Special Evaluation Study

SST: REG 2005-04

ADB Policy for the Health Sector

July 2005

Operations Evaluation Department
Asian Development Bank

ABBREVIATIONS

ADB	–	Asian Development Bank
ADF	–	Asian Development Fund
ADF IX	–	Eighth Replenishment of the Asian Development Fund
ARI	–	acute respiratory infection
CAR	–	Central Asian republic
CSP	–	country strategy and program
CSPU	–	country strategy and program update
DAC	–	Development Assistance Committee
DALY	–	disability-adjusted life year
DMC	–	developing member country
ECD	–	early childhood development
GAVI	–	Global Alliance for Vaccines and Immunization
GDP	–	gross domestic product
GFATM	–	Global Fund to Fight AIDS, TB and Malaria
GNP	–	gross national product
HIV/AIDS	–	human immunodeficiency virus/acquired immunodeficiency syndrome
HMIS	–	health management information system
HNP	–	health, nutrition, and population
IDA	–	International Development Association
IMR	–	infant mortality rate
IP	–	indigenous people
JFPR	–	Japan Fund for Poverty Reduction
LTSF	–	long-term strategic framework
MDG	–	Millennium Development Goal
MMR	–	maternal mortality ratio
NGO	–	nongovernment organization
OCR	–	ordinary capital resources
ODA	–	official development assistance
OED	–	Operations Evaluation Department
OOF	–	other official flows
ORT	–	oral rehydration therapy
PCR	–	project or program completion report
PHC	–	primary health care
PPAR	–	project performance audit report
SARS	–	severe acute respiratory syndrome
SES	–	special evaluation study
STI	–	sexually transmitted infection
TB	–	tuberculosis

TA	–	technical assistance
TCR	–	technical assistance completion report
UN	–	United Nations
WHO	–	World Health Organization

NOTE

In this report, "$" refers to US dollars.

Director General, Operations Evaluation Department:	Bruce Murray
Director, Operations Evaluation Division 1:	R. Keith Leonard
Evaluation Team Leader:	Kus Hardjanti

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Kus Hardjanti, senior evaluation specialist (mission leader) prepared this report. Sarah Barber, Ross McLeod, and Eireen Villa were the consultants. Maria Rosa Ortega and Agnes Anabo, evaluation officers, supported the study with research assistance in Manila.

The guidelines formally adopted by the Operations Evaluation Department (OED) on avoiding conflict of interest in its independent evaluations were observed in the preparation of this report. To the knowledge of the management of OED, there were no conflicts of interest of the persons preparing, reviewing, or approving this report.

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EXECUTIVE SUMMARY

The Operations Evaluation Department was requested by the Regional and Sustainable Development Department to conduct an independent fifth-year review of the Asian Development Bank (ADB) policy for the health sector (the Policy), approved in February 1999. The objectives of the special evaluation study (SES) were (i) assessing whether the issues and options highlighted in the Policy are still relevant, particularly in relation to its priorities and approaches; (ii) evaluating the adherence to and implementation of the Policy; (iii) assessing whether ADB's operational strategies in the health sector support efforts to meet the Millennium Development Goals (MDGs); (iv) reviewing areas of the health sector where ADB can use its comparative advantage to make a strategic contribution to the region and developing member countries (DMCs); (v) analyzing trends in ADB funding in the health sector; (vi) assessing whether an updated policy that integrates health, nutrition, population (HNP), and other related subsectors is warranted; and (vii) providing findings and recommendations for updating ADB's policy for the health sector, or for HNP and other related social sectors.

The Asia and Pacific region is home to 690 million people living on incomes of less than $1 per day, more than two thirds of the world's poor. The MDGs emphasize the many dimensions of poverty and explicitly recognize that health interventions can reduce poverty. Most poor people live in areas where health services are poor or nonexistent. Poverty leads to poor nutrition and inadequate access to health care, which cause health to deteriorate, which in turn prevents the poor from being productive members of the workforce. This is a vicious cycle of impoverishment. Health is also a key input to economic development, because good health enhances the productivity of the workforce and increases the attractiveness of the economy for investors, both domestic and foreign. Such diseases as malaria, tuberculosis, acquired immunodeficiency disease syndrome; and emerging diseases, such as severe acute respiratory syndrome and avian influenza can increase human suffering and have significant economic costs. Developing countries continue to endure high rates of avoidable illness and premature death. Inequalities in health status and access to health care are pervasive and growing, both among and within countries. While technical interventions to prevent and treat the majority of health conditions in these countries are known, the challenge is ensuring access to them.

Progress in Achieving the Health, Nutrition, and Population Millennium Development Goals

Significant differences are seen in the efforts of DMCs to reduce the mortality rate of children less than 5-years old (under-5 mortality rate), infant mortality rate (IMR), and maternal mortality ratio (MMR). If the present trend continues, only 12 countries are on track to achieve the targeted reduction in the under-5 mortality rate by 2015. Except for five countries, the improvement recorded has been insufficient to achieve the IMR MDG by 2015. This situation should be a call for DMCs, donor community, and civil society to work together in saving the region's unborn children. A mixed picture is seen in the effort to achieve the MMR MDG. Only 13 countries are on track and if the current rate of progress continues, more than half of the DMCs will not achieve this MDG.

Governance and the Health Sector

The results of a regression analysis of the relationship between IMR, MMR, income levels, and governance suggest that an increase in gross domestic product per capita can improve the IMR and the MMR. Better governance is also associated with fewer deaths of mothers and children, although the relationship is rather weak. An International Monetary Fund working paper on *Corruption and Provision of Health Care and Education Services* that provides

a cross-country (62 countries) analysis of the relationship between corruption perception indices and indicators of provision of health care and education services, highlights four policy implications for the dominant role played by governments in providing health care: (i) in improving health care indicators, it is important to institute transparent procurement procedures and enhance financial accountability of public spending, (ii) reduced levels of corruption in the provision of health services help improve their quality, (iii) conditions that facilitate private sector entry into the provision of public services could curb the monopoly power of government service providers and limit their ability for bribery, and (iv) participation of the poor in deciding the allocation of public resources helps to mitigate possibilities for corruption. Transparency International, a nongovernment organization devoted to combating corruption, conducts studies based on corruption perceptions with the intention of raising awareness of corrupt practices in different countries and sectors. These Transparency International studies indicate that although the health sector is not ranked as the most corrupt, corruption in this sector is present at varying magnitudes among the countries studied.

ADB's anticorruption policy, approved in July 1998, was revised in 2004 to clarify and expand fraud- and corruption-related terms and definitions. The implementation of ADB's governance and anticorruption policies is presently being reviewed by the Regional and Sustainable Development Department. The health sector policy does not provide explicit strategies for preventing corruption in the sector. An HNP strategy for ADB should refer health sector corruption to the wider context of ADB's broader initiative of fighting corruption in each DMC.

Asian Development Bank's Current Lending in Health

Per capita health expenditures in more than 40% of DMCs fall below $34 per person—the estimated minimum level of health spending for basic services. A large financing gap needs to be closed in many DMCs if basic health services are to be delivered. Health spending in low-income countries is usually very low, the capacity to increase domestic spending is limited, and the disease burden is often high. ADB's current lending in the health and population sector has remained stable at 2–3% of total ADB lending. Thus, the Policy did not result in a significant growth in the health portfolio, and ADB remains a minor player in this important sector.

Mobilizing Concessional Funds for the Health Sector

The agreement to establish a substantial grant program as part of Eighth Replenishment of the Asian Development Fund (ADF IX) provides another tool that, potentially, could be used to expand ADB's health program. However, unless a concessional lending modality can be developed, ADB will not be a major player in areas that are at the core of its development mandate (such as health, education, and poverty) in middle-income countries (MICs). If ADB wishes to continue to be involved in the health sector and make a direct contribution to the achievement of health-related MDGs in MICs, a serious effort is required in order to develop a broader range of lower-cost products. Some concessionality is needed to make the cost of such loans cheaper than ordinary capital resources (OCR) terms. There are several strategies that ADB could consider: (i) mobilizing greater cofinancing with bilateral donors or blending the concessional funds of bilateral donors with OCR funds for MICs for health sector operations, (ii) becoming more actively involved in the international discussion on developing innovative financing modalities for the MDGs, (iii) work out its strategic focus in the health sector within the poverty reduction strategy framework and in harmony with development partners, (iv) developing innovative partnerships with the private sector and civil society, (v) considering whether a proposal should be developed to argue for a change in ADF eligibility from country-

based to sector-based considerations, and (vi) explore modified (hybrid) technical assistance (TA) modality.

Assessment of the Policy

The SES reviewed 209 ADB documents, consisting of health loans and advisory and regional TA projects, including those funded through the Japan Fund for Poverty Reduction, and nonhealth loans. All health loans and TA projects were categorized into a 5-year period pre-approval of the Policy (February 1994–January 1999) and a 5-year period post-approval (February 1999–January 2004). Health documents from the pre-Policy and post-Policy periods were reviewed and compared. The most recent country strategy and program or country strategy and program updates for 33 DMCs were also reviewed to assess whether progress in attaining the MDGs was considered in the documents. The SES concludes that the basic principles of the Policy remain relevant and ADB's adherence to and implementation of the Policy are considered satisfactory. The Policy had a positive impact in changing the way ADB operates in the health sector. Some important positive trends were the large increase in the number of loans using specific health-outcome indicators, the inclusion of cost-benefit and/or economic sustainability analysis in all projects approved since 2001, and the inclusion of economic internal rate of return calculations in the design of most of these projects. There was also more attention to supporting governance through health sector reforms and institutional capacity building. However, the Policy did not result in changes that led to a substantial increase in health lending. In the future, many clients will not wish to borrow OCR from ADB for the health sector. This issue reflects broader ADB policies, strategies, and products than can be addressed in a single sector policy study.

Issues to be Considered in Revising Asian Development Bank's Health Policy

(i) The SES supports ADB's plan to update the Policy and make it a strategy that covers HNP and other related social sectors (the Strategy). The Strategy, to be completed by 2006, should draw on the findings of this SES.

(ii) The Strategy should clearly set out the staffing and cost requirements of different options. Unfunded mandates and differences between aspirations and commitments to staffing raise false expectations and can affect portfolio quality and development impact.

(iii) ADB, with the guidance of the HNP panel/committee, should identify specifically what it aims to achieve in the HNP sector over the long term. It should develop short- and medium-term implementation strategies.

(iv) In preparing the Strategy, the HNP panel should include both internal and external experts. External experts could include international, regional, and in-country academics; specialized technical agencies; and/or civil society.

(v) ADB should undertake sound economic research to provide a basis for its lending and advocacy roles. Major inputs from country economists, Economics and Research Department, and the ADB Institute will be needed.

(vi) Within the poverty reduction strategy framework and in harmony with development partners, ADB needs to work out its strategic focus in the health sector.

(vii) ADB should continue using its strength as a regional organization to address public health infrastructure, particularly on issues of cross-border significance. Communicable disease surveillance is one example. ADB should also build on its solid track record and continue playing the role of a catalyst in nutrition and food fortification development efforts in the region.

(viii) ADB could promote primary health care by building on its strengths and supporting "upstream" approaches that emphasize structural changes for good governance and incentives to help governments take on the health functions of a modern bureaucracy.

(ix) More coordination within ADB is needed to integrate communicable and noncommunicable diseases, environmental health, occupational health, and water and sanitation into support for this larger "sector." Staff will need to be appropriately recognized and rewarded for providing input and adding value to nonhealth sector loans. Care must be taken to ensure that such initiatives do not overly complicate project design or unduly raise transaction costs, from a DMC perspective, of doing business with ADB.

(x) Strategies for good governance and for preventing corruption in the HNP sector should be identified in the Strategy within the context of ADB's overall initiative of fighting corruption in each DMC.

(xi) The restriction from supporting investments in infrastructure and equipment in the health sector should be removed in the Strategy. A full range of interventions should be allowed and the priority for ADB's interventions be determined by sound diagnostics and the priorities of the DMC.

(xii) Staffing types, levels, and incentives need to be examined from a long-term perspective.

(xiii) ADB financing mechanisms are not appropriate for health interventions, particularly for some large OCR borrowers. Unless this issue is resolved, ADB will play only a minor and inconsequential role in the health sector in those countries. The Strategy must address the issue of financing modalities for the health sector.

Recommendations

This study has identified many issues that should be considered in the formulation of the Strategy. It would not be appropriate to cover all of them by explicit recommendations. However, some issues are particularly important in the view of the Operations Evaluation Department. The following explicit recommendations are made.

The Strategy should

(i) be a strategy covering HNP, and other related social sectors;
(ii) identify innovative loan and grant products that will facilitate greater ADB involvement in the health sector;
(iii) cover governance and corruption in the context of ADB's overall initiative of fighting corruption in each DMC;
(iv) allow ADB to finance health infrastructure and equipment;
(v) place more emphasis in developing partnerships with other donors, the private sector, and civil society; and
(vi) analyze the staffing implications associated with different options considered in the Strategy so that the Board and Management understand the trade-offs between strategic options and resource considerations.

Bruce Murray
Director General
Operations Evaluation Department

I. INTRODUCTION

A. Background

1. The Millennium Development Goals (MDGs) are based on the United Nations Millennium Declaration endorsed by all 189 United Nations (UN) Member States in 2000. The means to achieve them were addressed at the UN Conference on Financing for Development held in Monterrey, Mexico, in March 2002. The MDGs focus on results, provide a benchmark for monitoring progress, and enshrine poverty reduction as the overarching mission of development. They have also raised the importance of health in development among the international donor community and developing member countries (DMCs) of the Asian Development Bank (ADB). This broad consensus on the need to achieve shared and measurable goals within a fixed time frame is expected to lead to unprecedented collaboration among multilateral organizations, UN agencies, bilateral donors, and governments in developing countries. Four of the eight MDGs relate to health and nutrition (Appendix 1). It is widely recognized that poor health contributes to poverty and that improving people's health is, therefore, an important way of reducing poverty.

2. The Asia and Pacific region is experiencing a complex disease transition. There is an increasing burden of noncommunicable diseases while communicable diseases remain a serious challenge, in addition to the threat of the new emerging communicable diseases, such as severe acute respiratory syndrome (SARS), and avian influenza. Pneumonia, diarrhea, measles, malaria, and malnutrition cause 70% of childhood deaths globally. Tuberculosis (TB) and HIV/AIDS[1] account for about two thirds of the disease burden among adults in developing countries worldwide. About 30% of the world's population live in areas without safe water and sanitation, which exacerbates the spread of communicable diseases. Chronic and growing air pollution in many of the world's cities, including Asia's megacities, contributes to increases in respiratory diseases and lung cancer.

3. The Asia and Pacific region is home to around 690 million people living on incomes of less than $1 per day, more than two thirds of the world's poor.[2] Addressing the link between poverty and health, nutrition, and population (HNP) is a major challenge, as the vast majority of poor people live in areas where health services are poor or nonexistent. Poverty leads to poor nutrition and inadequate access to health care. Because of the resulting health deterioration, the poor cannot always be productive members of the workforce, and this vicious cycle further impoverishes them.

4. Good health is a key input to economic development. It enhances the productivity of the workforce and increases the attractiveness of the economy for investors, both domestic and foreign. Such diseases as malaria, TB, HIV/AIDS, SARS, and avian influenza can increase human suffering and have significant economic costs. Developing countries continue to endure high rates of avoidable illness and premature death. Inequalities in health status and access to health care are pervasive and growing, both among and within countries. While technical interventions to prevent and treat the majority of health conditions in these countries are known, the challenge is to ensure access to them.[3] Good health is prerequisite for the poor to be able to use their labor, often their only asset. Poor health results in a discounting of future economic

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[1] Human immunodeficiency virus/acquired immunodeficiency syndrome.

[2] UNESCAP. 2004. *Economic and Social Survey of Asia and the Pacific 2004*. Available: www.unescap.org/pdd/publications/survey2004/index.asp

[3] UN Millennium Project. 2005. *Investing in Development: A Practical Plan to Achieve the Millennium Development Goals*. New York.

opportunities and can adversely influence decision-making at the household level related to education and participation in micro-level poverty alleviation initiatives. Hence, poor health can be a significant constraint to poverty reduction. Moreover, besides commitment to social sector development, public sector investments in health must be viewed as a signal of a commitment to provide a conducive climate within which economic activities (including foreign direct investment) can flourish, resulting in economic growth, employment generation, and poverty reduction.[4] The basic economic conditions, demographic changes, and other changes affecting the health sector are discussed in Appendix 2.

5. By 2020, the prevalence of predominantly lifestyle-influenced noncommunicable diseases, such as cardiovascular disorders, is expected to nearly double that in 1998. Over the same period, it is predicted that the prevalence of communicable diseases will decrease substantially. Cardiovascular disorders is forecast to become the largest single cause of disability-adjusted life years (DALYs).[5] Tobacco use and lung cancer will increase considerably, particularly in Southeast Asia and among women. For men aged 15–44 years, road traffic accidents are the biggest cause of ill health and premature death in the world. In developing countries, five of the ten leading causes of DALYs for women from the same age group are caused by diseases related to reproductive health. This underlines the importance of attaining the MDG related to maternal mortality.

6. The 1999 ADB policy for the health sector (the Policy)[6] built on previous ADB papers on health and population, particularly *Health, Population and Development in Asia and the Pacific* (1991)[7] and the *Population Policy* (1994).[8] The Policy was designed to provide direction to ADB operations in the health sector, inform DMCs about ADB priorities, and assist DMCs in identifying their own priorities and strategies for achieving them. The policy included recommendations for an overall increase in ADB's efforts in the health sector in terms of sector work, loans, and staff.

7. The five strategic considerations highlighted in the Policy are: (i) primary health care (PHC) for vulnerable groups, paying particular attention to the poor, women, children, and indigenous peoples (IPs); (ii) strengthening monitoring and evaluation, emphasizing effective interventions, and improving project quality at entry and during project implementation; (iii) supporting innovations and pilot testing new approaches to health care financing, organization, and management, and the deployment of new technologies, particularly new vaccines; (iv) encouraging DMC governments to conduct health sector reforms; and (v) increasing sector efficiency by improving managerial capacity and collaboration with partner institutions.[9] Nutrition issues are not covered in the Policy in detail. A separate policy on nutrition, originally planned for 2002, did not materialize. The Operations Evaluation Department (OED) reviewed ADB's role in nutrition in a separate special evaluation study (SES) of selected ADB interventions on nutrition and food fortification, finalized in December 2004.[10] That evaluation concluded that a separate policy on nutrition was not required. Rather, nutrition issues should be incorporated into an HNP strategy.

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[4] Tandon, Ajay. 2005. *Population Health and Foreign Direct Investment: Does Poor Health Signal Poor Government Effectiveness?* Manila: ADB.

[5] DALYs are the number of years of potential life lost due to premature mortality and the years of productive life lost due to disability.

[6] ADB. 1999. *Policy for the Health Sector*. Manila.

[7] ADB. 1991. *Health, Population and Development in Asia and the Pacific*. Manila.

[8] ADB. 1994. *Population Policy Paper: Framework for Bank Assistance to the Population Sector*. Manila.

[9] A more detailed summary of the Policy and the health sector policy matrix is given in Appendix 3.

[10] ADB. 2004. *Special Evaluation Study of Selected ADB Interventions on Nutrition and Food Fortification*. Manila.

8. ADB's Population Policy was approved in 1994. Therefore, the Health Policy did not cover population issues in detail. The population policy's framework covers three priorities: (i) enhancing the economic, educational, and social status of women; (ii) protecting the reproductive rights and health of women as exemplified in the safe motherhood initiative to promote safe pregnancy and reduce infant and maternal mortality; and (iii) promoting demand for, delivery of, and equitable access to family planning services. It describes a typology of countries and recommends specific actions for ADB in order to advance population issues based on a continuum of political commitment (footnote 8, pp. 40–41). However, the Population Policy did not discuss migration or urbanization issues. It stressed the need for political commitment, policy dialogue, a database for monitoring and evaluation, and the integration of family planning into a basic set of reproductive health services. These principles are also covered by the Policy, suggesting that the Policy encompasses the broader values and goals previously contained in the Population Policy.

