born without HIV. Also youth is an increasing risk group for HIV due to urbanization, migration, and changing social standards.

11. All ministries of health have quite an extensive network of public health facilities in place that could serve the majority of the population, but ministries have been seriously affected by lack of funding, in particular in Lao and Myanmar, and staff constraints. Out of pocket spending is high and use of health services is still low, thereby posing a health security risk for the countries.

12. Ministries also have management issues that affect performance of health services, such as the limited numbers of competent staff at central and provincial/state levels to manage services. Projects are typically implemented as self-standing investments, and insufficiently integrated in general health services and annual plans and budgets, making them less sustainable. Lack of competent technical staff and consultants in Project Management Units (PMUs) has also been a challenge. There are also challenges in procuring quality equipment and implementation of gender action plan and social safeguards.

13. Regional coordination mechanisms and flow of funds for regional activities are also a challenge and are being tackled through the regional coordination unit based in MOH Vientiane.

1.2 Activities carried out during PPTA

1.2.1 Sector work

Based on the basic understanding of the GMS setting as provided by the ADB R-PPTA paper and the inception report of November 2014, PPTA consultants have conducted a situation analysis and a project planning process in Cambodia, Lao PDR, Myanmar and Viet Nam (CLMV). Basically situation analysis was from July to December 2015, and project planning

from January to June 2016. However, due to advancing of the ADB processing schedule, preparation of the project proposal was advanced, and the situation analysis completed later. To do so, the PPTA team carried out 4 rounds of missions, whereby Viet Nam, and also Myanmar, required more field time for various reasons. While the intention was to do workshops in each country in each round, primarily to ensure participation and by-in, ministries of health decided whether this was required or not. Viet Nam and Myanmar were keen to organize workshops. Cambodia MOH organized one very good workshop and so did Laos MOH, and these ministries felt that this was adequate.

1.2.2 Missions

1.2.2.1 **Inception mission** to CLMV from 13 July to 22 August 2015 carried out by the team leader and national co-team leaders.

Laos	13-17 July 2015
Cambodia	18- 27 July 2015
Viet Nam	28 July to 13 August 2015
Myanmar	14-22 August 2015

1.2.2.2 **Situation analysis mission** to CLMV from 19 September to 8 November 2015 including team leader, deputy team leaders, national consultants for procurement, finance, gender and social safeguards, and international consultant for finance, health economics, laboratory, gender, and social safeguards.

Myanmar	20 September to 3 October	MOH Workshop 24 September
Viet Nam	4-17 October	National workshop 9 October
Laos	19-27 October	
Cambodia	28 October-8 November	National Workshop 5 November
Regional	8 October, in Hanoi	Regional meeting with ADB and Conseil Santé

1.2.2.3 **Project planning mission** to CLMV from 20 January to 27 February 2016 including team leader, deputy team leaders, national consultants for procurement, finance, gender and social safeguards, and international consultants for finance, laboratory, procurement, and environment.

Viet Nam	21-29 January	
Laos	1-5 February	Workshop 2 February
Cambodia	7-12 February	
Myanmar	13-23 February	

1.2.2.4 **Project appraisal mission** to CLMV from 28 February to 10 May intermittent including team leader, deputy team leaders joint ADB, loan appraisal team.

Viet Nam:	28 February to 5 March	
Laos:	13 to 19 March	14-15 March 2015
Cambodia:	21 to 25 March	
Myanmar:	25 April to 2 May	MOH workshop 26-27 May 2016
Viet Nam:	3 to 10 May	National workshop 9 May 2016

1.2.3 Outputs

1.2.3.1 During **Inception**, following outputs had been prepared:

Inception Outputs

1. 4 Aide Memoires for inception mission CLMV
2. 4 Background papers of health sectors and settings for CLMV
3. Problem tree
4. Results framework
5. Draft Project Outline
6. Draft Design and Monitoring Framework (DMF)
7. Inception Report, including updated work plan, personnel schedule, mission schedule
8. Updated terms of reference and proposed subsector assessment
9. Directory and Project Manual.
10. Questionnaires for APSED/IHR, laboratory, gender and IP

Total 18 documents

1.2.3.2 During **Situation Analysis**, following outputs were prepared

Situation Analysis Outputs

1. Aide memoires situation analysis mission
2. Development Coordination Matrix
3. Draft RRP, DMF, implementation arrangements, and risk analysis
4. 4 Country Summary Poverty Reduction and Social Strategy
5. 4 Country Health Sector Analysis CLMV including for:
    a) IHR/APSED,
    b) Surveillance and Response,
    c) Laboratory Services,
    d) Infection Prevention and Control,
    e) CDC in border areas,
    f) Regional and Cross-border Cooperation
6. 4 Country Gender Analysis
7. 4 draft Migrants and Mobile People Analysis
8. 4 Financial Management Analysis
9. Mid-term/Project Planning Report.