9. The Regional and Sustainable Development Department (RSDD) and the regional departments, with the guidance of the Health, Nutrition, and Social Protection (HNSP) Committee, made an attempt to produce a mid-term review of the Policy. The mid-term review never reached a final version deemed appropriate for circulation. Instead, an analytical note on *ADB and the Health Sector* was prepared. RSDD requested OED to conduct an independent evaluation of the Policy in 2004, the Policy's fifth year of implementation.

B. Methodology and Approach of the Special Evaluation Study

10. The objectives of the SES included (i) evaluating the effectiveness of the Policy's implementation; (ii) assessing whether the issues and options highlighted in the Policy are still relevant, particularly in relation to its priorities and approaches; (iii) assessing whether ADB's operational strategies in the health sector are in place to support efforts to meet MDGs; (iv) reviewing areas of the health sector where ADB can exercise its comparative advantage and make a strategic contribution to the region and DMCs; (v) analyzing the trends in ADB funding in the health sector compared with world health trends; (vi) assessing whether an updated policy that encompasses HNP, and other related subsectors is warranted; and (vii) providing findings and recommendations for updating ADB's policy for the health sector, or for an HNP strategy.[11]

11. The SES adopted qualitative and quantitative methods of data collection and inquiry by (i) reviewing documents and files on ADB's assistance to the health sector; (ii) conducting interviews and meetings with staff in the operational departments and divisions and the HNSP Committee to solicit their views on issues for in-depth review; (iii) collecting and analyzing primary and secondary data on the sector in relation to the Policy; (iv) conducting in-country interviews and consultations in DMCs, reflecting a mix of concessional and nonconcessional borrowers;[12] and (v) consulting stakeholders, including governments, key development partners, beneficiaries, and civil society representatives in these DMCs.

12. The Policy was assessed by reviewing 209 ADB documents, consisting of health loans, technical assistance (TA) projects, and regional TA projects—including those funded through the Japan Fund for Poverty Reduction (JFPR)—and nonhealth loans. All health loans and TA projects were categorized into a 5-year period before approval of the Policy (February 1994–January 1999) and a 5-year period after approval of the Policy (February 1999–January 2004).

[11] It was not possible to conduct impact analysis of post-policy health sector projects because none had been completed at the time of the special evaluation study, and some were recently approved.

[12] Seven countries were chosen for in-depth review: Bangladesh, People's Republic of China, Indonesia, Mongolia, Papua New Guinea, Philippines, and Viet Nam.

In addition, 79 nonhealth sector loans (including multisector, agriculture and natural resources, social infrastructure, transportation and communication, energy, finance, industry, and nonfuel mineral loans), representing 20% of the total number of such loans approved by ADB from 1999 to 2004, were selected at random and analyzed.

13. In the selected DMCs, structured interviews and discussions were held with (i) policymakers from the ministries of health, ministries of finance, national development agencies, and other related ministries; (ii) multilateral and bilateral agencies (Australian Agency for International Development, Canadian International Development Agency, DFID, European Union, Swedish International Development Cooperation, UNICEF, United Nations Development Programme, United Nations Population Fund, World Bank, World Food Programme, WHO);[13] (iii) project implementers (government officials and consultants); (iv) academics (School of Public Health, University of California, Berkeley, USA; Center for Health Services Analysis, Gadjah Mada University, Indonesia; and Department of Statistics, University of Dhaka, Bangladesh); (v) international and local civil society organizations, including nongovernment organizations (NGOs) dealing with HNP issues; and (vi) the private sector, particularly in relation to food fortification.

14. The SES (i) assessed whether the issues and options highlighted in the Policy were still relevant, particularly in relation to its priorities and approaches, and whether ADB had appropriate mechanisms to provide assistance to the health sector; (ii) reviewed the DMCs' HNP, and early childhood development (ECD) strategies, policies, plans, and constraints in relation to the Policy; (iii) prepared an analysis of the progress in achieving the health related MDGs and how the Policy has incorporated these MDGs; and (iv) prepared an analysis of ADB's role in the health sector and in complementing other development partners in this sector.

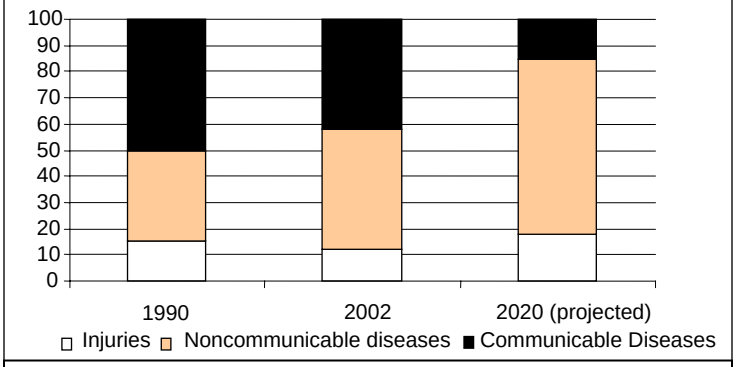
II. HEALTH, NUTRITION, AND POPULATION PROFILE

A. Trends in the Burden of Disease and Health Sector Issues

15. **Burden of Disease Changes Over Time.** The Policy identified an increasing burden of noncommunicable diseases between 1990 and 2020. The SES examined this shift by comparing 1990, 2002, and projected 2020 data estimating the proportion of DALYs by disease group for the Asia and Pacific region. The disability attributable to noncommunicable diseases increased from 35% in 1990, to 45.9% in 2002, with a projected figure of 67% in 2020. Communicable diseases, on the other hand, declined relatively slow between 1990 and 2002 and accounted for 42.1% of all DALYs in 2002 (Figure 1). These trends are broadly consistent with the assumptions made when the Policy was formulated.

[13] Department for International Development of the United Kingdom, United Nations Children's Fund, and World Health Organization.

Figure 1: Change in DALYs between 1990 to 2020, Asia and Pacific Region



DALYs = disability-adjusted life years.
Source: World Health Organization Burden of Disease.

16. **Health Sector Issues.** Health sector issues growing in emphasis are (i) health sector reform and health care financing reform, including social health insurance; (ii) sector-wide approach programs; (iii) vertical, communicable disease control programs; and (iv) governance. Although addressing these issues is meant to complement the PHC approach, they often compete for funding, particularly with PHC networks that are mostly in place.

B. Progress in Achieving the Health and Nutrition Millennium Development Goals[14]

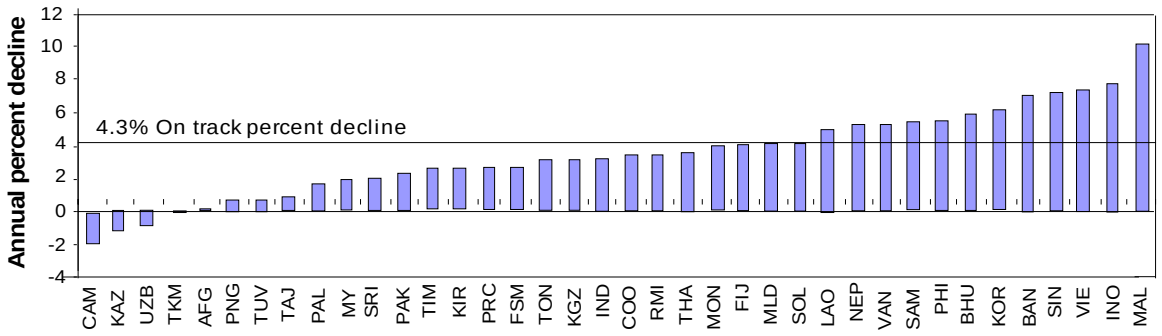
17. **Halve the Proportion of People Suffering from Hunger by 2015.** The proportion of underweight children is the indicator used to measure progress toward achieving this goal. The greatest reduction in underweight children has occurred in East Asia (83.6%), and the lowest in West Asia (28.5%).[15,16] The World Bank recently published global estimates of successes in reducing the prevalence of underweight children;[17,18] significant variations can be seen among DMCs (Appendix 4). The prevalence of underweight children exceeds 40% in five DMCs in the Asia and Pacific region: Bangladesh, Cambodia, India, Nepal, and Timor-Leste, with the highest prevalence in Nepal (48%).

18. **Reduce Child Mortality.** Most deaths among children less than 5-years old are related to communicable diseases, many of which could be prevented or treated with existing technologies. The UN has reported that Southeast Asia is on track to achieving the goal of reducing child mortality by two thirds (footnote 3). Less progress can be seen in South Asia. Little progress has occurred in the Pacific region, and slight increases can be seen in the Central Asian republics. With the assistance of ADB's Economics and Research Department (ERD), the SES conducted an assessment of DMCs' achievements in reducing the under-5 mortality rate

[14] This assessment omits the indicators for water, sanitation, and access to essential drugs. The first two are not comprehensively covered under this special evaluation study and data are lacking for an assessment of access to essential drugs.
[15] Defined as less than negative 2 standard deviations from the National Commission for Human Development and World Health Organization reference median weight for age.
[16] Onis et al. 2004. Global *Prevalence of Underweight. Global Database on Child Growth and Malnutrition*. Geneva.
[17] World Bank. 2004. *The MDGs for Health: Rising to the Challenges*. Washington, DC.
[18] The World Bank estimates that, in the East Asia Pacific region, 46% of countries (88.7% of the region's population) are on track; in East Central Asia, 38% of countries (88.2% of the region's population); and in South Asia, 33% of countries (or 86.4% of the region's population).

and infant mortality rate (IMR)[19] against the target MDG levels between 1990 and 2002, using indicators from ADB's 2004 Key Indicators.[20] These assessments are shown in Figures 2 and 3. If present trends continue, 12 DMCs are on track to achieve the targeted reduction in the under-5 mortality rate before 2015: Bangladesh, Bhutan, Indonesia, Republic of Korea, Lao People's Democratic Republic (Lao PDR), Malaysia, Nepal, Philippines, Samoa, Singapore, Vanuatu, and Viet Nam. There are four others almost on track: Fiji Islands, Maldives, Mongolia, and Solomon Islands. Based on progress to date, there is a risk that some DMCs might not achieve this MDG.

Figure 2: Percent Decline in Under-five Mortality, 1990-2002



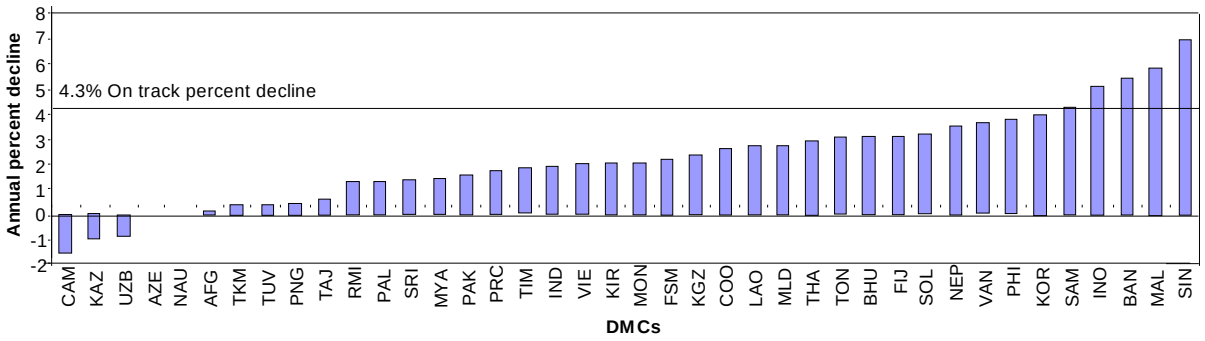
AFG = Afghanistan, BAN = Bangladesh, BHU = Bhutan, CAM = Cambodia, COO = Cook Islands, DMCs = developing member countries, FSM = Federated States of Micronesia, FIJ = Fiji, IND = India, INO = Indonesia, KAZ = Kazakhstan, KIR = Kiribati, KOR = Korea, KGZ = Kyrgyz Republic, LAO = Lao People's Democratic Republic, MAL = Malaysia, MLD = Maldives, MON = Mongolia, MY = Myanmar, NEP = Nepal, PAK = Pakistan, PAL = Palau, PNG = Papua New Guinea, PRC = People's Republic of China, PHI = Philippines, RMI = Republic of the Marshall Islands, SAM = Samoa, SIN = Singapore, SOL = Solomon Islands, TAJ = Tajikistan, THA = Thailand, TIM = Timor-Leste, TON = Tonga, TKM = Turkmenistan, TUV = Tuvalu, UZB = Uzbekistan, VAN = Vanuatu, VIE = Viet Nam.
Source: Asian Development Bank Key Indicators 2004.

19. The outlook in the Asia and Pacific region regarding attaining the IMR MDG is discouraging. If the current trend continues, the improvement recorded by all DMCs, except Bangladesh, Indonesia, Malaysia, Samoa, and Singapore has been insufficient to achieve this MDG by 2015 (Figure 3). It should be possible for the DMCs, donor community, and civil society to work together to save more infants (children below one-year old) in the Asia and Pacific region. The data in Figure 3 should be a call for saving the unborn children in the region.

[19] Defined as the number of infant deaths within the first year of life per 1,000 live births per year.

[20] For under-5 mortality rate and infant mortality rate, if x is the rate in 1990, then the reduction must be $(2/3)^x x$. This implies that for one year, the reduction should be $1-(1/3)^{1/25} = 0.0429$ or approximately 4.3%. For the maternal mortality ratio, if x is the ratio in 1990, then the reduction must be $(3/4)^x x$. This implies that for one year, the reduction should be $1-(1/4)^{1/25} = 0.0539$ or approximately 5.4%.

Figure 3: Percent Decline in Infant Mortality, 1990-2002



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Source: Asian Development Bank Key Indicators 2004.

20. A recent ERD[21] publication argues that countries would need per capita gross domestic product (GDP) growth rates higher than 6% to achieve the target of a 4.3% annual reduction in child mortality, and economic growth rates would have to be even higher for those countries that are below target so they can catch up. The policy implication is that economic growth helps, but in practical terms, other measures are also required to reach the MDG target of lowering child mortality. The health system, the water sector, and other nonincome factors are also essential in facilitating the achievement of the desired MDG target.

21. **Improve Maternal Health**. Little progress has been made in meeting the MDG of reducing maternal mortality.[22] Much of the progress globally is driven by increased presence of medical doctors at births.[23] Among DMCs, South Asia has the widest range of attendance of medical personnel at birth—from 11.9% in Nepal to 94.1% in Sri Lanka. Tables 1–4 in Appendix 5 show (i) the countries that contribute the most child deaths to the global burden; (ii) under-5 mortality rates, IMRs, and the proportion of 1-year olds immunized against measles; (iii) the change in the maternal mortality ratio (MMR)[24] and the number of maternal deaths during 1995–2000; and (iv) the change in the proportion of women with skilled attendants at birth in 1990–2000.[25] The SES conducted an assessment of the rate of decline in MMR among DMCs,

[21] Tandon, Ajay. 2005. *Attaining Millennium Development Goals in Health: Isn't Economic Growth Enough?* Manila: ADB.

[22] The United Nations Secretary General's report relies on these figures originating from specialized UN agencies. The World Bank estimates that 14.0% of countries in the East Asia Pacific region (68.5% of the region's population) are on track, 25.0% of countries in East Central Asia (18.8% of the region's population), and 12.5% of countries in South Asia (or less than 1.0% of the region's population).

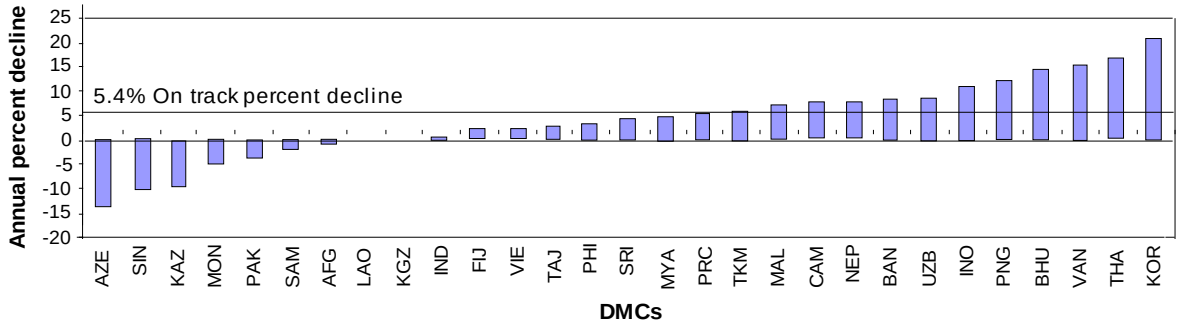
[23] United Nations Statistics Division. 2003. *World and Regional Trends. Millennium Indicators Database: UNICEF and WHO*. Geneva.

[24] Defined as the annual number of deaths of women from pregnancy-related causes, when pregnant or within 42 days of termination of pregnancy, per 100,000 live births.

[25] The indicator for births attended by skilled attendants is absolute. Therefore, an "on track" percentage increase is not possible to present because the target is 100% regardless of the 1990 base figure. In contrast, IMR, MMR, and under-5 mortality are relative indicators, whereby a certain fraction of the 1990 base figure has been specified. In

against the MDG's "on track" requirement (Figure 4). A mixed picture is seen in the effort to achieve the MMR MDG. Only 13 countries are on track: Bangladesh, Bhutan, Cambodia, People's Republic of China (PRC), Indonesia, Republic of Korea, Malaysia, Nepal, Papua New Guinea (PNG), Thailand, Turkmenistan, Uzbekistan, and Vanuatu. If the current rate of progress continues, more than half the DMCs will not achieve this MDG, particularly seven countries in which the situation is most severe.

Figure 4: Percent Decline in Maternal Mortality Rate, 1990-latest year



AFG = Afghanistan, AZE = Azerbaijan, BAN = Bangladesh, BHU = Bhutan, CAM = Cambodia, DMCs = developing member countries, FIJ = Fiji, IND = India, INO = Indonesia, KAZ = Kazakhstan, KOR = Korea, KGZ = Kyrgyz Republic, LAO = Lao People's Democratic Republic, MAL = Malaysia, MON = Mongolia, MYA = Myanmar, NEP = Nepal, PAK = Pakistan, PNG = Papua New Guinea, PRC = People's Republic of China, PHI = Philippines, SAM = Samoa, SIN = Singapore, TAJ = Tajikistan, SRI = Sri Lanka, THA = Thailand, TKM = Turkmenistan, UZB = Uzbekistan, VAN = Vanuatu, VIE = Viet Nam.
Source: Asian Development Bank Key Indicators 2004.

22. **Combat HIV/AIDS, Malaria, and Other Diseases.**[26] Tables 1–4 in Appendix 6 present information on HIV/AIDS prevalence, knowledge of HIV among women, estimated TB incidence and mortality in 2002, and new TB cases detected and successfully treated under directly observed treatment, short-course. Globally, the numbers of people living with HIV reached 39.4 million in 2004; more than 20 million people have died since the start of the epidemic.[27] In Asia, the epidemic is "fast-growing" with an estimated 7.4 million people living with HIV, and 1.1 million newly infected persons in 2003. ADB assessed the economic loss of HIV/AIDS at $7.3 billion in 2001.[28] Sharp increases in new infections have been reported in the PRC, Indonesia, and Viet Nam. India has the largest number of people living with HIV (5.1 million) apart from South Africa. An increase from 160,000 to 1.3 million people living with HIV occurred in Europe and Central Asia between 1995 and 2003, mainly among injecting drug users under the age of 30.[29] Cambodia and Thailand have succeeded in slowing the progression of HIV/AIDS because of proactive public campaigns addressing high-risk behavior. An indicator used to measure progress in halting HIV/AIDS is the proportion of women with correct knowledge of how to

the case of IMR and under-5 mortality, a 2/3 decline is targeted for each DMC, while for MMR it is ¾. These fractions apply to all DMCs.

[26] The indicators for HIV/AIDS, malaria, measles, and tuberculosis are absolute indicators. Therefore, an "on track" percentage decline is not possible to present because the target is zero regardless of the 1990 base figure (see footnote 20 for an explanation of relative indicators for IMR, MMR, and under-5 mortality).

[27] United Nations Programme on HIV/AIDS (UNAIDS). 2004. *AIDS epidemic update December 2004*. Geneva. Available: http://www.unaids.org/wad2004/ report.html

[28] ADB and UNAIDS. 2004. *Asia-Pacific's Opportunity: Investing to Avert an HIV/AIDS Crisis*. Manila.

[29] WHO. 2004. *The HIV/AIDS Epidemic in Europe and Central Asia*. Geneva.

protect themselves from HIV. Only a few DMCs have such data. In those, the proportion of women with this knowledge is less than 25%.[30]

23. An estimated 1.5–2.7 million deaths and 300–500 million cases of malaria are reported annually;[31] 90% of the global burden is in Africa and 90% of deaths occur in young children.[32] The 2 billion people at risk live mostly in subSaharan Africa, Bangladesh, India, and Pakistan.[33] This disease remains problematic in many other parts of Asia. Calls for a renewed global campaign to increase awareness and financing are based on the resurgence of malaria-related morbidity and mortality because of widespread resistance to first-line drugs and insecticides,[34] large human and economic losses, availability of existing technologies to control the disease effectively, and promising advances in drugs and vaccines.[35]

24. Mycobacterium TB infects one third of the world's population and of those, 5–10% will become sick or develop a communicable case of TB.[36] In 2002, the Southeast Asia and Western Pacific regions of WHO combined accounted for 57% of global cases; the Southeast Asia region contributes nearly one third of all new communicable cases. The rate of multidrug-resistant TB in the Central Asian republics is believed to be among the highest in the world.[37] A primary means of addressing TB is through active case detection. Once detected, treatment success rates are relatively high.

25. There is great demand for information on what specific strategies would work best in achieving health-related MDGs. Compiling and analyzing information on the cost-effectiveness of HNP interventions would stimulate interest in this sector.

C. New and Emerging Issues

26. Among the 50 internationally important disease outbreaks that occur annually, most new diseases (with the exception of HIV/AIDS) are limited to a given geographical area or have features that limit their capacity to pose a threat to international public health.[38] SARS (footnote 38), however, was exceptional for several reasons: (i) diagnosis is difficult given nonspecific and common symptoms, and the limitations of diagnostic tests; (ii) the absence of vaccine or treatment resulted in the use of isolation wards for suspected cases; (iii) the epidemiology and pathogenesis remain poorly understood, and the virus family is characterized by frequent mutations, suggesting that it will be difficult to develop an effective vaccine and that

[30] Percentage of women who know that a person can protect herself from HIV by consistent condom use, 1996/2001. Progress toward the MDGs. UN Statistical Division.
[31] Malaria disease information. UNICEF/UNDP/World Bank/ WHO Special Program for Research. Available: www.who.int/tdr/diseases/malaria/diseaseinfo.htm
[32] WHO/UNICEF. 2003. *The Africa Malaria Report 2003*. Geneva.
[33] Scientific Research against Malaria. UN General Assembly. Fifty-first session Item 12 of the provisional agenda, 19 September 1996.
[34] Board on Global Health, US National Academy of Sciences. 2004. *Saving Lives, Buying Time: Economics of Malaria Drugs in an Age of Resistance*. Washington, DC: The National Academies Press.
[35] Sachs, Jeffrey. 2002. *A New Global Effort to Control Malaria*. Science 298: 122–124.
[36] WHO. 2004. *Global Tuberculosis Control Report 2004*. Geneva.
[37] Godinho, J., T. Novotny, H. Tadesse, and A. Vinokur. 2004. *HIV/AIDS and TB in Central Asia: Country Profiles*. Washington, DC: World Bank.
[38] Some, such as the Nipah virus, failed to establish efficient human-to-human transmission. Others depend on food as a vehicle of transmission (Escherichia coli O157:H7, variant Creutzfeldt-Jakob disease). Others that have spread geographically require a vector as part of the transmission cycle (West Nile fever and Rift Valley fever). Still others (Neisseria meningitidis W135 and the Ebola, Marburg, and Crimean-Congo hemorrhagic fevers) have limited geographical spread. Excerpted from WHO. 2004. *SARS: Status of the Outbreak and Lessons for the Immediate Future*. Geneva.

there is potential for future outbreaks; (iv) the 10-day incubation period allows the virus to spread globally by air travel; (v) case fatality can exceed 50% among older persons; and (vi) the health costs resulting from the SARS outbreak were estimated at $30 billion in Asia alone.

27. Experts believe that pandemic influenza will occur at some point in the future. The magnitude of such a pandemic could be similar to that of the 1918–1919 "Spanish flu" pandemic. One of the three known subtypes of avian influenza viruses (H5N1, H7N7, and H9N2) is thought to be the most likely next pandemic virus.[39] Outbreaks of avian influenza are increasingly frequent, and result from a combination of intensive agricultural practices, high virus transmissibility, and the presence of natural reservoirs in migratory birds.[40] There is a need for better coordination between ministries of health and agriculture to detect and contain such diseases. The question remains as to when the next pandemic will occur and how quickly it will spread.[41] The focus is on the poorest countries in Asia, which have limited resources for surveillance and health care and relatively poor population health status.

28. In some areas, postconflict conditions have devastated health delivery services, and natural disasters—such as the 2004 Asian tsunami—pose serious threats to HNP and other social infrastructure. Because of increased cross-border mobility and air travel, regional cooperation will become an increasingly important element in controlling the spread of disease. Countries will not be able to protect their citizens by working in isolation.

D. Infant Mortality Rate, Maternal Mortality Ratio, Income Levels, and Governance

29. A regression analysis of the relationship between IMR, MMR, income levels, and governance was conducted. Appendix 7 presents the results of this analysis.[42] The governance index was derived by applying the principal components approach to a database of governance indicators.[43] The index includes four indicators: control of corruption, government effectiveness, regulatory quality, and rule of law. The results suggest that an increase in GDP per capita can improve the IMR and the MMR—a 1% increase in GDP per capita leads to 0.58% decrease in IMR. For MMR, a 1% increase in GDP per capita leads to a 0.80 percentage point decrease in MMR. Better governance is associated with fewer deaths of mothers and children, although the relationship is weak—a 1% improvement in governance indicators translates into a 0.16 percentage point improvement in IMR and a 0.23 percentage point improvement in MMR. While improved governance might help to achieve these MDGs, rapid economic growth will have a greater contribution to lowering the IMR and MMR. This suggests that a conducive policy environment for efficient economic growth and improved governance will make a contribution, albeit indirectly, to achieving health-related MDGs.

30. The analysis was not intended to identify all the factors that influence these outcomes. Available empirical studies suggest that many economic and social factors other than income levels and governance are important for the achievement of these MDGs. The extent of poverty and inequality, public health expenditures (their composition, allocation, and efficient use),

[39] The 1918–1919 "Spanish" influenza resulted in an estimated 40–50 million deaths globally, half of them in otherwise healthy adults. Nicholson, K.G., J.M. Wood, and M. Zambon. 2003. Influenza. *The Lancet* 362: 1733–1745.

[40] Larrazi, S., and K. Stohr. 2004. Avian Influenza and Influenza Pandemics. *Bulletin of the World Health Organization*: 82 (4). Geneva.

[41] Webby, J.R., and R.G. Webster. 2003. Are We Ready for Pandemic Influenza? *Science* 302: 1519–1522.

[42] This analysis was undertaken by M.G. Quibria, advisor in the Operations Evaluation Department, ADB.

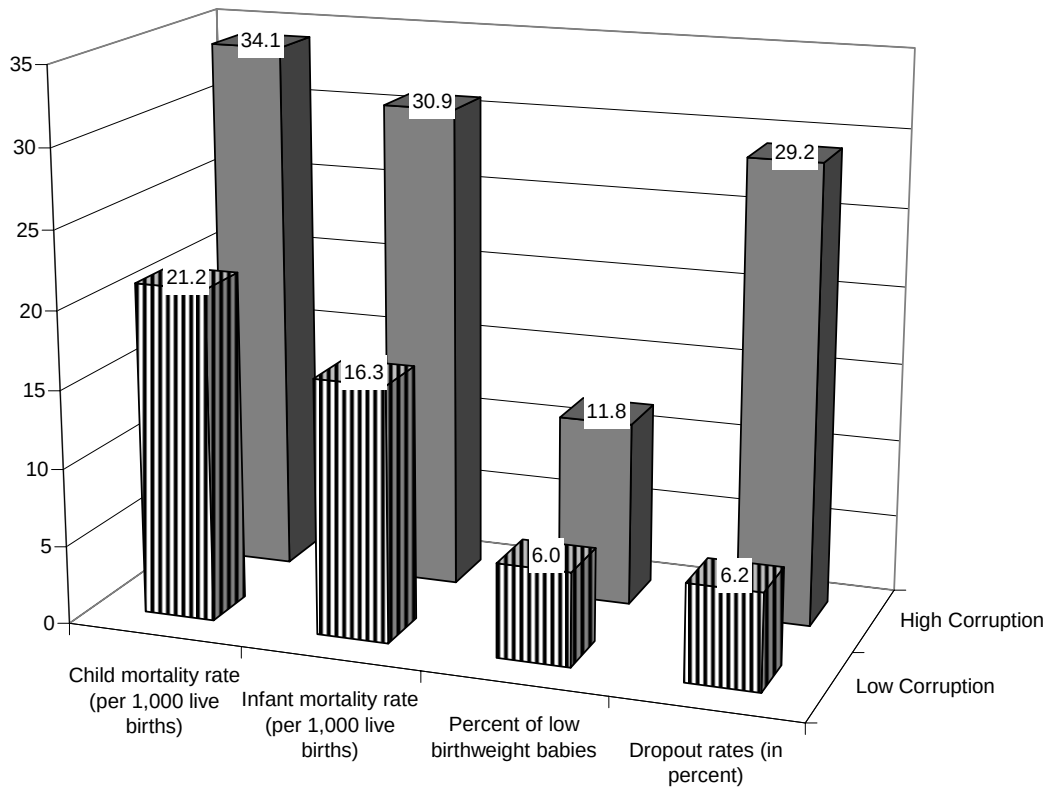
[43] Kaufmann, D., A. Kraay, and P. Zoido-Lobaton. 2003. Governance Matters III: Governance Indicators for 1996–2002. *Policy Research Paper No. 3106*. Washington, DC: World Bank.

housing and sanitation, maternal education, cultural factors, and social capital all have a bearing on IMR and MMR outcomes.

E. Corruption and the Health Sector

31. An International Monetary Fund working paper[44] provides a cross-country (62 countries) analysis of the relationship between corruption perception indices and indicators of provision of health care and education services. The empirical analysis shows that high levels of corruption adversely affect a country's child and IMRs, proportion of low birth-weight babies in total births, and dropout rates in primary schools. Specifically, child mortality rates in countries with high corruption are around one third higher than in countries with low corruption. IMR and proportion of low birth-weight babies are almost twice as high, and school dropout rates are five times as high, as shown in Figure 5.

Figure 5: Corruption and Social Indicators



Source: *IMF Working Paper*. Corruption and the Provision of Health Care and Education Services.

32. Results of this study highlight four policy implications on the dominant role played by governments in providing health care:[45] (i) in improving health care indicators, it is equally, if not more, important to institute transparent procurement procedures and enhance financial

[44] Sanjev, G., H. Davoodi, and E. Tiongson. 2000. Corruption and the Provision of Health Care and Education Services. *IMF Working Paper*. Washington, DC: International Monetary Fund.

[45] This SES focuses mainly on the results of the study related to the health sector.

accountability of public spending, as it is to provide higher public spending; (ii) reduced levels of corruption in the provision of health services improve their quality; (iii) conditions that facilitate private sector entry into the provision of public services could curb the monopoly power of government service providers and limit their ability for bribery; and (iv) participation of the poor in deciding the allocation of public resources helps to mitigate possibilities for corruption.

33. Transparency International, an NGO devoted to combating corruption, conducts studies based on corruption perceptions with the intention to raise awareness on corrupt practices in different countries and sectors. In one of these studies, surveys were undertaken to ask people's perceptions of corruption in South Asia related to seven selected sectors (education, health, power, land administration, tax department, police service, and judiciary).[46] The results indicate that although the health sector is not ranked as the most corrupt in all participating countries, corruption is present in this sector and the magnitude differs by country. The perceptions on corruption were based on people's claims of paying bribes, either because they were asked for money or gave voluntarily to get better service. Bribes may be directly requested or demanded through a third party.[47] Respondents perceived that a lack of accountability and the power of monopoly are the main reasons for corruption in the health sector.

34. An analysis of the reports and recommendations of the President on 14 loan projects in the health sector since 1999, showed that corruption and anticorruption measures were not mentioned in 10 of the 14 reports (71%). In four of the projects, it was reported that ADB explained to the executing and implementing agencies the need for maintaining transparency and accountability in all project activities. Greater effort was made to address corruption in one of these projects, the Second Decentralized Health Services Project in Indonesia,[48] where detailed measures to prevent fraud and corruption were to be included in the project administration memorandum. Thus, ADB has not made serious efforts to implement its Anticorruption Policy in health loans. However, since adoption of the Policy, there has been increasing support given to health sector reforms and institutional capacity building related to governance. Core elements of health sector reforms are contained in strategies 3, 4, and 5 of the Policy.

35. ADB's Anticorruption Policy was approved in July 1998 and revised in 2004 to clarify and expand fraud- and corruption-related terms and definitions. The implementation of ADB's governance and anticorruption policies is presently being reviewed by RSDD. Public expenditure tracking surveys, service provider surveys, and enterprise surveys have been used to measure corruption in the health sector.[49] These techniques can be used to assess corruption in operations where there is a significant risk that users of health services are required to make unofficial payments. The strategy that encompasses HNP (the Strategy) and other related social sectors should refer dealing with corruption in the health sector to the wider context of ADB's overall initiative of fighting corruption in each DMC.

[46] Transparency International. 2002. *Corruption in South Asia. Insights & Benchmarks from Citizen Feedback Surveys in Five Countries*. Berlin. The sample sizes ranged from 2,278 in Sri Lanka to 5,157 in India. Available: http://www.transparency.org/pressreleases_archive/2002/dnld/southasia_ report.pdf.

[47] The average bribe was expressed in each country's local currency. This was converted to US dollars using the average exchange rate prevailing at the time of the survey.

[48] ADB. 2003. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to Indonesia for the Second Decentralized Health Services Project*. Manila (Loan 2074/2075-INO, for $100.0 million, approved 19 December 2003).

[49] World Bank. 2003. *Survey Techniques to Measure and Explain Corruption*. Washington, DC.

III. FINANCING FOR HEALTH

A. Trends in Health Spending

1. Total Health Spending and Sources

36. There is a wide disparity in the level of health expenditures across the region. Appendix 9 presents three figures showing (i) total health care and out-of-pocket health expenditures per capita, (ii) government contribution to total health expenditures, and (iii) health expenditure per capita and external assistance. Generally, health expenditures increase with national incomes.[50] Annual health expenditures in most DMCs are below $34 per capita—the required level of provision for basic health services—with the lowest at $6 (Tajikistan).[51] Health care expenditures in some of the larger Asian countries have stagnated in recent years. In Pakistan, the level has decreased in absolute terms. Palau has the highest proportion of public sector expenditure devoted to the health sector (Figure A9.1, Appendix 9). Total regional health expenditures were equivalent to 4.7% of GDP in 1997–2000. About 61% came from the private sector and the remainder from public expenditures. Conventional analysis of the health sector often pays too little attention to private health expenditures.

37. Social insurance is not widely available across the region. Typically, a certain level of GDP per capita, economic growth, and a critical mass in the formal wages sector[52] are needed for social insurance plans to succeed. Hence, out-of-pocket financing by families and individuals is still the primary source of health financing for most DMCs. The out-of-pocket proportion of private health expenditures in Indonesia is 91.8%, although this is a decrease from 95.7% in 1997. In India, 82% of health care expenditure is from out-of-pocket funds. In most of the populous DMCs, 65% of total health expenditures come from out-of-pocket spending.

2. External Aid in the Health Sector

38. In many low-income countries, development assistance contributes substantially to overall spending. The percentage contribution of development assistance to overall health expenditure is significant in Afghanistan (11%), Azerbaijan (8%), Bhutan (35%), Cambodia (20%), Kyrgyz Republic (13%), Lao PDR (21%), and Mongolia (15%).

39. According to the Organization for Economic Co-operation and Development (OECD) database, the share of official development assistance (ODA) allocated to health and population globally increased from 4% of total assistance in 1990 to 9% by 2002. For the World Bank, 12% of total International Bank for Reconstruction and Development (IBRD)-International Development Association (IDA) lending went to the HNP sector, which also includes other social services. In July 2002, negotiations for the 13th replenishment of the IDA were concluded, with a commitment of SDR18 billion (about $23 billion) to poor IDA members over the following 3 years. A key feature of the negotiations was an agreement to increase the use of IDA grants to address the challenges faced by the poorest and most vulnerable countries. One of the key priorities for poverty reduction in IDA 13 was communicable diseases, particularly the need to pay more attention to HIV/AIDS, especially in Africa, and other communicable diseases and to increase resource allocations to fight these diseases.[53] As a result of IDA 13, the proportion of

[50] Peabody, et al. 1999. *Policy and Health – Implications for Asia*. New York: Cambridge University Press.
[51] WHO. 2004. *World Health Year Book*. Geneva.
[52] ADB. 1999. *Health Sector Reform in Asia and the Pacific; Options for Developing Countries*. Manila.
[53] IDA. 2002. Additions to IDA Resources: Thirteenth Replenishment, Supporting Poverty Reduction Strategies, Report from the Executive Directors of IDA to the Board of Governors, 25 July.

total World Bank lending for HNP rose to 19% in 2003 but fell to 15% in 2004.[54] Overall, global funding for health and population accounts for 15% of all allocable international funding in Africa, 12% in Oceania, and 7% in Asia.[55] Appendix 10 shows overall ODA, the allocation to health, and OECD data on health aid as a percentage of total assistance by region.

40. Levels of support from bilateral agencies to health and nutrition increased from an average of $2.56 billion per year in 1997–1999 to $2.9 billion in 2000.[56] The USA is the largest bilateral supporter of the health sector in absolute terms; the United States Agency for International Development provided $1.4 billion to health in 2001.[57] This is likely to increase with the launch of the Millennium Challenge Corporation, launched in 2002 in Monterrey, Mexico. Under the Millennium Challenge Corporation, development assistance will be provided to countries that rule justly, invest in their people, and encourage economic freedom. The US Congress provided $1 billion in initial funding for fiscal year 2004 and increased funding has been pledged to reach $5 billion a year by fiscal year 2006. Appendix 11 shows the average annual commitment and total sector allocation of donors.

41. From the beginning of health sector operations in 1978 to December 2004, ADB loaned $2.45 billion to support 66 health projects, including two private sector projects. This represents 2.7% of total ADB lending. Over the same period, 144 TA projects, including some funded by the JFPR, were approved, amounting $71.9 million. In addition, 34 regional TA projects, including four funded by JFPR, were financed at a total cost of $34.8 million.

42. Although the data are not exactly comparable, it is reasonable to conclude that ADB is playing a smaller role in the health sector in Asia and the Pacific than does the World Bank, whether considered as a proportion of total lending (2.7% for ADB versus 4.5% for the World Bank) or in absolute lending for the health sector in the region ($2.45 billion for ADB versus $13.45 billion for the World Bank). However, the World Bank's classification of the health sector includes HNP, and other social sectors.