Subtotal 27 documents

1.2.3.3 During **fact finding**, following outputs were prepared:

Fact finding Outputs

1. 4 Aide memoires fact finding mission
2. 4 Country Poverty and Social Analysis
3. Gender analysis and GAP for CLMV countries
4. 4 Indigenous people analysis and plan
5. 4 Involuntary Resettlement Frameworks
6. 4 Procurement Analysis
7. 4 Budgets/Cost estimates
8. 4 Procurement Risk Analysis
9. 4 Laboratory Analysis
10. 4 Initial Environmental Examinations and Plans
11. Details on target populations
12. Economic and Financial Analysis

Subtotal 34 documents

1.2.3.4 During **appraisal,** following outputs were prepared.

Appraisal Outputs

1. 4 aide memoires of appraisal mission
2. 4 Procurement Plans
3. Health Analysis
4. Project Proposal (RRP)
5. Project Administration Manual
6. Financial appendices for PAM
7. Project Implementation Schedule
8. Project Implementation Plan
9. Project Indicators
10. Final PPTA report

Subtotal 16 documents

In total, 95 documents, many of over 40 pages, due to the fact that in a regional project separate documentation is still required for each country.

1.3 Project Scope

1.3.1 Direction during Inception

14. *For the record*, the inception mission was carried out by the team leader with help of deputy team leaders (except in Lao) and some national consultants. In Myanmar, the inception mission was assisted by the ADB GMS health coordinator, who facilitated meetings with MOH and partners. The support of the Regional Coordinator, CDC2, was also critical in completing the inception mission.

15. The inception mission focused on getting Governments' support and priorities for the project, with a focus on IHR/APSED and CDC for migrants and mobile people, ethnic minorities and vulnerable groups (MEVs) in border areas. Priority areas are regional and cross-border cooperation, surveillance and response, hospital infection control, quarantine, laboratory services, and access to CDC for migrant and mobile populations (MMPs) including extending HIV, malaria and tuberculosis (HMT) programs and dengue control. In general, MOH in Cambodia and Lao PDR wish to continue to scope of CDC2. Viet Nam MOH also proposes a broadening of the scope to improving district health services, including non communicable diseases (NCDs). Myanmar MOH was particularly interested in regional cooperation, CDC in border areas surveillance and response, and improving state laboratories and hospitals. The project outline that was prepared was based on those discussions with governments as documented in aide memoires. These then were used for the second (analytical) and third (project preparatory) phase.

1.3.2 Proposed Project Scope

16. At the end of 4 cycles of consultations with the 4 countries (and Viet Nam 5 times), the overall scope was generally agreed as follows.

17. The Project Rationale is straightforward given the nature of infectious diseases, market failure, potential heath and economic impact, and need for government interventions. There are

equity and extended MDG dimensions: those people not reached are the ones that prevent countries from reaching MDG targets.

18. A strong CDC system is desirable at all levels including for EIDs, HMT, dengue, NCDs, food-born infections, unknown fevers and coughs, and other important diseases, with general improvement of village outreach, laboratory services, and infection control to bring multiple benefits. Surveillance and response need to reach to the village and patient level and be nation-wide, including borders and point of entry.

19. The proposed project goal is strengthened GMS health security to reduce impact of outbreaks to less than 100 fatalities and less than 0.5% impact on Gross Domestic Product in any quarter of the year. The proposed project outcomes are (i) improved coverage of GMS public health security system and compliance with IHR/APSED and (ii) increased CDC coverage of MEVs in border areas. The proposed project outputs are (i) improved GMS collaboration and MEV access to communicable disease control in border areas; (ii) strengthened national surveillance and response systems; and (iii) improved capacity to diagnose and manage infectious diseases. The project is proposed to target 13 provinces in Cambodia, 12 provinces in Lao PDR, 5 states and one region in Myanmar, and 36 provinces in Viet Nam.