43. Other official flows[58] (OOF) to health include financial flows without a substantial grant element, such as those from the World Bank's IBRD and ADB's ordinary capital resources (OCR). Bilateral donors extend limited amounts of OOF loans to the health sector. IBRD lending to health is about $400 million a year and has increased in recent years. The OECD Development Assistance Committee notes that 45% of OOF loans to health have been directed to general health sector programs and 18% to medical research. In the case of ADB, OCR loans totaling $703.36 million were extended to Indonesia in 1994–2003, while in 2004, health-related OCR loans totaling $243 million were approved for the Philippines and Uzbekistan. The PRC and India, ADB's two largest middle-income clients, have adopted a policy of not borrowing from OCR for health, preferring to use their own funds or concessional funds.

44. The Global Alliance for Vaccines and Immunization (GAVI) and the Global Fund to Fight AIDS, TB and Malaria (GFATM) are providing additional resources for child immunization and for

[54] World Bank. 2002, 2003, and 2004. *Annual Reports*. Washington, DC.
[55] OECD. 2004. Net Aid by Region 2002. OECD international aid data. Available: www.oecd.org/dac/stats/regioncharts
[56] Michaud, C. 2003. Development Assistance for Health (DAH): Recent trends and resource allocation. Paper prepared for the Second Consultation on the Commission on Macroeconomics and Health, WHO, Geneva, 29–30 October.
[57] USAID. 2004. *Health–Funding*. Washington, DC.
[58] Other official flows are transactions by the official sector whose main objective is other than development-motivated, or, if development-motivated, whose grant element is below the 25% threshold which would make them eligible to be recorded as ODA.

HIV/AIDS, TB, and malaria prevention and care (Appendix 12). GAVI's fund disbursement began in 2002 and the first round of Global Fund financing began in 2003. These funds will make an important contribution to overall health sector assistance in Asia and the Pacific. GAVI represented about 5% of external assistance to the region, and contributed 3–4% of total immunization resource requirements. An innovative feature of GAVI is the involvement of public and philanthropic organizations, such as the Bill and Melinda Gates Foundation. ADB should proactively explore such innovative public–private partnerships to increase its involvement in the health sector. This would require ADB to carefully consider active partnerships with major pharmaceutical companies and the conditions under which these would be appropriate.

45. GFATM disbursed about $86 million (13% of all external health assistance) to the region in 2003. This level of assistance is similar to that provided by ADB. In 2001, GFATM accounted for 12% of the resources needed to meet the challenge of HIV prevention and care (estimated at $700 million per year). With levels of new infections increasing, the resources required to fight the epidemic could reach about $5 billion per year by 2007.[59, 60] The Bill and Melinda Gates Foundation spent approximately $1.4 billion in global health initiatives in 2002 alone, and in January 2003, the *US President's Emergency Plan for AIDS Relief* pledged to spend $15 billion over 5 years in 15 countries.

46. The nature of the above new health financing mechanisms are mainly focused on disease-specific interventions. Some concerns have been raised by countries and the international community regarding the potential disruption of the countries' health systems, unless strong support for complementary initiatives, such as strengthening public health systems, capacity building, monitoring and evaluation systems, and health infrastructure, which are not the core mandate of this type of funding, are being provided. ADB could take the opportunity of continued support for these initiatives by increasing innovative funding modalities in partnership with these new health financing mechanisms, such as GFATM and GAVI.

B. Health Financing Gaps

47. Low levels of health spending are a key constraint to attaining the MDGs. The Commission on Macroeconomics and Health estimated that an additional $30 billion in public expenditure is required to support increased coverage of interventions to combat communicable diseases and provide maternal and child care in South Asia and East Asia and the Pacific by 2007. This increase in support was split evenly between South Asia, East Asia, and the Pacific and is equivalent to a total health expenditure of $31–34 per person.

48. The health sector must compete with other sectors for budgetary resources. Government budgets are under pressure in all DMCs. Particularly in the low-income DMCs, potential sources of government revenues are limited. Tax evasion is widespread. However, economic growth facilitates increased expenditures on public goods, such as health programs. As GDP increases, the proportion of total health expenditure also increases along with the share of public expenditure as a share of GDP. Economic growth also generates an increase in health spending as incomes rise. The elasticity of health spending to income is just over one in low-income countries.[61] Even rapid economic growth has not been sufficient to bridge the financing gap of

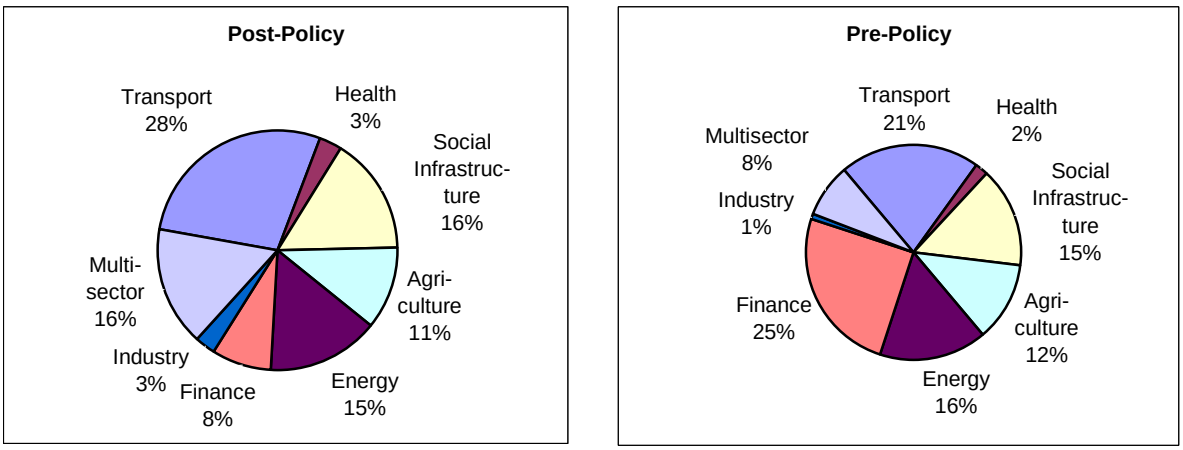
[59] ADB and UNAIDS. 2004. Funding Requirement to Confront the HIV/AIDS Epidemic in the Asia and Pacific Region, prepared by the Futures Group. Prepublication draft.
[60] Global Fund. 2004. *A Force for Change, The Global Fund at 30 months*. Geneva: The Global Fund.
[61] Schieber, G., and A. Maeda. 1997. A Curmudgeon's Guide to Health Care Financing in Developing Countries. In G. Schieber, ed. 1997. *Innovations in Health Care Financing*. Washington, DC: World Bank. (Proceedings of a

nearly $30 billion for the Asia and Pacific region. Given that many low-income countries spend less than 2% of GDP on health care, small increases in the share of health spending would go a long way to bridging these financing gaps. The Commission on Macroeconomics and Health recommended an increase in health expenditure equivalent to 1% of gross national product by 2007 and a further increase to 2% by 2015 in selected low- and middle-income countries (MICs) of Asia and the Pacific. In 2007, these increases would generate a total annual domestic resource mobilization for health of $34 billion in South Asia and $40 billion in East Asia and the Pacific. Given that health expenditure as a proportion of GDP in Asia is low by world standards, these projected increases are relatively optimistic. ADB should address issues related to financing the health sector in its broader policy dialogue related to fiscal reform and public sector management.

C. Asian Development Bank and Health Lending

49. Despite ADB's explicit policy commitments to increase lending and investments in health, and widespread international agreement on the importance of increasing the financing available for the health sector, the sector has maintained a relatively steady share of 2–3% of lending during the 5 years before and the 5 years after the Policy was adopted (Figure 6). A comparative analysis of loans (ADB and partner contributions) indicates that Indonesia accounted for more than 60% of ADB's health lending (mostly from OCR) before and after the adoption of the Policy (Figure 6). If the large health sector loans to Indonesia during the Asian financial crisis of the late 1990s are excluded, there was a decline in lending to health during this period and a sharp decline from 1999 to 2002. Figure 7 shows that there was no lending to support the health sector in the Philippines after the Policy was adopted, up to the end of the study period (January 2004). However, in December 2004, ADB provided a $213 million sector development loan for the health sector in the Philippines. Of the total amount, $200 million was to support policy reform and $13 million was to finance investments in the health sector. This pattern of lending is inconsistent with ADB's overarching objective of poverty reduction and its commitment to achieving the MDGs. It raises fundamental questions about the limited demand for ADB assistance in the health sector.

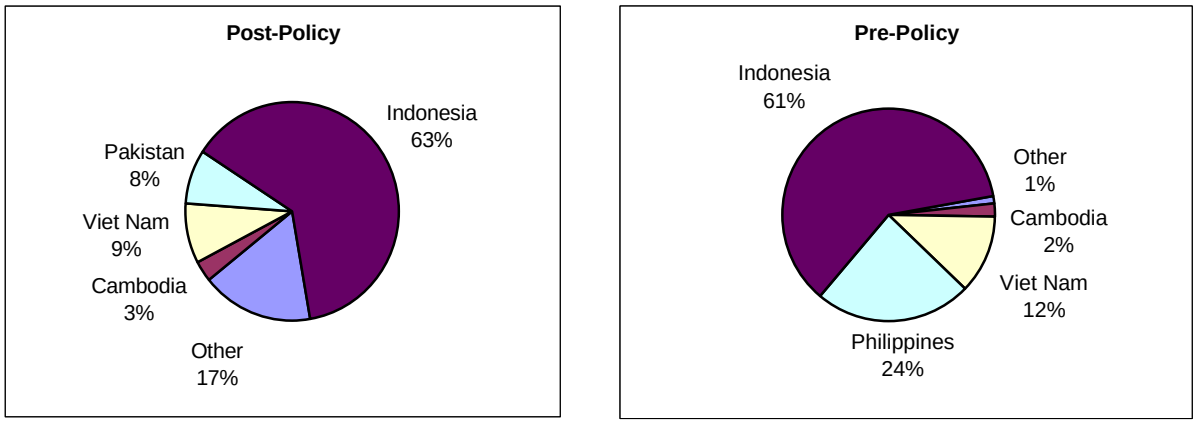
Figure 6: Health Sector Lending Volume by Sector Allocation



Source: Asian Development Bank loan and technical assistance documents.

World Bank Conference, 10–11 March 1997); Preker et al. 2004. Available: http://hc.wharton.upenn.edu/impact conference/Preker%20031505.pdf

Figure 7: Health Sector Lending Volume by Country Allocation

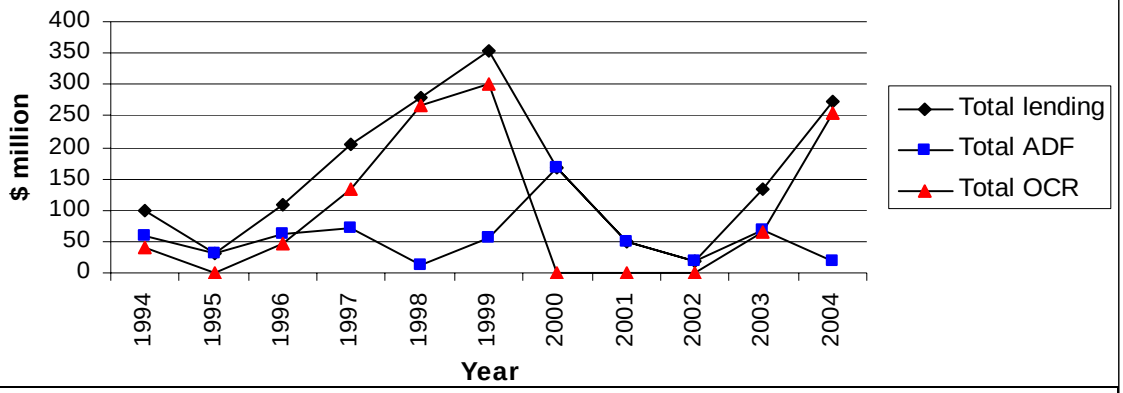


Source: Asian Development Bank loan and technical assistance documents.

50. The terms of ADB's lending products strongly influence whether DMCs are likely to seek ADB support for the health sector. Two of ADB's largest borrowers, the PRC and India, have chosen to use their own resources or concessional funds for their social sectors, including health, and have decided not to borrow from OCR for these sectors. Overall, Asian Development Fund (ADF) resources have become increasingly important as a funding source for health projects. Prior to the Policy, 37% of these projects were financed from ADF. After the Policy, the ADF share increased to 48%. Following the adoption of the Policy until end of December 2004, the share of health lending increased in Cambodia, Pakistan, Philippines, and Uzbekistan. However, it appears that the decisions of countries on borrowing for health projects were driven by factors other than the adoption of ADB's Health Policy.

51. The temporal pattern of ADB's lending (ADF and OCR) to the health sector is shown in Figure 8. The large peak in 1997 to 1999 partly reflects quick disbursing program loans that ADB provided as part of a broad strategy to address the Asian financial crisis. These operations helped to improve the policy environment in Indonesia, Mongolia, PNG, and Thailand (amounting to $337.34 million or 40% of total health lending during this period), and financing of fixed assets in the health sector in Bangladesh, Indonesia, Kyrgyz Republic, Mongolia, Pakistan, PNG, and Tajikistan (amounting to $498.94 million or 60% of total health lending during this period). There was no OCR lending for the health sector in 2000–2002, after which there was one OCR loan to Indonesia for $100 million ($65 million in OCR) in 2003, one loan to Uzbekistan for $40 million in 2004, and a program loan to the Philippines for $213 million ($200 million in OCR) in 2004. ADF lending for the health sector has also been erratic with no clear trend. However, there was never a year when ADF lending for the health sector was zero (see Appendix 13 for a list of health project loans, starting from the first loan in September 1978 until December 2004, and the assistance pipeline for lending products in HNP and ECD in 2005–2007).

Figure 8: ADB Lending to the Health Sector by Year



ADF = Asian Development Fund, OCR = ordinary capital resources.
Source: Asian Development Bank loan and technical assistance documents.

52. Based on an analysis of future programs, health lending is expected to total $384.5 million during 2005–2008 (Southeast Asia, 28%; Mekong region, 13%; South Asia, 39%; East and Central Asia, 17%; and the Pacific, 2%). Of the planned health lending, 23% will be financed by OCR and 77% by ADF. Health sector lending in 2005–2008 is expected to account for 1.2% of total ADB lending (0.03% of OCR lending for all sectors in ADB, 5.6% for ADF lending of all sectors in ADB). Overall, these figures indicate that ADB has not been successful at significantly increasing lending for the health sector, despite its congruence with ADB's strategic priorities and the core of its development mandate (Table A13.2, Appendix 13).

1. Mobilizing Concessional Funds for the Health Sector

53. The agreement to establish a substantial grant program as part of Eighth Replenishment of the ADF (ADF IX) provides another tool that, potentially, could be used to expand ADB's health program. ADF-associated grants are designed to (i) account for the debt burden in the poorest countries, (ii) assist in the transition from postconflict situations to peace and stability, (iii) combat HIV/AIDS and other communicable diseases, and (iv) support priority TA. Grants will represent up to 21% of total ADF IX operations, including an allocation of 3% as priority TA and 2% for HIV/AIDS and other communicable diseases.[62] However, the health sector will have to compete for priority with other sectors, and ADB still does not have financing mechanisms that provide it with comparative advantage in the health sector in countries that borrow from OCR. ADB's major source of concessional funds is ADF. The current ADF eligibility criteria are country- rather than sector-based. Thus, OCR borrowers are not eligible for ADF lending for their social sectors. Unless a concessional lending modality can be developed, ADB will not be a major player in areas that are at the core of its development mandate (such as health, education, and poverty) in MICs.

54. Given ADB's strategic priorities, it is a matter of concern that lending for the health sector is expected to fall to 1.2% of total lending and that there is no demand for traditional OCR products to support the health sector in many MICs. Given the need for sector selectivity on areas where ADB has a competitive advantage, it is reasonable to ask whether ADB should

[62] ADB. 2004. *Eighth Replenishment of the Asian Development Fund (ADF), ADF IX Donors Report: Development Effectiveness for Poverty Reduction*. Manila.

continue to be involved in the health sector at such low levels of lending, despite the clear and direct relationship between the health sector, ADB's core development objectives, and the achievement of the MDGs. If ADB's involvement in health is to continue, a serious effort to develop a broader range of lower-cost products is needed. Some concessionality is needed to make the cost of such loans cheaper than OCR terms. There are several strategies that ADB could consider:

(i) **Mobilizing greater cofinancing with bilateral donors or blending the concessional funds of bilateral donors with OCR funds for MICs for health sector operations**. The traditional cofinancing model is for a bilateral donor to finance a component of an ADB project. This type of financing is mobilized on a case-by-case basis, rather than on a broader portfolio basis. The transaction costs are usually perceived to be high. DFID is actively partnering with ADB[63] and the World Bank, using a model that goes far beyond the traditional cofinancing mode. The DFID partnerships allow multilaterals to do more in areas directly related to poverty reduction in MICs. The principal advantages of this model are to (i) blend the concessional and multilateral funds to make the cost of funds more attractive from the point of view of the borrower; (ii) allow for more scaling-up and replication using the financial resources of multilateral development banks, which are larger than those normally available for a bilateral donor working alone; (iii) provide the bilateral donor with a seat at the policy dialogue table that is sometimes available to multilaterals but not bilaterals; (iv) promote harmonization; and (v) reduce the transaction costs to governments of dealing with different donors. ADB should actively consider promoting this model of integrated multilateral/bilateral aid delivery in high-level international forums and high-level dialogue with bilateral donors. ADB needs to find ways in which to blend OCR resources with concessional resources from the international community (e.g., bilaterals) with more predictability and greater access, in a more regular and systematic manner. This will enhance the financial incentive for DMCs to borrow for the health sector.

(ii) **Becoming more actively involved in the international discussion on developing innovative financing modalities for the MDGs**. There has been a marginal increase in the ODA of Development Assistance Committee countries from 0.22% to 0.25% in 2003, much lower than 0.34% in 1990, the reference year for MDGs. Although donors have pledged to increase ODA to 0.7% of gross national product, progress in realizing this objective has fallen short of expectations. ODA will need to double in the next 5 years to support achievement of the MDGs. Because of the time that will be required to reach this objective, there is an ongoing discussion in the international community about innovative ways of mobilizing aid flows to complement traditional ODA.[64] Innovative proposals that are being discussed include (i) the International Finance Facility (IFF) proposed by the United Kingdom, under which donors would make off-budget pledges to increase future ODA. The pledges, in turn, would be used to

[63] A Joint Statement of Partnership between ADB and DFID was signed in March 2002, and a Memorandum of Understanding (MOU) between ADB and DFID was signed on May 2005. This MOU highlights the support for programs that focus on poverty reduction and achieving the MDGs.

[64] The Development Assistance Committee is a Joint Ministerial Committee of the Boards of Governors of World Bank and the International Monetary Fund on the Transfer of Resources to Developing Countries. See Development Assistance Committee. 2005. *Moving Forward Financing Modalities Toward the MDGs.* Background document, 14 April 2005.

back the issuance of bonds, the proceeds of which would augment the budgets of existing aid programs; (ii) IFF for Immunization, sponsored by GAVI and the Vaccine Fund, which will pilot test the IFF concept, beginning in 2005, to help raise the funds necessary to achieve the immunization MDG target; and (iii) levying global taxes (e.g., carbon tax; taxes on financial transactions, international aviation,[65, 66] maritime pollution, or arms sales; and surcharges on multinational profits, value-added tax, or income tax) to generate additional financing for development.[67] Much work remains to be done to realize any of these concepts. If any come to fruition, additional funding would be available for the MDGs in general and the health sector in particular. However, if these funds are targeted at the poorer countries, rather than MICs, it would not help to open up opportunities for ADB to enlarge its health portfolio in countries for which only OCR financing is available.

(iii) **Strategic focus in health**. ADB needs to work out its strategic focus in the health sector within the poverty reduction strategy framework and in harmony with development partners. Lending and advocacy roles should be based on economic and analytical work, and ADB's comparative advantage.

(iv) **Developing innovative partnerships with the private sector and civil society**. The tsunami disaster demonstrated that private funds can be mobilized from foundations, philanthropic organizations, civil society organizations (including NGOs), private individuals, and private companies. There are many other examples of private donations to support development, some of which relate to the health sector (e.g., GAVI, the Bill and Melinda Gates Foundation, the programs of many NGOs, specialized medical services for diabetes and other disorders, and contributions by pharmaceutical companies). ADB has been involved in developing partnerships with the private sector and civil society to support development in general and the health sector in particular. However, more could be done in this area to encourage voluntary contributions to complement ADB's operations in the health sector. ADB's experience in food fortification indicates that it is possible to enter into partnerships with major companies in the salt and flour industries to achieve substantial health benefits. One of the MDG targets is to provide access to affordable, essential drugs in developing countries. ADB should explore the possibility of public-private partnerships with pharmaceutical companies to mobilize resources to help achieve this objective. ADB should develop guidelines that would recognize the benefits of such partnerships and include safeguards to ensure that ADB's name and reputation are not exploited for commercial gain.

[65] All G8 finance ministries (Canada, France, Germany, Italy, Japan, Russia, United Kingdom, and USA) have consented to use airline traffic income to boost aid to poor African countries. June 2005. Available: http://www.travelbiz.com.au/articles/f5/0c030df5.asp

[66] Zelius, Rolf Selrod. 1995. A Painless Solution? An Analysis of Two Alternatives for Global Taxation for Financing Climate Activities under the United Nations Umbrella. *CICERO Report* 1995:07. CICERO, Oslo, Norway. Available: http://www.cicero.uio.no/publications/detail.asp?publication_id=80&lang=en

[67] See the Report of the Technical Group on innovative Financing Mechanisms (2004) prepared by Brazil, Chile, France, and Spain. Germany has now joined that group.

(v) **Consider whether a proposal should be developed to argue for a change in ADF eligibility from country to sector/use considerations**.[68] This is a complex issue. In addition to consideration by the donors, the traditional ADF borrowers would also have a stake in such a decision as the pool of ADF resources is assumed to be largely fixed. Decisions regarding ADF eligibility do not rest solely with ADB. The international community, not just ADF donors, has over the years put into place a fairly coherent concessional resource allocation system across the major multilateral development banks (European Bank for Reconstruction and Development excluded) that takes into consideration three factors: (i) poverty (i.e., per capita income and population), (ii) debt sustainability, and (iii) performance. The objective is to direct concessional resources to countries that do not have significant access to private capital markets (except on prohibitive terms), where poverty is generally "mass poverty," and where good performance has been demonstrated. The secondary consideration is to provide the country with the "right" balance of concessional loans and grants so that even with concessional lending there is minimal risk that the country would encounter debt repayment difficulties. However, the debate about changing the criteria for ADF allocation has consistently come out in favor of country considerations. The prevailing view is that sector/thematic policies provide a framework for making operational decisions on the objectives, nature, content, and scope of ADB investment but that sector policy is not a tool for mandating shares of the organization's or borrowers' resources to the sector. Grant allocation is not based on use, except for HIV/AIDS. This may provide a useful precedence to open a discussion on this topic for broader initiatives in the health sector. The foregoing concerns are all valid. However, the implication of continuing the status quo is that ADB will play a marginal role in the health sector, particularly in MICs. The issue is whether this is an acceptable outcome.

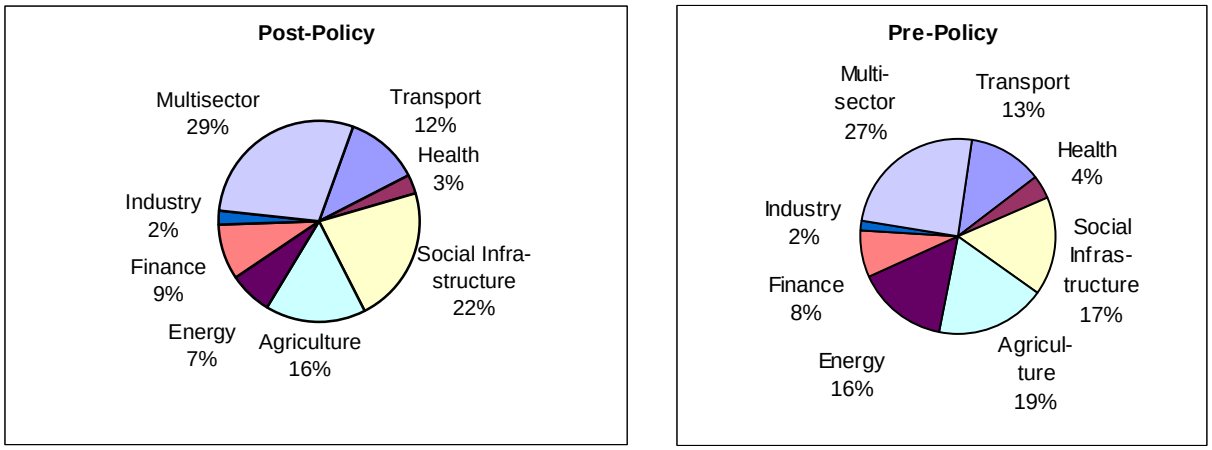
(vi) **Explore modified (hybrid) TA modality**. TA modality that allows small investment components could be a potential modality in enhancing effectiveness and ensuring sustainable impact of TAs, which will also enable optimum utilization of ADF IX grants for TA. ADB should further explore the possibility of this modified (hybrid) modality in its ongoing effort to restructure TA operations.

2. Health-related Technical Assistance

55. The volume of health-related TA before the Policy (41 TA projects totaling $21.2 million) and after the Policy (49 TA projects totaling $26.8 million) is shown in Figure 9. Although the volume of TA allocated to the health sector increased, the proportion of TA allocated to health decreased slightly from 4% to 3%.

[68] Thorough discussion of this broad issue is beyond the scope of this evaluation study of ADB's Policy on the health sector.

Figure 9: Technical Assistance by Sector Allocation



Source: Asian Development Bank loan and technical assistance documents.

56. Some of the key areas covered in the health TA program include public health and nutrition, ECD, combating SARS and other new emerging communicable diseases, social protection, and policy reforms. Allocations for HIV/AIDS and communicable diseases, ECD, and nutrition have increased since 1999. In the area of communicable diseases, the approval of the following TA projects demonstrates the dramatic increase in TA financing in this area: a regional project on community action to prevent HIV/AIDS ($8 million),[69] HIV/AIDS—preventive education in the cross-border areas of the Greater Mekong Subregion (GMS) ($1 million),[70] emergency regional support to address the outbreak of SARS ($2 million),[71] and combating SARS in the western region of the PRC ($2 million).[72]

57. A number of large nutrition-related regional TA projects related to nutrition and ECD have been approved since 1999, totaling $11.7 million. Of this amount, $6.85 million focused on Asian countries in transition. Capacity building TA, typically used to support decentralization and other health sector reforms, accounted for a large amount of TA before (77.8%) and after (97.1%) the Policy was adopted. After the Policy, the proportion of TA resources allocated to health care financing and women's health decreased.

58. Since 2001, the annual number of advisory TA projects in health declined. The draft medium-term review of the Policy found that many advisory TA projects are related to specific projects or general capacity building. The draft review and reorganization review noted that there is considerable pressure on the availability of funds for financing TA projects as well as a trend toward establishing thematic TA trust funds. Prioritization of advisory TA funds is becoming more critical, along with improvements to ADB's capacity to acquire, share, and apply knowledge. Such information is needed by country and project teams to promote knowledge sharing and for country strategy and program (CSP) preparation and project design.[73]

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[69] ADB. 2001. *Technical Assistance for Community Action for Preventing HIV/AIDS*. Manila (TA 9006-REG [JFPR], for $8.0 million, approved 8 May 2001).
[70] ADB. 2002. *Technical Assistance for ICT and HIV/AIDS Preventive Education in the Cross-Border Areas of the Greater Mekong Subregion*. Manila (TA 6083-REG, for $1.0 million, approved 19 December 2002.)
[71] ADB. 2003. *Technical Assistance for Emergency Regional Support to Address the Outbreak of Severe Acute Respiratory Syndrome*. Manila (TA 6108-REG, for $2.0 million, approved 23 May 2003).
[72] ADB. 2003. *Technical Assistance to the People's Republic of China for Combating Severe Acute Respiratory Syndrome in the Western Region*. Manila (TA 4118-PRC, for $2.0 million, approved 22 May 2003).
[73] ADB. 2003. *Implementation of the Reorganization of the Asian Development Bank*. Manila.

59. A review of ADB's TA support to the sector by region over the periods before and after approval of the Policy shows that Southeast Asia (34% pre-Policy and 27% post-Policy) received most TA funds, followed by East and Central Asia (17% pre-Policy and 25% post-Policy), the Mekong region (24% pre-Policy and 22% post-Policy), South Asia (12% pre-Policy and 19% post-Policy), and the Pacific (13% pre-Policy and 7% post-Policy). Since adoption of the Policy, an increasing proportion of health-related TA has been used to support work in East and Central Asia and South Asia.

3. Staffing for the Health Sector

60. During SES preparation, five health specialists, and three full-time and two part-time health economists worked at ADB headquarters. It is difficult to determine the optimal number of staff given the operations of different sectors. The ADB reorganization in 2001 was designed to maximize the effectiveness of ADB's available resources by (i) allocating staff resources more efficiently by rationalizing functions; (ii) introducing the team concept, and forming country and project teams; (iii) introducing effective mechanisms for knowledge dissemination through internal sector and thematic networks; and (iv) assigning cross-cutting specialists to enhance knowledge of cross-cutting concerns and safeguard policies in operations units.[74]

61. There was concern that the reorganization would result in a shift of experienced professional staff to nonoperational departments and that this might adversely affect project administration and portfolio management. To address this, the number of positions in regional departments at headquarters was increased in the 2002 and 2003 budgets. The recent reorganization review revealed that the numbers of professional staff did not necessarily reflect the regional departments' lending and nonlending activities.[75] This is the case with the health sector: forecast staff additions to social sector operations have not been made. Given that achieving the health-related MDGs in the region will prove difficult, and given ADB's pledge of greater health-related sector assistance in ADF IX replenishments, it appears that the staffing levels of health professionals need to be optimized. However, health lending is expected to fall to 1.2% of total ADB lending in 2005–2008. This disturbing trend suggests that any decision to increase the number of health professionals in ADB should be viewed with caution.

IV. ASSESSMENT OF THE POLICY

A. Methodology

62. This SES reviewed 209 ADB documents, consisting of health loans, TA projects, and regional TA projects—including those funded through the JFPR—and nonhealth loans. All health loans and TA projects were categorized into a 5-year period before approval of the Policy (February 1994–January 1999) and a 5-year period after approval of the Policy (February 1999–January 2004). Tables 1 and 2 of Appendix 13 list all the health-related loans, TA projects and regional TA projects up to 31 December 2004, and the pipeline for lending products in the HNP and ECD sector for 2005–2007. The most recent CSP or CSP updates (CSPUs) for 33 DMCs were reviewed to assess whether progress in attaining the MDGs had been considered in the documents. Health documents from the pre-Policy (19 loans, 27 TA projects) and post-Policy (17 loans, 34 TA projects) periods were reviewed and compared.

[74] ADB. 2001. *Reorganization of the Asian Development Bank*. Manila.
[75] ADB. 2003. *Implementation of the Reorganization of the Asian Development Bank: A Review of Progress after One Year*. Manila.

63. Seventy-nine nonhealth sector loans (including multisector, agriculture and natural resources, social infrastructure, transportation and communication, energy, finance, industry, and nonfuel minerals loans), representing 20% of the total number of such loans approved by ADB from 1999 to 2004, were selected at random and analyzed. The objective was to identify whether health concerns were integrated into nonhealth sectors. The Policy and loan portfolio were assessed against the five strategic considerations in support of (i) PHC for the vulnerable groups; (ii) strengthening monitoring and evaluation, emphasizing effective interventions, and improving project quality at entry and during implementation; (iii) innovations and pilot testing new approaches to health care financing, organization, and management, and the deployment of new technologies; (iv) encouraging DMC governments to conduct health sector reforms; and (v) increasing sector efficiency by improving managerial capacity and collaboration with partner institutions.

B. Strategy 1: Improve the Health of Vulnerable Groups and Maintain Emphasis on Primary Health Care

1. Focus on Vulnerable Groups

64. The Policy identified a need to ensure improved access by vulnerable groups—such as the poor, women, children, and IPs—to basic health services. The review of the documents showed that the focus on vulnerable groups increased after the adoption of the Policy (Table 1). Five years before the Policy, health loans tended to focus on the health needs of the poor and women. This focus continued after adoption of the Policy and all post-Policy loans addressed the needs of the poor. The most significant change in targeting was a near doubling of the proportion of health loans for IPs. There was also a marked improvement in the targeting of TA and JFPR projects on the health needs of the poor and women. After adoption of the Policy, 64.7% of all such operations targeted vulnerable groups, compared with 18.5% before the Policy. Overall it seems reasonable to conclude that the Policy contributed to better targeting of vulnerable groups. After the policy was adopted, ADB's health operations were more tightly targeted on improving the access of vulnerable groups to enhanced basic health services. This better targeting should enhance development results, contribute to the achievement of MDGs, and is consistent with ADB's overarching objective of poverty reduction.

Table 1: Health Loans and TA Projects Addressing Concerns of Vulnerable Groups
(Percentage of all health loans and projects)

Vulnerable Groups	Health Loans		TA, Regional TA, and JFPR Projects	
	Pre-Policy	Post-Policy	Pre-Policy	Post-Policy
Poor	89.5	100.0	14.8	61.8
Women	84.2	88.2	11.1	26.5
Indigenous Peoples	23.6	41.2	3.7	2.9
Focus on at least one vulnerable group	100.0	100.0	18.5	64.7

JFPR = Japan Fund for Poverty Reduction, TA = technical assistance.
Source: Asian Development Bank loan and TA documents.

65. Some examples of adherence by ADB health loans and TA projects to strategy 1 of the Policy are (i) mitigating the impact of the Asian financial crisis on vulnerable groups; (ii) responding to emerging needs with a focus on vulnerable groups; (iii) focusing PHC

interventions on the rural and urban poor; (iv) focusing PHC interventions on women, infants, and children; and (v) focusing on IPs. These are described below.

a. Mitigating Impact of the Asian Financial Crisis on Vulnerable Groups

66. Some loans, both before and after the Policy, were designed to mitigate the effects of the Asian financial crisis on the poor. Examples include the health and nutrition sector program (1999)[76] and the decentralized health services project (2003) (footnote 48), both in Indonesia. The social sector rehabilitation project in Tajikistan (1999) was designed to promote social recovery in a difficult postconflict and economic transition situation. Before the Policy, the social sector program (1998)[77] for Thailand aimed to mitigate the short-term adverse impact of the financial crisis on the most vulnerable groups and the unemployed. The social protection sector development program loan (1998)[78] in Indonesia was provided in response to the economic crisis that began early 1997.

67. Examples of TA and JFPR projects designed to protect the health of vulnerable groups in postconflict situations or during administrative transitions are (i) a project with the Islamic Transitional Administration of Afghanistan to develop partnerships for PHC for the poor;[79] (ii) a project in Pakistan to improve access to health services by the poor (2003); and (iii) a project that supported improvements in the nutrition of mothers and children in Asian countries in transition (2001).

b. Responding to Emerging Needs with Focus on Vulnerable Groups

68. ADB supported two TA projects for emergency assistance to DMCs affected by SARS. The first was a project on emergency regional support to address the outbreak of SARS (2003), funded by the Japan Special Fund. The total value was $5 million, of which $3 million was used for the five most affected DMCs, and to support a regional team of communicable diseases experts based in the Western Pacific Regional Office of WHO. The project covered 22 DMCs. The second project[80] was designed to help contain the SARS epidemic by setting up surveillance and establishing an emergency response mechanism (2003). In both cases, ADB worked closely with WHO. The projects were good examples of applied donor coordination. Interviews with stakeholders found that the project on emergency regional support was much appreciated; it demonstrated ADB's capacity to collaborate and coordinate with partners in providing timely support to DMCs, and its ability to be a catalyst.

69. There were six (31.6% of total health loans) pre-Policy and seven (41.2%) post-Policy ADB loans for HIV/AIDS prevention. There was a substantial increase in the number of HIV/AIDS TA projects, from one (3.7%) during the pre-Policy period to six (17.6%) post-Policy.

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[76] ADB. 1999. *Report and Recommendation of the President to the Board of Directors on Proposed Loans and Technical Assistance Grants to the Republic of Indonesia for the Health and Nutrition Sector Development Program*. Manila (Loan 1675/1676-INO, for $300.0 million, approved 24 March 1999).

[77] ADB. 1998. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan and Technical Assistance Grants to the Kingdom of Thailand for the Social Sector Program*. Manila (Loan 1611-THA, for $500.0 million, approved 12 March 1998).

[78] ADB. 1998. *Report and Recommendation of the President to the Board of Directors on Proposed Loans and Technical Assistance Grants to the Republic of Indonesia for the Social Protection Sector Development Program*. Manila (Loan 1622/1623-INO, for $300.0 million, approved 9 July 1998).

[79] ADB. 2002. *Technical Assistance to the Islamic Republic of Afghanistan for Primary Health Care Partnership for the Poor*. Manila (TA 9030-AFG, for $3.0 million, approved 19 December 2002).

[80] ADB. 2003. *Technical Assistance to the People's Republic of China for Combating SARS in the Western Region*. Manila (TA 4118-PRC, for $2.0 million, approved 22 May 2003, and $3.0 million was added in September 2003, totaling $5.0 million).

c. Focusing Primary Health Care Interventions on the Rural and Urban Poor

70. There was a modest increase in support for PHC interventions to the poor after the Policy was adopted. Three pre-Policy health loans (15.8%) focused their PHC interventions on the poor: (i) the health sector development project[81] for PNG (1997); (ii) the social service delivery and finance project[82] for the Kyrgyz Republic (1998); and (iii) the urban PHC project for Bangladesh (1997).[83] Four post-Policy health loans[84] (26.7%) were designed to respond to the PHC services needs of the poor by (i) expanding PHC to the rural poor in Lao PDR (2000), (ii) supporting rural health services for the poor in Viet Nam (2000), (iii) improving the health status of IPs in the Central Highlands of Viet Nam (2004), and (iv) improving the nutrition and psychosocial and health status of children in the 12 poorest regions in the Kyrgyz Republic (2003).

d. Focusing Primary Health Care Interventions to Women, Infants, and Children

71. Before the Policy, 84.2% of health loans addressed the needs of women, infants, and children (Table 1). This increased slightly to 88.2% in the post-Policy period. There was a much greater increase in TA and JFPR projects. After the Policy, 26.5% of TA projects addressed the health needs of women, infants, and children. This was more than double the proportion before the Policy was adopted (11.1%). Examples of this trend can be seen in (i) the women's health and safe motherhood project[85] in the Philippines (1994), (ii) the women's health project[86] in Pakistan (1999), and (iii) the reproductive health project[87] in Pakistan (2001). At the regional level, a TA project focused on strengthening the safe motherhood program region-wide (1998) by identifying priorities and key strategies for the policy and institutional framework on safe motherhood in the region.

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[81] ADB. 1997. *Report and Recommendation of the President to the Board of Directors on Proposed Loans and Technical Assistance Grant to Papua New Guinea for the Health Sector Development Project*. Manila (Loan 1518-PNG(SF), for $10.0 million, approved 20 March 1997).