20. Viet Nam MOH has already received Government approval of the Project Outline from the Government.

21. While most of the scope is much in support of current government activities, the project also proposes to give more attention to vulnerable groups in border areas that are underserved, including ethnic minorities. This is discussed in ethnic group development plans. Governments are typically focused on the common good, and will need to make special effort to target these marginal groups.

22. Migrants are also a hard to reach group with unknown or higher infectious disease burden. This includes legal and illegal cross-border migrants, internal migrants (the majority) working in industry, plantations, and services. Workers in casinos, factories and plantations may not be accessed easily by MOH, and are inspected through another ministry. Provincial health departments may not know the size of the migrant population, and this is not considered in budget allocation.

23. Governments are generally in agreement that these groups should be reached somehow as they need health care and constitute a regional health security risk. However, Governments lack capacity (rules, funds, staff, community engagement) to do so and are reluctant to consider engaging other agencies.

24. There has been no dialogue as yet with Thailand and China for possible in cross-border and regional activities. This probably needs to be initiated by ADB, for example inviting these countries at the GMS health security workshop. While each province has its own priority MEV, there also needs to be further dialogue on the specific interventions for CDC in border areas, and cross-border cooperation.

25. As requested by ADB, a separate project management output had been left out and the budget integrated with the 3 outputs.

1.3.3 Gender and Safeguards

26. The project is categorized as gender mainstreaming. A gender analysis and GAP for each country was prepared.

27. The project is assessed as IP category B due to positive impact. EMG analysis and EGDP has been prepared for each country (see Part III-4 of the Final Report)

28. As there is no resettlement, this is assessed a Category C and a resettlement framework has been prepared (see Part III-5 of the Final Report)

29. Because the project scope concerns handling infectious diseases during surveillance and response, in border areas and in hospitals and laboratories, an IEE was prepared for each country and the project was categorized as Category B. Each province will need to prepare an EMP for its interventions (see Part III-6 of the Final Report)

30. A financial management assessment was done for each country, and the financial risk was assessed as moderate but high in Myanmar. A mitigation plan has been proposed (see Part III-7 of the Final Report)

31. A procurement risk assessment was done in each country and the risk was assessed as moderate to high. Mitigating actions have been proposed (see Part III-8 of the Final Report).

1.3.4 Project Financing

32. Governments are generally reluctant to use loan funds for less “tangible” outputs and want a proportion of loan funds, usually about 70%, for hardware (in this case equipment and vehicles as there are no civil works). Some flexibility exists when it comes to priority interventions such as for dengue control. Governments are also reluctant to invest at village level as this is seen as private sector subsidy, not investment in Government (staff in this case). However, governments have indicated satisfaction with the model healthy village program that improves basic conditions at village level.

33. Governments have processing difficulty financing participation in regional activities abroad using loan funds, such as for workshops. Grant funds would be more appropriate for regional travel. Governments are also less prepared to finance international consultants, and at the same time cannot offer competitive rates to national consultants.

1.3.5 Project Preparation

34. One RRP has been prepared that is included in the Final Report (Part II). With some inputs from the PPTA, ADB prepared the Project Administration Manual. For each country, separate analysis, budget and safeguard documents have been prepared. In case processing in any of the countries delays, an additional RRP will be required for that particular country, but basically it will be similar in content.

35. This being a four-country project preparation within a timeframe of one year, and with many consultants only engaged for about 6 weeks, the team felt that there was insufficient time for reading, team meetings, consultations and discussions, field visits, data collection, analysis, and report writing, in particular for the gender and safeguard specialists.

36. As per technical assistance paper, the PPTA follows an iterative participatory process to ensure government ownership and buy-in of loan financing of preventive services. The 4 countries agree on the overall scope. However, there was not much time for detailed discussions and preparations. Consultants felt that fewer but longer missions, not back to back in 4 countries which is tiring, could be an alternative to planning regional projects. However, ADB explained that there was a time constraint for processing in view of availability of ADF.

37. All parties agree that the project design should be evidence-based. If there are no agreed strategies based on available literature, at least the process including monitoring and adjustment needs to ensure that evidence will guide decision making. Knowledge management activities should not be self-standing as during CDC1 and CDC2 but tightly linked with developing GMS strategies for disease control.

38. Consultants have given special attention to ensuring the sustainability of the project design, basically by asking that investments need to be part of a provincial five-year plan with agreed priorities and recurrent cost financing.

Part 2: PPTA Administration

2.1 PPTA Implementation

39. The contract signed on 7 July and field mission started on 13 July 2015. The contract is until 30 June 2016. The TA was divided in 4 phases to deliver the inception report, interim (technical) report, draft final report (project proposal) and final report:

- **Inception phase (2 months)**
- **Analytical project design phase (4 months)**
- **Detailed project design phase (3 months)**
- **Refinement, and consensus building phase (2 months)**

40. The inception period was relatively long (2 months) as (i) it is a 4-country TA, (ii) a large number of consultants had to be mobilized, and (iii) the inception report is not only to provide the detailed TA plan, but, based on a participatory planning process and sectoral and economic analysis, prepare a project outline including draft DMF and draft Project Design Outline (PDO) in Viet Nam.

41. The second analytical phase before the interim report should examine a wide range of technical, administrative and social aspects. In this phase, the time schedule should also allow time for the Government for internal consultation and data collection. Based on the proposed timetable, the interim report should have been completed by mid-December 2015. However, very early there were concerns that the assessment could not be completed at that time.

42. Over an 11 months TA period, a total of 4-5 visits to each country were carried out by at least the team leader, namely: (i) for inception, (ii) for sector analysis, (iii) for the project design, and (iv) for the final report. The composition depended on the work to be conducted. Field visits lasted from 1 week to a maximum once of 2.5 weeks in Viet Nam.

2.2 PPTA Management

43. There were no management changes. The team leader jointly with deputy team leaders, was responsible for the dialogue with the Governments. Deputy-team leaders were the PPTA managers in each country including for managing national consultants, workshops, data collection, and liaison with the Government and partners. This worked out very well.

44. Conseil Santé provided continuous administrative support and engaged another administrative assistant to provide secretarial support which proved very helpful.

45. There have been no major issues in the flow of funds for transport and workshops. Collection of documentation for invoicing reimbursables was satisfactory and no major problem is anticipated in this regard. Office space for team meeting in the countries was provided on a case by case basis: the TA contract indicated that office accommodation was to be provided by Governments and Conseil Santé did not plan on having available full time office space in each of the four countries.

46. The consultants experienced time constraints in the field. Each MOH needed extra time to discuss the project internally and arrange for field visits and data collection. The time in between inception and situation analysis missions needed to prepare the situation analyses had to be reduced by 2 weeks to ensure completion before the government elections in Myanmar. For round 3, for the detailed project preparation, ADB had to adhere to an advanced processing schedule to allow the Government of Viet Nam enough time for internal approval.

47. Accordingly, ADB requested the consultants to proceed preparing the project proposal ahead of schedule and allowed consultants to delay completion of the situation analysis report. Unfortunately, the situation report was delayed for six months due to the time it took to prepare the long versions of the health analysis, the poverty and social analysis, the gender analysis, the ethnic group development analysis, and the procurement risk assessments. This was not only due to problems with unavailability or underperforming consultants, but due to the workload of preparing projects for 4 countries at the same time.

2.3 TA Completion Plan and Issues

2.3.1 TA Completion Plan

48. Conseil Santé is submitting final documentation later than planned due to the reasons explained above. Conseil Santé including the team leader remain available to respond to any further queries until ADB board approval.

2.3.2 TA Inputs

49. The inputs provided by the consultants are in Appendix 3. Services of team leader, Viet Nam team leader, and gender and social safeguards experts were extended, and services of procurement specialists and several national consultants were shortened, in particular for field visits. A schedule of field visits is in Appendix 2. Two international consultants were engaged under Conseil Santé's administrative budget. A final contract variation will be submitted to ADB after submission of Conseil Santé's financial reporting.

The national experts spent less time in the field than planned. National experts are already well informed about the situation in the field, and field time was too short to do more systematic assessments. They also had to accompany the international experts during missions and time of gender and social safeguards experts was insufficient. Field visits were also difficult to organize, in particular in Myanmar and Viet Nam, with permissions needed from Government, and requiring Government staff to participate in field visits except in Myanmar.