[82] ADB. 1998. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan and Technical Assistance Grant to the Kyrgyz Republic for Social Services Delivery and Finance Project*. Manila (Loan 1645-KGZ(SF), for $4.1 million, approved 27 November 1998).

[83] ADB. 1997. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the People's Republic of Bangladesh for the Urban Primary Health Care Project*. Manila (Loan 1538-BAN(SF), for $40.0 million, approved 16 September 1997).

[84] ADB. 2000. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the Lao People's Democratic Republic for the Primary Health Care Expansion Project*. Manila (Loan 1749-LAO(SF), for $20.0 million, approved 24 August 2000); ADB. 2000. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the Socialist Republic of Viet Nam for the Rural Health Project*. Manila (Loan 1777-VIE(SF), for $68.3 million, approved 9 November 2000); ADB. 2004. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the Socialist Republic of Viet Nam for the Health Care in the Central Highlands Project*. Manila (Loan 2076-VIE(SF), for $20.0 million, approved 9 January 2004); and ADB. 2003. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan and Technical Assistance Grant to the Kyrgyz Republic for the Community-Based Early Childhood Development Project*. Manila (Loan 2007-KGZ(SF), for $10.5 million, approved 29 September 2003).

[85] ADB. 1994. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the Republic of the Philippines for the Women's Health and Safe Motherhood Project*. Manila (Loan 1331-PHI(SF), for $54.0 million, approved 10 November 1994).

[86] ADB. 1999. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the Islamic Republic of Pakistan for the Women's Health Project*. Manila (Loan 1671-PAK(SF), for $47.0 million, approved 16 March 1999).

[87] ADB. 2001. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the Islamic Republic of Pakistan for the Reproductive Health Project*. Manila (Loan 1900-PAK(SF), for $36.0 million, approved 20 December 2001).

72. ADB's focus on improving the children's health was reflected in two health loans on ECD: (i) an ECD project[88] in the Philippines (1998), and (ii) a community-based ECD project in the Kyrgyz Republic. A TA project in Viet Nam was designed to further understand the status and availability of ECD services among the poor and in remote areas (2003).

e. Focusing on Indigenous Peoples

73. Fewer loans and TA projects focused on IPs than on other vulnerable groups, before and after the adoption of the Policy (Table 1). However, there was a substantial increase in the percentage of loans addressing the health needs of IPs, from 23.6% before the Policy to 41.2% after it was adopted. The percentage of TA projects focusing on IP health needs remained low at about 3% of total health TA and JFPR projects. ADB began to address the health needs of IPs before the Policy was adopted. A population and family health project in Viet Nam (1996) tested a service delivery model for ethnic minorities. It also tested a health outreach system centered on village-based health posts in remote mountainous areas, where most of the ethnic minorities live. An intensified communicable disease control project[89] in Indonesia (1997) designed its education and communication program to suit cultural minorities, and an ECD project in the Philippines (1995) incorporated research studies on how ECD services can be best delivered to cultural minority groups. In Thailand, through the social sector program, ADB suggested the design of a monitoring and evaluation system to assess the welfare of women, the poor, and ethnic minorities.

74. Examples of post-Policy projects focusing on IPs include (i) a health care program in Bhutan (2000) that aims to strengthen the immunization program by establishing six units in district hospitals to serve ethnic minorities and to acknowledge the cultural aspects of traditional medicine; (ii) a reproductive health project in Pakistan that develops culturally-sensitive educational programs in local languages and traditions; (iii) a health sector reform program in Cambodia (2002) that provides a development plan for ethnic minorities in its social strategy; and (iv) the second decentralized health project in Indonesia, which ensures that IPs will benefit from the district health plans by including an assessment of the needs of IPs, the constraints that prevent them from accessing health services, and a plan for their participation in community activities and in monitoring the impact of the project. A regional TA project was designed to improve the human development levels of ethnic minorities (1998) in DMCs in the GMS.[90] A TA project in the Lao PDR supported the extension of a PHC project to IPs (2000).[91]

2. Maintain Emphasis on Primary Health Care

75. The Policy encouraged ADB to (i) focus its lending on activities that will disproportionately improve the health of the poor, women, children, and IPs, and continue its emphasis on PHC interventions, including reproductive health; and (ii) encourage DMC governments to expand PHC budgets and discuss means to improve their allocation

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[88] ADB. 1998. *Report and Recommendation of the President to the Board of Directors on Proposed Loans to the Republic of the Philippines for the Early Childhood Development Project*. Manila (Loan 1606/1607-PHI, for $24.5 million, approved 27 January 1998).

[89] ADB. 1997. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan and Technical Assistance Grant to the Republic of Indonesia for the Intensified Communicable Disease Control Project*. Manila (Loan 1523-INO, for $87.4 million, approved 19 June 1997).

[90] ADB. 1998. *Technical Assistance for the Study of Health and Education Needs of Ethnic Minorities in the Greater Mekong Subregion*. Manila (TA 5794-REG, for $800,000, approved 30 June 1998).

[91] ADB. 2000. *Technical Assistance to the Lao People's Democratic Republic for Capacity Building for Primary Health Care*. Manila. (TA 3478-LAO, for $800,000, approved 10 August 2000).

efficiency. Selected PHC interventions were recommended: (i) immunization, (ii) vitamin A supplementation, (iii) family planning, (iv) iodine supplementation, (v) treatment of tuberculosis, (vi) treatment of sexually-transmitted infections (STIs), (vii) control of acute respiratory tract infection (ARI), (viii) oral rehydration therapy (ORT), (ix) malaria prevention, (x) tobacco taxation, and (xi) hygiene education.

76. This evaluation assessed (i) the extent to which these recommended priorities were incorporated in the design of loans and TA projects; (ii) the scope of projects and programs that supported PHC; (iii) the extent of consideration of MDGs and targets in the design of loans, TA projects, and CSPUs; (iv) specific elements or components supported by loans or TA projects; and (v) the incorporation of MDGs.

77. Overall, the emphasis on women's health; management, and control of communicable diseases, particularly HIV/AIDS; the promotion of healthy lifestyles; tobacco and alcohol reduction; and environmental health improved after the Policy was approved. There was a significant post-Policy increase in the proportion of loans and TA projects supporting health education and information dissemination. Appendix 14 compares the loans and TA projects with an emphasis on women's health; children's health; nutrition; control and management of reproductive tract infections (RTIs), STIs, and HIV/AIDS; management and control of communicable diseases; healthy lifestyles; and environmental health. The emphasis on children's health, nutrition for women and children, and the management and control of communicable diseases decreased slightly from 1999 to 2004.

a. Incorporation of the Policy's Priorities for Public Health Interventions

78. The SES review found that the proportion of loans emphasizing the identified priorities for public health interventions as recommended by the Policy generally decreased after the Policy was adopted. The two exceptions were the number of HIV/AIDS prevention and tobacco control projects, which increased. There was a notable increase in support for HIV/AIDS prevention, which increased almost five-fold after adoption of the Policy. ADB support for immunization, vitamin A supplementation, iodization of salt or water supply, treatment of STIs and HIV/AIDS prevention, ARI, management of diarrhea or ORT, and malaria prevention was generally in the form of TA projects rather than loans. Appendix 15 shows the proportion of loans or TA projects emphasizing the provision of PHC services. While TA projects have the potential to improve the policy framework and build capacity in these areas, it remains a challenge for ADB to find ways to use loan resources, rather than grants, to scale-up activities related to these important priorities.

b. Scope of Programs/Projects Supported by Loans and Technical Assistance Projects

79. The focus of the majority of loans in the health sector shifted to strengthening decentralized health delivery systems and introducing health sector reforms. This shift was not driven by the Policy. Rather it reflected ADB's efforts to respond to external circumstances and developments in its client DMCs. The Asian financial crisis prompted DMCs to develop a sectoral approach to sustain earlier health care initiatives during a period of fiscal crisis. ADB supported these efforts with program loans to Indonesia and Thailand in 1998. Most of the TA projects before 1999 focused on helping DMCs in the review and formulation of policies and strategies related to health sector reforms (74% before the Policy compared with 41% after it was adopted). This was partly due to the preparation of the Policy. Reforms in health care financing, health insurance, and health management information systems (HMIS) were covered

by these TA projects. The majority of post-Policy TA projects focused on program strengthening in specific areas, particularly in emerging issues, such as HIV/AIDS and SARS, and nutrition policies and strategies (53% after the Policy compared with 22% before it). The remaining TA projects had links with social services and showed a slight post-Policy increase.

c. Specific Elements/Components Supported by Loans and Technical Assistance Projects

80. The proportion of loans supporting major components of health sector reforms before and after adoption of the Policy is shown in Appendix 16. A review of the specific components in both loans and TA projects showed that ADB continued to emphasize PHC services by helping to establish a supportive health policy environment, installing efficient management systems, and institutionalizing sustainable financing mechanisms. Support for renovations and minor building of hospitals was noted in the Policy, although it discouraged such activities. The review of documents and interviews during the operations evaluation mission (OEM) found that, despite the Policy, ADB did provide support for renovating dilapidated district hospitals as well as build a few district hospitals in areas without referral systems, and these district hospitals also provide PHC services. During the period under review, ADB also provided two private sector loans that supported tertiary health care in India and Viet Nam. The OEM concluded that the portion of the Policy that discouraged ADB support for renovation and minor building of hospitals was inappropriate. The operational decisions to support such activities were justified. During the OEMs for the SES and other OEMs related to HNP, DMCs said that support for equipment and infrastructure for HNP is still needed, particularly in decentralized health systems.

81. Developing an integrated health system also requires investment in infrastructure and equipment. District hospitals, clinics, rural health clinics, and PHC centers are particularly important for delivering good quality health services and PHC services to the poor. To enhance the quality of care in HNP, infrastructure and equipment are also needed to train health care workers—doctors, midwives, nurses, and health technicians. Many DMCs that are lagging in the achievement of the health-related MDGs still require more investments in health infrastructure and equipment. ADB should not, as a matter of policy, discourage such investment. Rather, ADB should enter into dialogue with DMCs to identify government strategies and priorities to develop a well-functioning integrated health system and to learn about the DMCs' views on how ADB can best help.

82. Overall, there was a significant increase in the proportion of loans and TA projects related to health insurance and financial management and budgeting. Such a focus reflects the need in most DMCs for a more sustainable mechanism to respond to the health demands of their population because of their limited resources and the effects of the financial crisis. To ensure the quality of PHC, staff training continued to be emphasized, including training in regulations and licensing. More focus was placed on monitoring and evaluation, including setting up surveillance systems. The emphasis on HMIS was maintained.

d. Incorporation of the Millennium Development Goals

83. The Policy contributed to an increased focus on the health-related MDGs in ADB operations. Of the 14 MDG indicators in Appendix 17, half received greater emphasis in the post-Policy environment. These include MMR and the proportion of births attended by health personnel. Several ADB loans and TA projects addressed these matters, including a women's health and reproductive health project in Pakistan (footnotes 86 and 87), a PHC expansion

project in Lao PDR (footnote 84), the first[92] and second (footnote 48) decentralized project in Indonesia, a basic social services project in Federated States of Micronesia,[93] health sector and development projects in Cambodia[94] and Mongolia,[95] and a health care project in the Central Highlands of Viet Nam (footnote 84). Among the TA projects approved from 1999 to 2004, four incorporated these indicators—a region-wide women's health and safe motherhood project (footnote 85), a capacity building for rural health project in Viet Nam, a health sector reform project in Pakistan,[96] and public-private partnership for a PHC project for Asian countries in transition.

84. A sharper focus on the MDG indicator related to the proportion of underweight children is evident from a review of approved loans and TA projects supporting health and nutrition, including a health and nutrition sector development project in Indonesia (footnote 76), improving nutrition for poor mothers and children in Azerbaijan, and strengthening capacity to promote food safety in Viet Nam.

85. There was also more focus on the MDG related to HIV/AIDS (see previous section). A slightly greater emphasis on malaria prevalence is evident in a regional TA project in the GMS for the Rollback Malaria Initiative.[97] Of the post-Policy loans, those that incorporated malaria indicators included the second decentralized project in Indonesia and a PHC expansion project in Lao PDR. The number of projects containing indicators related to the access of households to improved sanitation is also increasing, as demonstrated by the two TA projects in PNG (on provincial town water supply and sanitation; and low-cost sanitation, community awareness and health education) and a TA project in the PRC on safe drinking water and sanitation for the poor.

86. A review of CSPs and CSPUs found that there was greater emphasis on achieving the MDGs and including them in ADB's system for country performance monitoring. All the CSPs and CSPUs reviewed included IMR and HIV prevalence indicators. Other indicators included in most CSPs and CSPUs were malaria incidence rate, TB prevalence, and percentage of underweight children. More advocacy is needed to highlight the importance of indicators covering immunization and better sanitation. The above findings, the support through this strategy for international efforts to promote public funding for universal basic services, ADB's poverty reduction goals, the operating principles of the long-term strategic framework (LTSF), and the development and implementation of poverty reduction strategies in many DMCs, demonstrate that strategy 1 is highly relevant. However, discouraging support for renovation and building of district hospitals, especially in a decentralized health system where a good quality referral system is essential, is inappropriate. Overall, strategy 1 is considered relevant.

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[92] ADB. 2000. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan and Technical Assistance Grant to the Republic of Indonesia for the Decentralized Health Services Project*. Manila (Loan 1810-INO, for $65 million, approved 14 December 2000).

[93] ADB. 2000. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the Federated States of Micronesia for the Basic Social Services Project*. Manila (Loan 1816-FSM, for $8.019 million, approved 20 December 2000).

[94] ADB. 2002. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the Kingdom of Cambodia for the Health Sector Support Project*. Manila (Loan 1940-CAM, for $20.0 million, approved 21 November 2002).

[95] ADB. 2003. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to Mongolia for the Second Health Sector Development Project*. Manila (Loan 1998-MON, for $14.0 million, approved 5 June 2003).

[96] ADB. 1999. *Technical Assistance to the Islamic Republic of Pakistan for Health Sector Reform in North-West Frontier Province*. Manila (TA 3386-PAK, for $500,000, approved 29 December 1999).

[97] ADB. 2000. *Technical Assistance for Roll Back Malaria Initiative in the Greater Mekong Subregion*. Manila (TA 5958-REG, for $600,000, approved 7 December 2000).

87. Reinforcing the inclusion of women in the design and implementation of projects is an important step toward addressing women's health concerns. Collecting data about economic, social, and health-related benefits can be useful in informing policy options. However, ADB has not been sufficiently active in undertaking such analysis in order to influence policymakers in the health sector.

C. Strategy 2: Focus on Achieving Tangible Results

88. The Monterrey Statement in March 2002 emphasized the importance of demonstrating development effectiveness. To do this, such institutions as ADB need to adopt a more systematic way of managing for development results. Strategy 2 emphasizes the need to achieve tangible, measurable results in the health sector, and to increase DMC capacity for monitoring and evaluation to provide data can be used for decision making. Improving the quality of loans at entry is an extremely important way of promoting technically sound health activities and ensuring participatory design and approaches to promote good governance. Strategy 2 is highly relevant to achieving the MDGs.

1. Strengthening Monitoring and Evaluation

89. Efforts to focus on measurable, tangible results by strengthening monitoring and evaluation in the health sector became more pronounced since the adoption of the Policy. All loans approved before and after the Policy incorporated a monitoring plan. Earlier loans made use of the benefit, monitoring, and evaluation framework. In 1997, the loans started to use the logical project/program framework, which became mandatory in 1998. This framework became ADB's principal tool for ensuring the design quality of its projects, and for monitoring and evaluation through the periodic project or program performance report or TA performance report during implementation; for subsequent evaluation through the project or program completion report (PCR) or TA completion report; and finally through the project performance audit report (PPAR) or TA performance audit report. There was an increase in the proportion of loans and TA projects that specified a budget allocation for monitoring and evaluation following adoption of the Policy, and an increase in the proportion of loans and TA projects that planned to collect baseline information (Table 2). There was a marked increase in the proportion of health-related TA projects with a plan to measure results, from 14.8% pre-Policy to 94.1% post-Policy, although this also reflects ADB's institution-wide efforts in this area.

Table 2: Proportion of Loans and TA Projects Incorporating Monitoring and Evaluation Plans and the Level of Specificity

	Loans		TA projects	
Item	Pre-Policy	Post-Policy	Pre-Policy	Post-Policy
Total Number	19.0	17.0	27.0	34.0
Includes Measuring Results Plan (%)	100.0	100.0	14.8	94.1
Includes Budget for Data Collection and Analysis or Monitoring and Evaluation (%)	78.9	82.4	29.6	38.2

TA = technical assistance.
Source: Asian Development Bank loan and TA documents.

a. Monitoring Plans with Specific Indicators and Targets to be Achieved

90. Efforts to provide better quality monitoring plans increased (Table 3). Post-Policy health loans and TA projects all included monitoring plans. Although the incorporation of specific,

tangible indicators and performance targets has increased for both loans and TA projects, it is still low for TA projects. This could be attributed to the fact that the TA framework was introduced much later than that for loans (the benefit, monitoring, and evaluation or logical framework had been prepared for loans for many years).

Table 3: Proportion of Loans and TA Projects with Monitoring Plans that Specified Indicators and Levels of Targets to be Achieved

	Loans		TA projects	
Item	**Pre-Policy**	**Post-Policy**	**Pre-Policy**	**Post-Policy**
Total Number	19.0	17.0	27.0	34.0
Includes Specific Indicators and Target Levels (%)	63.2	88.2	11.1	50.0

TA = technical assistance.
Source: Asian Development Bank loan and TA documents.

b. Monitoring Plan Measuring the Access of the Poor to Health Services

91. Few of the pre-Policy loans and TA projects included clear indicators that were specific to the poor in their monitoring plans. Since adoption of the Policy, 70.6% of loans included such indicators. Since all health loans target the poor (Table 4), this figure needs to be improved further. Although 61.8% of health TA projects focus on the poor, only 44.1% have indicators that can be monitored. Some examples of good practice in this area include the PHC project for the poor in Afghanistan (footnote 79), which specifically stated as a target that "80% of the poor have access to quality care." The rural health project in Viet Nam (footnote 84) included targets to "increase in the rate of antenatal care for poor women by 40%" and reduce "the gap between the utilization of services by the poor and non-poor by 25% in pilot areas." The health care project in Central Highlands in Viet Nam (footnote 84) aimed to "reduce the private out-of-pocket expenditure by the poorest quintile by 100%" (Table 4). Despite some examples of good practice,[98] the results indicate that the health sector needs to make greater efforts to develop indicators that can be monitored to measure the access of the poor to health. This is an important issue given ADB's overarching objective of reducing poverty, the relationship of health to poverty, and ADB's commitment to achieving the MDGs.

Table 4: Proportion of Loans or TA Projects with Detailed Monitoring Plans that Specified Access Indicators for the Poor

	Loans		TA projects	
Item	**Pre-Policy**	**Post-Policy**	**Pre-Policy**	**Post- Policy**
Total No.	19.0	17.0	27.0	34.0
No. with Focus on the Poor	89.5	100.0	14.8	61.8
No. with Indicators Measuring Access by the Poor	26.3	70.6	3.7	44.1

No. = number, TA = technical assistance.
Source: Asian Development Bank loan and TA documents.

[98] In this context, the operation evaluation mission's assessment of good practice relates to the inclusion of clear, targets that can be monitored, not the feasibility of achieving the targets.

c. Strengthening Monitoring and Evaluation, Including Health Management Information System

92. The lack of specific performance or target indicators in monitoring plans could be a reflection of the poor quality of baseline data available in many DMCs. It could also reflect the limited capacity of many DMCs, as well as the associated costs of data collection, management, and analysis. There is a need to strengthen monitoring and evaluation, including the setting up of better HMIS as part of the objectives or components of loans and TA projects. The proportion of loans incorporating capacity building for monitoring and evaluation more than tripled after the Policy was adopted. However, the number of loans providing assistance for improving HMIS showed only a very modest increase of 6.2%. There was no increase in the proportion of TA projects related to HMIS, which remained at about 15%. There was a slight increase in the proportion of TA projects related to strengthening, monitoring, and evaluation. Details are given in Table 5.