50. The other inputs (flights, workshops) were as per budget. Not all workshops (one per country per visit) could be realized due to time needed for field visits and government time constraint and a contract variation reduced workshop budget accordingly.

Appendix 1 – List of documents prepared for the PPTA

Situation Analysis

- Poverty and Social Analysis and SPRSS for Cambodia
- Poverty and Social Analysis and SPRSS for Lao PDR
- Poverty and Social Analysis and SPRSS for Myanmar
- Poverty and Social Analysis and SPRSS for Viet Nam
- Economic and Financial Analysis

1. Health Situation Analysis
   - General Health Situation Analysis
   - Situation Analysis for Cambodia
   - Situation Analysis for Lao PDR
   - Situation Analysis for Myanmar
   - Situation Analysis for Viet Nam
   - Improving Laboratory Services: Cambodia
   - Improving Laboratory Services: Lao PDR
   - Improving Laboratory Services: Myanmar
   - Improving Laboratory Services: Viet Nam

2. Project Proposal

   - Project Proposal (Draft Report and Recommendation of the President -RRP) including
     - Design and Monitoring Framework
     - Surveillance and Response Issues and Options in CLMV countries
     - Problem Tree
     - Results Framework
   - Project Administration Manual including:
     - Design and Monitoring Framework
     - List of Project Provinces and Target Populations
     - Project Implementation Plan
     - Project organization and roles and responsibilities
     - Project Costs Estimates and Financing
     - Financial Management Assessment
     - Terms of reference of Consultants
     - Key Positions of EA, IA and PMU
     - Procurement Plans
     - Gender and Safeguards Summary
     - Project Implementation Activities
     - Project Monitoring

3. Gender, Safeguards and Risk Assessment
   - Gender Analysis and Action Plan general
   - Gender Analysis and Action Plan Cambodia
   - Gender Analysis and Action Plan Laos

- Gender Analysis and Action Plan Myanmar
- Gender Analysis and Action Plan Viet Nam
- Ethnic Group Development Plan for Cambodia
- Ethnic Group Development Plan for Laos
- Ethnic Group Development Plan for Myanmar
- Ethnic Group Development Plan for Viet Nam
- Resettlement Framework for Cambodia
- Resettlement Framework for Lao PDR
- Resettlement Framework for Myanmar
- Resettlement Framework for Viet Nam
- Initial Environmental Examination for Cambodia
- Initial Environmental Examination for Lao PDR
- Initial Environmental Examination for Myanmar
- Initial Environmental Examination for Viet Nam
- Procurement Risk Assessment for Cambodia
- Procurement Risk Assessment for Lao PDR
- Procurement Risk Assessment for Myanmar
- Procurement Risk Assessment for Viet Nam
- Financial Management Assessment Cambodia
- Financial Management Assessment Laos
- Financial Management Assessment Myanmar
- Financial Management Assessment Viet Nam

4. Memorandums of Understanding (on request, as these were for ADB mission).

Appendix 2 – Schedule of Field Visits

Our technical proposal included the following field missions for the international experts:

- A first mission in July 2015 in each of the four countries, one week in each country, for the inception phase
- A second mission in October 2015 in each of the four countries, one week in each country, for the analytical project design phase
- A third mission in January-February 2016 in each of the four countries, one week in each country, for the detailed project design phase
- A fourth mission in May 2016 in each of the four countries, one week in each country, for the refinement and consensus building phase.

The following international experts' missions were planned in our technical proposal:

Time – Phase	Cambodia (nr days)	Lao (nr days)	Myanmar (nr days)	Viet Nam (nr days)
July 2015 – Inception phase	- Team Leader (7) - Financial (7) - Procurement (7)	- Team Leader (7) - Financial (7) - Procurement (7)	- Team Leader (7) - Financial (7) - Procurement (7)	- Team Leader (7) - Financial (7) - Procurement (7)
October 2015 – Analysis	- Team Leader (7) - Health Econ (7) - Laboratory (7) - Environment (7) - Social Safeg. (7) - Gender (7)	- Team Leader (7) - Health Econ (7) - Laboratory (7) - Environment (7) - Social Safeg. (7) - Gender (7)	- Team Leader (7) - Health Econ (7) - Laboratory (7) - Environment (7) - Social Safeg. (7) - Gender (7)	- Team Leader (7) - Health Econ (7) - Financial (7) - Laboratory (7) - Procurement (14) - Environment (7) - Social Safeg. (7) - Gender (7)
Jan-Feb 2016	- Team Leader (7) - Laboratory (7) - Procurement (7) - Financial (7)	- Team Leader (7) - Laboratory (7) - Procurement (7) - Financial (7)	- Team Leader (7) - Laboratory (7) - Procurement (7) - Financial (7)	- Team Leader (7) - Laboratory (7) - Procurement (7) - Financial (7)
May 2016	- Team Leader (7)	- Team Leader (7)	- Team Leader (7)	- Team Leader (7)