Table 5: Loans/TA projects with Plans to Improve Monitoring and Evaluation

	Loans		TA Projects	
Item	**Pre-Policy**	**Post-Policy**	**Pre-Policy**	**Post-Policy**
Total Number	19.0	17.0	27.0	34.0
Strengthening Monitoring and Evaluation (%)	26.3	88.2	29.6	38.2
Improving HMIS (%)	52.6	58.8	14.8	14.7

HMIS = health management information system, TA = technical assistance.
Source: Asian Development Bank loan and TA documents.

2. Improve Quality of Health Sector Loans at Entry

93. If properly used, participatory processes have the potential to improve project quality. Participatory processes were used in the preparations for most health loans, both before and after the Policy. Groups involved included partner agencies, international organizations, government agencies, NGOs, local counterparts, and beneficiaries. Consultative workshops and meetings, field surveys, focus-group discussions, and interviews were the most common form of participation. The design of most TA projects included a plan to organize consultative meetings to review the quality of outputs, obtain inputs from concerned agencies and implementers, and disseminate results. The consultation process often consists of tripartite meetings between ADB, the DMCs, and the contracted party undertaking the TA, including a series of meetings and workshops involving program implementers and beneficiaries. While participatory processes were evident in the design of the most loan and TA documents, few were subjected to a peer process review involving other development partners in health-related work, e.g., WHO, UNICEF, the World Bank, and bilateral agencies. ADB should make greater use of external peer reviews as part of a broader strategy to improve quality at entry of loans and the quality of knowledge-based products.

94. Adequate supervision of loan and TA implementation was emphasized before and after the Policy. Mid-term reviews were part of the overall project monitoring plan. A few of the people surveyed cited the need for more frequent mission visits and reviews. Mechanisms were in place to report project and program status to ADB. Preparation of a procurement plan as a means to ensure achieving more tangible results was also observed. Only the TA project on emergency regional support to SARS explicitly mentioned the need to observe flexibility considering the emergency situation. All TA projects attached specific scope of work and terms of reference of consultancy services to be contracted. Overall, strategy 2 is considered to be highly relevant.

D. Strategy 3: Support the Testing of Innovations and Deployment of New Technologies

95. This strategy focuses on the rigorous testing of new approaches to service delivery and finance, health system management, and organization. Given that there is no single way to finance and organize health services, small-scale pilot schemes need to be rigorously tested before resources are dedicated to large-scale implementation. This supports decision-making based on knowledge and local needs. In addition, strategy 3 helps to finance the deployment of new and emerging technologies.

96. There was a focus on testing innovative health financing schemes before and after approval of the Policy. However, the degree of support has declined over time. There seemed to be a continuous emphasis on innovative program approaches and health management and organization systems. However, little support was provided for rapid deployment of effective and affordable new technologies (such as new vaccines) as recommended in the Policy. Based on this finding, ADB needs to reassess this element of the strategy and consider whether it has a competitive advantage in this area.

1. Health Financing Initiatives

97. ADB supported some DMCs to explore ways of establishing a more sustainable health care delivery system. Pilot testing was conducted for cost recovery, revolving drug funds, and provincial health care subscription schemes in Lao PDR (2000); health care and rural health insurance schemes in Viet Nam (2000); and options for the health facility to increase their income and improve their service delivery in the Federated States of Micronesia (2000). In Tajikistan, the concept of revolving funds was employed and tested on school text books and medicines. ADB is helping Bhutan to test the feasibility of a “telemedicine” program.

98. Alternative financing schemes increased in popularity and initial efforts started to show positive results. However, concerns were raised about their sustainability, because the poor may not be able to pay user fees. If fees are set too high or special mechanisms are not developed for the poor, there is a risk that vulnerable groups will not benefit. In some cases, difficulties were encountered when attempts were made to scale-up approaches tested in pilot areas to cover the general population. Currently, there is growing emphasis on social health insurance.

2. Health Management and Organization

99. A number of loans and TA projects supported testing of health management system approaches and organization innovations prior to wider implementation. Pilot testing of innovative safe motherhood approaches, especially those responsive to the ethnic minorities, was conducted in Viet Nam (2004) and as part of an ECD package of services for different groups of children in the Philippines (1998). In PNG, ADB financed the development of a national disease control program by pilot testing it through operations research. In response to HIV/AIDS, two TA projects were approved during 1999–2004 to help develop a model for designing HIV/AIDS programs and services in PRC and to establish a pilot center for people infected by HIV/AIDS in PNG.

100. In terms of management systems, province-wide health management systems covering integrated health planning, HMIS, Human Resources Department, health accounts, and hospital operations were pilot tested in six provinces in the Philippines. In Indonesia, ADB supported the development and testing of a model for consolidated budgeting. A TA project for Tajikistan

conducted a study to develop and pilot test a drug procurement and distribution system. Cambodia tested the viability of contracting out certain health services (e.g., immunization) to NGOs in remote areas, and Mongolia pilot tested contracting out noncore hospital services to NGOs and tested an innovative small-scale project for community-based social welfare services. Mongolia also introduced the concept of family group practice to shift the focus from hospital-based services to PHC interventions at the field level.

3. Deployment of Effective and Affordable New Technologies (New Vaccines)

101. The Policy states that ADB will support the deployment of new cost-effective technologies, in particular integrating vaccines into national immunization programs and increasing availability of newly developed vaccines once their effectiveness has been demonstrated. However, the SES found little ADB involvement in this area. ADB's support was (i) a health reform program in Bhutan (2000) that supported the Government's plan to study the importance of H. influenza B in the epidemiology of ARI, and ADB's support for the establishment of six indigenous units in district hospitals to provide services to cultural minorities; and (ii) a public–private partnership health study (1996) that helped the Government of Pakistan explore ways of improving the local vaccine production capacity of the public and private sectors.

102. The main concerns about the deployment of new technologies are that (i) testing new technologies requires substantial investment and usually takes time, hence DMCs may opt not to prioritize this in their loans; and (ii) testing requires a large-scale pilot area if it is to be replicated successfully. Strategy 3 is considered highly relevant, particularly with regard to innovative approaches in health management and organization, and health financing. Deployment of effective and affordable new technologies (such as new vaccines) is also relevant. During the study, DMCs stated that they preferred to use TA projects or grants rather than loans to support pilot testing. ADB needs to consider whether it has a competitive advantage in this area. Overall, strategy 3 is relevant.

E. Strategy 4: Encourage Governments to Take an Activist Role in the Health Sector

103. Health expenditures in most DMCs fall below the level needed to provide basic health services to the entire population. Health expenditures are stagnating or even decreasing in larger Asian countries. ADB's advocacy of an activist role in the health sector for governments was expected to result in an increase in the resources available to ensure continuous and equitable access to basic quality health care, particularly by the poor and vulnerable. The proportion of health loans incorporating plans to measure the percentage of the public sector budget spent on health almost doubled from 21.2% pre-Policy to 41.2% post-Policy. ADB should monitor this key indicator more actively. Participation by the private sector, particularly by NGOs in TA projects, was also more evident post-Policy. In addition, support for public goods, particularly the quality of health services through applied research and food fortification, increased since the Policy for TA projects but not for loans. Knowledge-based products are the key instrument that ADB uses to engage in these areas. After the Policy was adopted, ADB placed slightly less emphasis in the area of licensing and regulations (Table 6).

Table 6: Proportion of Loans and TA Projects Incorporating Plans to Implement Strategy 4 (%)

	Loans		TA projects	
Item	**Pre-Policy**	**Post-Policy**	**Pre-Policy**	**Post-Policy**
Indicator Exists: Percentage of Public Budget Spent on Health	21.2	41.2	0.0	2.9
Working with the Private Sector or NGOs	78.9	70.6	40.7	73.5
Funds Budgeted for Applied or Operations Research	57.9	58.8	33.3	58.8
Food Fortification	10.5	0.0	3.7	11.8
Regulations in the Health Sector	57.9	41.2	11.1	17.6

NGOs = nongovernment organizations, TA = technical assistance.
Source: Asian Development Bank loan and TA documents.

1. Public Sector Budget Allotted for Health

104. Protecting and ensuring continuous access to essential health services is important, especially for DMCs affected by the financial crisis and those undergoing political transitions and major institutional changes. This issue was addressed in ADB health loans by incorporating indicators to increase resources for health in the project or program designs in Cambodia, Indonesia, Lao PDR, and Viet Nam.

2. Mobilizing the Private Sector and NGOs in the Health Sector

105. The design of 70–80% of health loans and an increasing proportion of TA projects (nearly three quarters in the pre-Policy environment) incorporated plans to mobilize the private sector and NGOs in the health sector. Examples of NGO involvement can be seen in (i) a Bangladesh urban PHC project; (ii) a project in Cambodia, where the services of NGOs were contracted to provide such PHC services as immunization; (iii) a project to provide preventive services for groups vulnerable to HIV/AIDS in the PRC; (iv) a pilot HIV/AIDS care center in PNG; (v) a project that contracted NGOs to develop a sustainable community-based health care system in Pakistan; (vi) support for street children and trafficked, migrant, and working children in Nepal; and (vii) training of commune-level health workers and assistance in organizing behavioral change campaigns in Viet Nam.

106. ADB's emphasis on mobilizing the private sector for health care delivery is reflected in the approval of two loans,[99] totaling $40.0 million, to finance private medical facilities. However, these loans were processed without involving health specialists in the concerned DMCs, emphasizing the need for better coordination between public and private sectors. Other examples include (i) TA projects in Pakistan that explored strategic options for potential private–public partnership in the local production of vaccines (1996), and to further study issues related to the growth of the private sector in the health sector (2003); (ii) participation by the private

[99] ADB. 2001. *Report and Recommendation of the President to the Board of Directors on Proposed Loan to the Socialist Republic of Viet Nam for the Far East Medical Viet Nam Ltd. Project*. Manila (Loan 7173/7174-VIE, for $10.0 million, approved 13 November 2001); and ADB. 2002. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the India for the Medical Service Network Project*. Manila (Loan 7182-IND, for $20.0 million, approved 17 December 2002).

sector in a food fortification initiative to eliminate malnutrition in Asia; and (iii) partnering with the commercial sector in the production of vaccines.

107. Concerns about public–private partnerships for health include (i) determining the right mix of public–private services to respond to the needs of the population while maintaining a balanced support for both sectors; (ii) the absence of, or a weak, regulatory system to ensure and monitor the quality of services delivered by the private sector; (iii) the tendency of private providers to respond to financial incentives even if this conflicts with the quality of care; (iv) the possibility of increased competition between public and private sectors for limited resources, such as personnel, which may lead to further deterioration of the PHC system as service providers leave the public sector for the private sector; and (v) emphasis on personal and hospital care rather than preventive services. As part of the broader tsunami relief effort, several major pharmaceutical companies made major donations. On balance, the OEM concluded that ADB should continue to support initiatives in the private sector, and explore possibilities for partnerships with major pharmaceutical companies to provide HNP services that can demonstrate development impact.

3. Support for Public Goods

108. Advocacy and support for operations research is common in both loans and TA projects. Areas covered included testing health financing options and evaluating the effectiveness of intervention approaches and the efficiency of management systems. Examples of research on health financing options include (i) testing of cost recovery for hospital services, revolving drug funds for health centers, and a provincial health subscription system in Lao PDR; (ii) studies to establish a sustainable level of premiums for health cards and benefit packages in Viet Nam; and (iii) studies in Indonesia to assess performance monitoring and evaluation, health service organization, human resource management, impact of decentralization, HMIS, and development of information networks. However, there are major constraints on DMCs undertaking operations research, including the high cost involved and the length of time for implementation. It is sometimes difficult to synchronize completion within the life of projects. There is always a possibility that applications may not be realized within the given period.

109. Food fortification is an integral part of the overall strategy to improve health by eliminating micronutrient deficiency. Various stakeholders in the government (national and local), the private sector, NGOs, and civil society have effectively partnered together to help eliminate micronutrient deficiency. Implementing food fortification needs intersectoral collaboration and involvement of the private sector. Of the 46 loans and 49 TA projects since the Policy, only six suggested food fortification. The first was a loan to the Philippines that included support for monitoring and assessing the acceptability and accessibility of salt iodization, the development of cost-effective means of fortifying common foods with iron, and the pilot testing of a food fortification program in selected provinces (1994). A second loan incorporated support for phasing out direct supplementation with intensive promotion for phasing-in comprehensive, industry-financed fortification of such staples as rice, sugar, flour, oil, and salt (1998). ADB funded a region-wide study on nutrition trends, policies, and strategies that covered food fortification (1999). A TA project for Asian countries in transition to help improve the nutrition of mothers and children included food fortification (1998). Another TA project explored strategies for establishing public–private partnerships to eliminate micronutrient deficiency in Asia through food fortification (2003).

110. This strategy is in line with the LTSF goal for ADB to play a “catalytic” and leadership role in advocating higher funding for health, among other sectors. Increased public funding to health

is extremely important in light of very low levels of health spending in the region, and the demonstrated vulnerability of the health sector to external shocks during times of economic crisis. There is interest in promoting insurance schemes in the region to generate funds for health, with pilot projects underway in the PRC, Indonesia, and Philippines, among others. The Policy emphasizes caution in promoting both social health insurance and user fees, however, noting practical difficulties in implementation. This strategy promotes greater cooperation with the private sector and NGOs, particularly in addressing the health needs of marginalized groups out of the health system's reach. An emphasis on regulatory functions is appropriate, given that many DMCs are reexamining the roles and functions of government and the private sector in health. Malnutrition, tobacco consumption, and road accidents remain primary contributors to excessive morbidity and mortality among adults. Research into emerging diseases is also appropriate, given the possible reemergence of SARS and the threat of pandemic influenza.

111. Although the Policy indicates that ADB will actively encourage DMC governments to implement regulations aimed at controlling tobacco consumption, and to raise taxes on tobacco, efforts to implement this were not identified during the SES. This is unfortunate, given the costs to both society and individuals of health problems related to smoking. In fact, support for health regulations decreased slightly after the Policy was approved. Assistance on regulations was related to food fortification, licensing and accreditation of hospitals, quality assurance for food safety, drug and medical supply formularies for hospitals and dispensaries, the inclusion of treatment for adult diseases in social insurance coverage, regulatory reforms to remove impediments to accessing safe motherhood facilities, licensing of pharmacies, and enforcement by monitoring and training—including developing the capacities of ministries of health to improve the performance of their regulatory functions. Overall, strategy 4 remains relevant.

F. Strategy 5: Increase Efficiency of Health Sector Investments

112. Some DMCs that obtained loans from ADB during 1994–2004 provided the OEM with documentation covering lessons learned from implementation of project or program loans. The most commonly-identified constraints to timely and effective implementation of their projects were (i) lack of professional and management skills of national, subnational, and local staff to coordinate, manage, and implement the project; (ii) centralized project management structures at the national level that were too far from implementing units in the field; (iii) complicated financial management systems; (iv) generally weak and delayed staffing of project coordinating units; (v) ambiguous demarcations of roles and responsibilities of those involved; and (vi) the lack of donor agency coordination and involvement of community leaders. These findings make strategy 5 highly relevant.

1. Improving Managerial Capacity

113. The review revealed that support for capacity building was incorporated into most loans and TA projects, with a substantial increase since the adoption of the Policy (Table 7). Capacity building is included in virtually all loans and TA projects. Although more diagnostic work is now being undertaken, there is room for further improvement. Institutional analysis in designing capacity-building approaches was also observed. The capacity-building efforts comprised a long list of different schemes and approaches, with varying degrees of clarity and emphasis. They included awareness-raising and skills development of key management staff, service providers, and communities; upgrading of health facilities with equipment and supplies; installing management support systems; organizational reviews; restructuring and mainstreaming; streamlining documentation; improving maintenance; and improving the flow of information and reports. Producing protocol manuals and guidelines, establishing financial management and

budget preparation systems, and human resource management were also seen as critical for project implementers and managers. Training, seminars, observation tours, meetings, and field visits were all used to build capacity. Local and external assistance to support implementation was also indicated. Institutional capacity assessment mechanisms included conduct of facility surveys, reviews, training needs assessments, and policy and guideline reviews.

Table 7: Loans and TA projects Incorporating Plans for Capacity Building

	Loans		TA projects	
Item	**Pre-Policy**	**Post-Policy**	**Pre-Policy**	**Post-Policy**
Total Number	19.0	17.0	27.0	34.0
Component on Capacity Building (%)	100.0	100.0	77.8	97.1
Institutional Analysis before Activity (%)	42.1	76.5	25.9	50.0

TA = technical assistance.
Source: Asian Development Bank loan and TA documents.

2. Strengthening Economic and Sector Work

114. Among other matters, increasing the efficiency of health sector investments requires more economic and sector analysis. The Policy recommends that to improve ADB's economic and sector work in the health sector, the critical links between the sector and ADB's medium-term strategic objectives should be ensured. This means (i) ensuring that CSPs properly reflect links between the health sector and economic growth, poverty, and improving the status of women; (ii) undertaking more frequent health sector reviews; (iii) giving greater attention to economic analysis of health projects; and (iv) developing a handbook for the economic analysis of health sector projects. Regional and country health sector reviews were commissioned, covering nutrition, population, and other social sectors. There has been more economic analysis included in health-related projects since the Policy. Environmental analysis and social impact analysis—including poverty, gender, and other social dimensions—have also been included in health operations. This suggests an increasing understanding of the critical links between the health sector and other strategic priorities.

115. A handbook on the economic analysis of health sector projects was published in August 2000. All HNP projects approved since 2001 included cost-benefit and/or economic sustainability analysis, and most of these projects included calculation of the economic internal rate of return, as shown in Table 8. In addition, two policy briefs related to health were produced by the ERD in 2005 (footnotes 4 and 21). The SES of selected ADB interventions on nutrition and food fortification reviewed 33 CSPUs and found that most mentioned the links between nutrition, poverty, and/or the status of women.

Table 8: Inclusion of EIRR, Cost-benefit, and/or Economic Sustainability Analysis

Project	EIRR (%)	Includes Section/Chapter on Cost Benefit/ Economic Sustainability Analysis
1900-PAK: Reproductive Health	—	+
1940-CAM: Health Sector Support	27.0	+
1998-MON: Second Health Sector Development	24.4	+
2007-KGZ: Community-Based Early Childhood Development	33.9	+
2054-TAJ: Health Sector Reform	24.1	+
2074/2075-INO: Second Decentralized Health Services	37.0	+
2076-VIE: Health Care in the Central Highlands	—	+
2090-UZB: Woman and Child Health Development	—	+
2136/2137-PHI: Health Sector Development	28.0	+

— = not available, + = yes, CAM = Cambodia, EIRR = economic internal rate of return, INO = Indonesia, KGZ = Kyrgyz Republic, MON = Mongolia, PHI = Philippines, TAJ = Tajikistan, UZB = Uzbekistan, VIE = Viet Nam.
Source: Asian Development Bank loan documents.

3. Strengthening Intersectoral Linkages

116. Well-designed health strategies recognize that many factors affect health. Population, nutrition, social welfare, education, and environment all have an impact on the health status of the population, especially the poor and other vulnerable groups. In addition to specific health interventions, a substantial number of ADB loans and TA projects cover health-related issues. An example was the integration of HIV/AIDS issues into the Western Yunnan Road Project in the PRC. This project was located in one of the provinces in the PRC with the highest incidence of HIV/AIDS. Environmental links were reflected in two projects in PNG on water supply and low-cost sanitation. Links with the education sector highlight the importance of addressing not only the health needs of the children but also their psychosocial development. However, the proportion of loans and TA projects that linked with nonhealth sectors decreased in the post-Policy period.