The field missions of international experts were as follows:

Time – Phase	Cambodia (nr days)	Lao (nr days)	Myanmar (nr days)	Viet Nam (nr days)
July 2015 – Inception phase	- Team Leader (5)	- Team Leader (7)	- Team Leader (8)	- Team Leader (18)
Sept-Oct. 2015 – Analysis	- Team Leader (12) - Financial (12) - Social Safeg. (12) - Gender (11)	- Team Leader (11) - Health Econ (6) - Financial (11) - Laboratory (6) - Social Safeg. (10) - Gender (11)	- Team Leader (13) - Health Econ (13) - Financial (14) - Laboratory (14) - Social Safeg. (14) - Gender (13)	- Team Leader (14) - Health Econ (14) - Financial (14) - Laboratory (14) - Social Safeg. (14) - Gender (14)
GMS health workshop				- Team Leader (6)
Jan-Feb 2016	- Team Leader (6) - Laboratory (6) - Procurement (7) - Financial (6) - Environment (6)	- Team Leader (7) - Laboratory (7) - Procurement (7) - Financial (7) - Environment (7)	- Team Leader (11) - Laboratory (8) - Financial (11) - Environment (15)	- Team Leader (11) - Laboratory (7) - Procurement (7) - Financial (11) - Environment (11)
March-April 2016	- Team Leader (7)	- Team Leader (8)	- Team Leader (9)	- Team Leader (8)
May 2016				- Team Leader (9)

Appendix 3 – Inputs Provided by the Team Members

The team was composed of the experts listed below. The table shows the number of person-months in the Terms of Reference, in our Contract with most recent contract variation and the total person-months used as of 30 June 2016

Position	Nr of person-months in ToRs	Nr of person-months contract	Nr of person-months used
International Experts			
Health Security Expert / Team leader	6	9.42	9,7424
Health Economist	3	3.25	3.2303
Financial Specialist	3	4.03	4.0743
Laboratory Management / Lab quality assurance Specialist	4	4	3.5668
Procurement Specialist	4	2.535	1.1546
Environmental Safeguards Specialist	1	1.691	1.6864
Social Safeguards Specialist	1	1.756	1.7242
Social Development/Gender Specialist	1	1.756	1.7489
Total	*23*	*26.682*	*25.2415*
National Experts - Cambodia			
Public health Specialist / Deputy Team Leader	5	5	4.8214
Financial Specialist	3	3	2.1091
Procurement Specialist	3	3	2.4728
Gender Specialist	1	1	1.0394
Social Safeguards Specialist	1	1	0.9592
National Experts – Lao PDR			
Public Health Specialist / Deputy Team Leader	5	5	4.6576
Financial Specialist	3	3	2.2712
Procurement Specialist	3	3	2.0273
Gender Specialist	1	1	0.7697
Social Safeguards Specialist	1	1	0.9971
National Experts – Myanmar			
Deputy Team Leader	5	1.5	2.2816
Public Health Specialist		2.46	1.3955
Financial Specialist	3	3	2.2697
Procurement Specialist	2	2	2.0076
Gender Specialist	1	1.23	1
Social Safeguards Specialist	1	1	0.9668
National Experts – Viet Nam			
Public health Specialist / Deputy Team Leader	5	6	5.9664
Financial Specialist	3	3	2.6786
Procurement Specialist	4	4	3.9696
Gender Specialist	1	1	1
Social Safeguards Specialist	1	1	0.9970
Total	*52*	*50.69*	*44.65*
Additional Experts added through contract variation			
National Environmental Expert for Viet Nam		0.6849	0.6516
International PH and Social Researcher		0.2727	0.2728

ADB Great Mekong Subregion Health Security Project - Project Preparation Technical Assistance

	Home	Field	TOTAL	JULY 2015 Home	JULY 2015 Field	AUGUST Home	AUGUST Field	SEPTEMBER Home	SEPTEMBER Field	OCTOBER Home	OCTOBER Field	NOVEMBER Home	NOVEMBER Field	DECEMBER Home	DECEMBER Field	JANUARY Home	JANUARY Field	FEBRUARY Home	FEBRUARY Field	MARCH Home	MARCH Field	APRIL Home	APRIL Field	MAY Home	MAY Field	JUNE Home	JUNE Field	Home	Field	TOTAL
Vincent DE WIT (Mr) Health Security Expert, Team	3,4200	6,0000	**9,42**	0,0909	0,6333	0,0455	0,8000	0,2273	0,4000		1,0000	0,3182	0,2667	0,2727	0,2000	0,2727	0,4000	0,0909	0,8333	0,4091	0,7000	0,7273	0,2667	0,4545	0,3333	1,0000		3,9091	5,8333	**9,7424**
Steve FABRICANT (Mr) Health Economist	2,0800	1,1700	**3,25**					0,2955	0,3833		0,7333							0,7273		0,5909		0,5000					2,1137	1,1166	**3,2303**
Victor VILLAREAL (Mr) Financial Specialist	0,9300	3,1000	**4,03**						0,4000		1,0000	0,6818	0,2667				0,4000	0,0455	0,7667	0,2727				0,2409				1,2409	2,8334	**4,0743**
John AASKOV (Mr) Lab mgt, Lab Quality Ass Specialist	2,1600	1,8400	**4**			1,0000			0,4000	0,0455	0,7333					0,2273	0,2667	0,0455	0,6667							0,1818		1,5001	2,0667	**3,5668**
Manmohan RUPRAI (Mr) Procurement Specialist	0,9500	1,5850	**2,535**							0,0909		0,1364				0,1364	0,2667	0,0909	0,4333									0,4546	0,7000	**1,1546**
Ricardo MIRANDA Environment Safeguards Specialist	0,0910	1,6000	**1,691**														0,4000		0,9000			0,3864						0,3864	1,3000	**1,6864**
Nurul HOQUE (Mr) Social Safeguards Specialist	0,1227	1,6333	**1,756**						0,4000		1,0000	0,0909	0,2333															0,0909	1,6333	**1,7242**
Bodil WARMING (Mrs) Social Devt/Gender Specialist	0,1435	1,6125	**1,756**						0,3792		1,0000	0,1364	0,2333															0,1364	1,6125	**1,7489**
James MIELKE (Mr) Support in Gender and Social Safeguard	0,2727		**0,2727**																			0,0455		0,2273			0,2728	0,0000	**0,2728**
TOTAL	10,1699	18,5408	**28,7107**																									10,1049	17,0958	**27,2007**
Touch SOK (Mr) Public Health Specialist/ Deputy TL	2,4700	2,5300	**5**	0,2273		0,5455		0,6364		0,7273	0,2000	0,7727	0,1667	0,6818		0,2273		0,2273		0,2273		0,1818						4,4547	0,3667	**4,8214**
Hap Chanthea Financial Specialist	1,6200	1,3800	**3**	0,0000	0,0000	0,0000	0,0000							0,1818		0,7273	0,2000	1,0000										1,9091	0,2000	**2,1091**
Nath EANG Procurement Specialist	1,6200	1,3800	**3**					0,0000	0,0000			0,2045		0,2955		0,7273	0,2000			0,5455				0,5000				2,2728	0,2000	**2,4728**
Sary BUN (Mrs) Gender Specialist	0,5400	0,4600	**1**	0,0000	0,0000	0,0000	0,0000	0,0000	0,0000	0,1818	0,1000	0,5909	0,1667															0,7727	0,2667	**1,0394**
Kimsreang BOUY (Mr) Social Safeguards Specialist	0,5400	0,4600	**1**							0,0455	0,1000	0,3864	0,1667					0,2273	0,0333									0,6592	0,3000	**0,9592**
Southammavong MANIVANH (Mrs) Public Health Specialist/ Deputy TL	2,4700	2,5300	**5**					0,4545		0,4545	0,1667	0,5455	0,4000	0,6818		0,2727		0,4545		0,6364		0,1364		0,2273		0,2273		4,0909	0,5667	**4,6576**
Simoune DARASMY (Mr) Financial Specialist	1,6200	1,3800	**3**	0,0000		0,0000	0,0000	0,4318		0,3182	0,1333	0,3182	0,4333	0,0000	0,0000			0,3636		0,2273				0,0455				1,7046	0,5666	**2,2712**
Sisomphone SOUTHAMMAVONG (Mrs) Procurement Specialist	1,6200	1,3800	**3**			0,0000	0,0000	0,1364		0,1364	0,1333	0,4545		0,1818				0,3182	0,1667	0,2273				0,2727				1,7273	0,3000	**2,0273**
Soumountha YOUTITHAM (Mrs) Gender Specialist	0,5400	0,4600	**1**			0,0000	0,0000	0,0000	0,0000	0,1364	0,1333	0,2727		0,0000	0,0000			0,2273										0,6364	0,1333	**0,7697**
Khamtanh BOUNMANY (Mr) Social Safeguards Specialist	0,5400	0,4600	**1**					0,1364		0,1364	0,1333	0,1364				0,1364		0,2273				0,0909						0,8638	0,1333	**0,9971**
Zaw Tun Win DTL	0,0000	0,0000	**0**			0,1761	0,0667																					0,1761	0,0667	**0,2428**
Sao Kyi Than Public Health Specialist	1,0100	1,4500	**2,46**					0,0000	0,0000									0,0455		0,0909		0,3864	0,1333	0,3182	0,1667	0,2045	0,0500	1,0455	0,3500	**1,3955**
Daw Swe Swe THEIN (Mrs) Financial Specialist	1,6200	1,3800	**3**						0,1000		0,1000		0,1000	0,1364	0,1000			0,0909	0,4000	0,1818		0,2727		0,4091	0,3333	0,0455		1,1364	1,1333	**2,2697**
Hlaing War War AUNG (Ms) Procurement Specialist	1,3100	0,6900	**2**															0,5000	0,3000			0,0227		0,8182	0,2667		0,1000	1,3409	0,6667	**2,0076**
Thet Htar MYINT (Mrs) Gender Specialist (2nd position) + DTL	2,0000	0,9200	**2,92**					0,4545				0,1818	0,1000	0,0909		0,3636		0,4091	0,2333			0,4545	0,1333	0,7273	0,1333			2,6817	0,5999	**3,2816**
Thet Htar MYINT (Mrs) Social Safeguards Specialist	0,5400	0,4600	**1**			0,2727	0,0667	0,0455	0,2333	0,0455	0,0667	0,1364	0,1000															0,5001	0,4667	**0,9668**
Cuong NGUYEN DINH (Mr) Public Health Specialist/ Deputy TL	3,4700	2,5300	**6**	0,2727		0,9545	0,0333	1,0000		0,8636	0,1333	0,7727	0,1333	0,7727	0,1667	0,4545								0,4091				5,4998	0,4666	**5,9664**
Trong NGUYEN (Mr) Financial Specialist	1,6200	1,3800	**3**			0,3636		0,4091		0,4545	0,1333	0,3636		0,3182		0,3636		0,2727										2,5453	0,1333	**2,6786**
Tran LE KHANH (Mrs) Procurement Specialist	2,1600	1,8400	**4**			0,5909		0,6818		0,3182	0,1333	0,3182	0,1333	0,7955	0,0667	0,1136						0,3636		0,4545				3,6363	0,3333	**3,9696**
Hoang HONG HANH (Mrs) Gender Specialist	0,5400	0,4600	**1**			0,0455		0,0000	0,0000	0,5000	0,1333	0,2273	0,0333		0,0606													0,7728	0,2272	**1**
Le TRUNG THONG (Mr) Social Safeguards Specialist	0,4600	0,5400	**1**			0,0682	0,0000	0,0000	0,0000	0,0682	0,1333	0,0455		0,3636		0,3182												0,8637	0,1333	**0,997**
Phan VU LOI (Mr) Environmental Specialist	0,3182	0,3667	**0,6849**																	0,3182	0,3334							0,3182	0,3334	**0,6516**
TOTAL	28,6282	24,4367	**53,0649**																									39,6083	7,9437	**47,5520**