117. An assessment was done to determine whether nonhealth sector loans incorporated health indicators in their monitoring plans, signifying that health-related concerns had been considered in the design of these projects (Table 9). The documents for 20% of the total nonhealth loans in each sector were reviewed. The review found that the social infrastructure loans most frequently specified at least one health indicator (55%) and at least one MDG health indicator (50%); followed by multisector loans, of which 42.8% had at least one health indicator; and agriculture and natural resources loans, of which 13.3% had MDG health indicators. Health indicators in the nonhealth loans, particularly in the agriculture and natural resources sector, included access of the population to safe drinking water and improved sewerage and sanitation. Targets to reduce traffic accidents and injuries, thereby contributing to improving health, were included in the design of many road projects. Social sector projects targeted a reduction in illnesses due to water-borne diseases and infections. Some multisectoral loans cited improvement to health facilities, training of traditional birth attendants, mobilization and training of health professionals, and participation in insurance for occupational injury and illnesses. Health-related MDG indicators were limited mainly to the proportion of the population with access to improved sanitation. Although ADB's direct lending for health projects was much lower than desirable given ADB's strategic objective of poverty reduction and ADB's corporate

commitment to the MDGs, it is clear from this analysis that some of ADB's nonhealth projects also contribute, sometimes indirectly, to improved health. However, this indirect impact is likely to be modest.

Table 9: Proportion of Nonhealth Sector Loans with Health Indicators 1999–2004 (Post-Policy)

Sector	Number of Sampled Projects	Percentage With at Least One Health Indicator	Percent With at Least One MDG Health Indicator
Multisector	7	42.8	0.0
Agriculture, Natural Resources	15	33.3	13.3
Social Infrastructure	20	55.0	50.0
Transportation, Communication	13	29.0	0.0
Energy	8	25.0	0.0
Finance	8	0.0	0.0
Industry	2	0.0	0.0
Others	6	50.0	0.0

MDG = Millennium Development Goal.
Source: Asian Development Bank loan and technical assistance documents.

4. Collaboration with Partner Institutions

118. In the Policy, ADB reiterated the need to strengthen its collaboration with bilateral and multilateral partner institutions and to maintain close coordination with, and use the expertise of, UN agencies, particularly WHO and UNICEF. As shown in Table 10, there was an increase in collaborative efforts with partner agencies after the Policy was adopted, although the level is still too low. More effort is needed, particularly for technical peer reviews in designing and implementing loans and TA projects. Projects on nutrition and food fortification support and the outbreak of SARS, among others, have demonstrated such collaboration, which needs to be further encouraged. ADB needs to take a broader view—there will continue to be constraints on the growth of ADB staffing, so innovative ways of drawing on the technical strengths of partner agencies will be needed.

Table 10: Collaboration with Partner Institutions

Item	Loans		TA projects	
	Pre-Policy	Post-Policy	Pre-Policy	Post-Policy
Total Number	19.0	17.0	27.0	34.0
Cofinancing with Bilateral Donors (%)	21.1	11.8	0.0	8.8
Cofinancing with Multilateral Donors (%)	15.8	17.6	7.4	17.6
Collaboration with the UN (%)	15.8	23.5	11.1	20.6

TA = technical assistance, UN = United Nations.
Source: Asian Development Bank loan and TA documents.

G. Overall Ratings of Health, Nutrition, and Population Projects and Lessons Identified

119. **Overall Ratings.** The SES reviewed the PCRs and PPARs of all HNP loans starting from the first loan in 1978. None of the first 11 PCRs of HNP loans—approved between 1978 and 1984—included overall ratings of the projects. However, out of these 11 loans, 10 had PPARs, which rated 3 of them as successful (30%) and 7 (70%) as partly successful. Overall project

ratings were provided in PCRs of HNP loans approved from 1985 onwards. Out of these loans (as of May 2005), 31 have been completed and 23 have completed their PCRs with the following ratings: 18 successful (78.3%), 4 partly successful (17.4%), and 1 unsuccessful (4.3%). There were 9 PPARs out of these 23 PCRs, which rated 7 loans as successful (77.8%) and 2 loans as partly successful (22.2%). The review indicates that HNP loans have substantially improved, and 78% of the HNP loans approved after 1985 have been evaluated both by the PCRs and PPARs as successful. See Appendix 13 for a detailed list of HNP loans, the status of these loans, and the PCR and PPAR ratings.

120. **Lessons.** Major lessons noted in PCRs of health-related projects approved since 1994 are described below:

(i) A project developed around a clear concept, with the right mix of infrastructure strengthening, capacity building, and health system reforms, can quickly generate benefits in terms of improved coverage and quality of services. Benefits will be significant if the project focuses on essential services (PHC services, including the district referral hospital) and targets the population groups at highest risk.

(ii) Frequent supervision and monitoring should be conducted at all levels of project implementation (central, provincial, and district) to improve project quality. Effective project monitoring and evaluation require that a simple system (e.g., a simple set of indicators and guidelines for data collection) be designed at the time of appraisal, and made operational at the beginning of a project. The project-related monitoring system must be integrated into the existing HMIS, and benchmark data must be collected at the beginning of a project.

(iii) National policy on development of health facilities is essential to achieve optimal coverage of health services.

(iv) External aid agencies are often in too much of a hurry to press governments to agree on policy conditions consistent with their own views and priorities, allowing too little time for the necessary political process. Also, pressures to include their own favorite topics often result in overly ambitious plans that do not reflect local needs in improving health outcomes.

(v) For social sector projects in the Pacific region, a 5-year implementation period is too short, particularly for the achievement of performance targets. An implementation period of 6–8 years appears more realistic.

(vi) One of the principal lessons from sector development loans is that it is possible for ADB and the government to develop an effective large-scale emergency package in a timely manner. However, strong leadership and support from government, good aid coordination, and simple and well-defined objectives are necessary.

(vii) Preparation of a complex and large-scale project, particularly in the context of devolution of health services and associated institutional reforms, should entail more in-depth analysis than at present of the potential risks affecting implementation.

(viii) Decentralization of health service management to provincial levels is crucial to enable management and supervisory systems at district levels.

(ix) A project management office anchored in an appropriate organic unit of the executing agency is more effective than a stand-alone structure, and project designs should envisage possible adjustments to emerging needs, making projects more relevant, efficient, and effective.

V. FINDINGS

A. Strengths, Weaknesses, and Opportunities

121. The Policy had a generally positive and measurable impact on changing the way that ADB operates in the health sector. Its strengths include its focus on poverty and disadvantaged groups, promotion of more rigorous monitoring and evaluation, identification of the need to improve the quality of loans at entry and implementation, promotion of participatory approaches, emphasis on coordinating with other development partners, and its stress on the need for ADB to play a catalytic and advocacy role in helping DMCs address the health dimensions of poverty. This focus is in harmony with ADB's poverty reduction strategy, the LTSF, ADF IX, and the MDGs, which reinforce performance benchmarks, systematic evaluation, and the use of feedback to improve and enhance the effectiveness of interventions.

122. After the Policy was adopted there was an increase in the number of loans using explicit health outcome indicators. This approach coincided with ADB's move to managing for development results and the LTSF's call for stronger monitoring and evaluation. In many cases, the indicators used were consistent with ADB's adoption of poverty as its overarching objective and the corporate decision to support the MDGs. Some interventions discouraged in the Policy were evident in post-Policy loans, such as support for hospital renovation and construction, mostly at district level. However, reviews show that support for such renovation and construction was justified because these district hospitals were providing PHC services, and this approach helped in the effort to reduce MMR and IMR in decentralized systems. In addition, during the OEMs for the SES and other OEMs related to HNP, DMCs said that support for equipment and infrastructure for HNP is needed, particularly within decentralized health systems. ADB should not, as a matter of policy, rule out support for such investments. Rather ADB should work with the DMCs to determine overall priorities for the development of the health sector and then provide support in the areas where the DMCs believe that ADB has a competitive advantage. In some cases, this may mean that ADB finances health infrastructure and equipment.

123. All loans incorporated a capacity-building component, and the proportion that used institutional analysis increased substantially after the adoption of the Policy. However, few components included impact indicators for coverage or quality of care, and no loans employed household or client data to measure success or ask the beneficiaries if they had to pay bribes or make unofficial payments to gain access to, or improve the quality of health care services. It appears that the result of capacity development was evaluated based on completion of training activities rather than the resulting impact on health system goals.

124. The Policy sets forth a set of actions to assist in its implementation. Broadly, it identifies the need to explore different financing mechanisms, including financing international public goods in health; flexible use of lending methods; and promotion of sustainable capital investment and funding for recurrent costs. The regional TAs covering SARS, avian influenza, and other

communicable diseases, as well as on nutrition and food fortification, were clear examples of promoting international public goods in health with the support of WHO and UNICEF, as well as collaborating with the private sector and civil society organizations in strengthening the regional response. However, substantial administrative and transaction costs were encountered and legal issues dissuaded staff from exploring different financing methods. The SES of selected ADB interventions on nutrition and food fortification recommended that ADB explore the possibility of hybrid TA projects that could finance small investments, currently provided by JFPR, as well as knowledge-based products. This would enhance the effectiveness and sustainability of TA projects. It would also make best use of ADF IX grants for HNP interventions. ADB needs to develop strategies for the ADF IX grants that are consistent with ADB's overarching strategy of poverty reduction.

125. There are several other strategies that ADB should consider in mobilizing concessional funds for the health sector: (i) mobilize greater cofinancing with bilateral donors or blending the concessional funds of bilateral donors with OCR funds for MICs for health sector operations; (ii) become more actively involved in the international discussion on developing innovative financing modalities for the MDGs; (iii) work out its strategic focus in the health sector within the poverty reduction strategy framework and in harmony with development partners; (iv) develop innovative partnerships with the private sector and civil society; (v) consider whether a proposal should be developed to argue for a change in ADF eligibility from country- to sector-based considerations; and (vi) explore modified (hybrid) TA modality (para. 54).

126. ADB should consider its broad strategic options in the health sector, for example whether to (i) increase support by adding new products, as discussed above; (ii) focus on impact with modest lending by addressing ADB's comparative advantages in health, and making greater use of ADB's strategic policy dialogue with ministries of finance; or (iii) in some DMCs give consideration to the need for continued involvement. With the dismal situation of HNP-related indicators for the MDGs in many DMCs, ADB's role and commitment as a regional development bank to help DMCs achieve the MDGs, and the presence of the majority of the world's poor in the region, this third option would limit ADB's ability to support these DMCs in achieving the MDGs.

127. The Policy does not provide a strategic direction or imply a unique role for ADB among other organizations. Although it has been recognized that donor coordination is central to ADB's work in countries and regionally, such coordination may be affected by the lack of country-based staff knowledgeable in the health sector. The importance of frequent coordination and communication across the donor community as well as the need to remain informed should be emphasized, given ADB's limited organizational presence in global, regional, and in-country health dialogues. ADB needs to be more active in developing partnerships in the health sector. Improving coordination and strengthening alliances across the donor community is part of ADB's in-country work.

128. ADB's supervision during project implementation was often inadequate. Insufficient emphasis on monitoring and evaluation during implementation prevents full appreciation of a project's impact, sharing of lessons learned, and identifying improvements in the project design or taking action to resolve problems. Although the government is responsible for implementation, good supervision of loans by ADB improves the impact of health operations and ADB's credibility in the sector.

129. The Policy missed an opportunity to address issues related to governance and corruption in the health sector. It did not provide strategies for good governance or for preventing

corruption. ADB should encourage available client surveys to track corruption in its HNP operations and make more use of information that is available regarding governance and corruption issues in the health sector. ADB has not taken steps to mitigate the potential risk that corruption may limit the development impact of its operations in this sector and discourage the poor from benefiting from ADB's projects.

130. There is an absence of a clear institutional direction articulating what ADB hopes to achieve in the health sector. Consequently, in practice, ADB's agenda is mostly driven by individual staff strengths and initiatives. These individual efforts do not necessarily work toward the achievement of a shared goal. Moreover, ensuring the quality of loans and TA during project design and implementation sometimes require access to TA external to ADB, given ADB's limited number of health specialists. To address this, and recognizing limits to staff size, ADB should make greater use of technical peer review, and whenever possible, involve external experts or establish a formal technical relationship with specialized health agencies.

131. Some major OCR countries do not believe that ADB has the right financing products to be involved in the health sector. ADF is not available to the PRC and India, both of which contribute substantially to the global health burden because of their population sizes. Health sector loans rely heavily on ADF financing. There are relatively few OCR-financed health projects. During the OEM interviews in MICs, such as Indonesia and Philippines, policymakers expressed their reluctance to borrow OCR for future health projects, especially when infrastructure and equipment support are discouraged. Most large OCR loans in health were program loans. This is despite the fact that the London Interbank offered rate declined sharply after the Policy was adopted. The offered rate was 5.07% in 1999, and has averaged 3.06% since 2000. This compares with a 1–1.5% ADF service charge. Despite the low OCR rate, most DMCs are unwilling to borrow OCR resources for health and other social sector projects, partly because of the risk that rates will increase over the medium term. Moreover, some governments have explicit or implicit policies against borrowing nonconcessional loans for health and other nonrevenue-generating sectors. In DMCs nearing or having reached middle-income status, limitations on external grant resources narrow the scope for softening lending terms via cofinancing. Unless ADB can develop financial products that respond to the needs of its major clients, it will continue to play a marginal role in the health sector in many OCR borrowing countries.

132. Some large health loans experienced constraints and delays, which were not only costly but also limited the achievement of programmatic goals. Some of these delays were related to government decision-making processes. Others, however, could have been minimized with sound technical and participatory project preparation, timely restructuring of projects when major obstacles occur, greater participation of the resident mission in logistical oversight, better supervision, and accessing appropriate local expertise.

133. Few health projects are delegated to resident missions, other than at the end of a project's life. This reflects the lack of qualified health sector staff in resident missions, which weakens the supervision of the health portfolio. Adequate ADB supervision of loans is a serious issue because lack of supervision can prevent attainment of development results from health loans and lower ADB's credibility in the sector.

134. Most bilateral agencies and specialized agencies active in the health field focus their policy dialogue on ministries of health and have limited access to the economic management ministries. In addition to having access to ministries of health, ADB holds regular dialogue with ministries of finance and other nonhealth economic ministries on a wide range of issues. Thus,

ADB is in a position to advance the agenda of the Commission on Macroeconomics and Health and to ensure that health and social sectors are prioritized within government development agendas. A good example is the ADF allocation to Bangladesh, which is now based on, among other factors, an increased allocation of the public budget to social sectors, including health and education. Stakeholders emphasized that ADB had an important role to play in emphasizing the importance of health with the ministry of finance, the ministry of economic affairs, planning commissions, and other nonhealth ministries. ADB has not fully capitalized on this competitive advantage.

135. Many DMCs are facing the negative impact on health due to urbanization. Urban health care is a complex issue that also relates to institutions beyond the Ministry of Health, and includes the community, civil society organizations, and the private sector. ADB has a comparative advantage to deal with this type of approach, as demonstrated by the Urban Primary Health Care project in Bangladesh (footnote 83).

B. Incorporating Millennium Development Goals

136. The MDGs were formally adopted by the UN General Assembly, ADB, and other development partners in 2002, 3 years after the Policy was approved. However, they are consistent with the intent and direction of the Policy. The OEM found that if progress continues at the current rate, most countries in the Asia and Pacific region will not achieve the health-related MDGs. This should be a matter of concern to both DMCs and the donor community. ADB had made consistent efforts to design its health portfolio to support achievement of the MDGs and to monitor progress towards the health-related MDGs in DMCs.

137. The under-5 mortality rate was included as an outcome indicator in the majority of post-Policy loans. Over half of these loans included ARI management and promotion of ORT, thus addressing two important causes of child mortality. The indicator used to measure progress toward this goal is the proportion of children less than 1-year of age immunized against measles. An immunization indicator and activities were specified in three quarters of recent ADB loans. Thus, many ADB operations in the health sector will contribute to reductions in IMR.

138. It is difficult to assess the extent to which ADB projects have contributed to achieving the health-related MDGs. There are several problems: (i) many projects are new and have not been completed; (ii) it is difficult to measure accurately the health outcomes and health impact of short-term interventions; and (iii) it is not always possible to separate out the impact of the many determinants of health. There are also analytical difficulties associated with attributing the extent to which health system changes contribute to health outcome indicators, particularly given the dominance of domestic funding in most DMCs, the presence of many other externally-financed projects and the influence of other sectors (e.g., water and sanitation, education). However, it is clear that successfully implemented post-Policy loans and TA projects should contribute toward achieving the MDGs for underweight children, IMR, and HIV/AIDS.

139. The UN reported no change in global progress toward the MMRs. It noted an increase in the MMR in Asia as a whole, particularly in South Central Asia. All CSPs and CSPUs reviewed by the OEM included MMR in their assessment of MDG progress. MMR was also used as an indicator in most recent loans. Referral hospital renovation or construction and medical specialist training included in post-Policy loans could support the goal of reducing maternal mortality by increasing access to emergency obstetric services. Skilled presence at delivery as part of universal basic services was also specified in some loans.

C. Comparative Advantage in the Health Sector

140. In examining ADB's performance and future directions in the health sector, it is important to assess the organization's strengths and weaknesses. One of ADB's most important strengths is its regional presence. ADB is in a position to support regional initiatives for public goods (e.g., cross-border disease surveillance).

141. Unlike many other donors active in the health sector, ADB and the World Bank maintain a dialogue with ministries of finance and other economic ministries. In theory, ADB can use this to leverage support and financing for HNP within the government's own development agenda. ADB also has the capacity to address institutional change in the sector through its HNP operations. This is particularly important in countries that are adopting major reforms as part of decentralization strategies. Experience has shown that large-scale decentralization is often difficult to implement and requires capacity building, setting up systems at all levels to address structural constraints, and incentives. In a number of DMCs, basic planning, management, and financing of public health do not provide appropriate incentives for the sector to perform efficiently and effectively.

142. ADB is in a good position to undertake broad-based policy dialogue when supporting development of 5-year plans and fiscal reviews, or including health perspectives when undertaking macroeconomic work to encourage governments to prioritize health and social sectors. Stakeholders contacted by OEM emphasized the relevance of broad health policy advocacy, and stressed that ADB had an important role in bringing the significance of health as a cross-cutting issue to the attention of such powerful ministries as finance, economic affairs, and planning. To date, ADB has not fully used this opportunity.

143. ADB has shown timeliness and flexibility in answering the HNP needs of its DMCs. During the Asian financial crisis and the implementation of decentralization by DMCs, ADB responded rapidly, sometimes by using a "damage control" approach that aimed at protecting access to essential health services for poor and vulnerable groups. During the SES interviews, DMCs expressed their appreciation to ADB for being client-oriented, and for prioritizing local conditions in its assistance to the HNP sector. With other development partners, ADB played a role in HNP during the SARS and other new emerging communicable diseases outbreaks, and in response to the tsunami disaster.

144. Poorly functioning health systems contribute to poverty across the region. Improving health as a means of poverty reduction and achieving the MDGs are organizational priorities for ADB and should provide a basis for strong technical collaboration with DMCs and other agencies. However, ADB has not adequately demonstrated that improving health is a priority in its operations. ADB can help to address issues in other ministries of importance to HNP (e.g., road safety, tobacco control, food fortification, environment, and occupational health). ADB is uniquely placed to support collaboration with the private sector toward development goals, given that it has both public and private operations within the same institution.

145. ADB is well placed to support urban PHC, which has become, and continues to become, more prominent due to increased urbanization in the DMCs.

VI. CONCLUSIONS

A. Relevance

146. The SES concludes that the basic principles of the Policy remain relevant. This is based on the overall assessments of Strategy 1 as relevant, Strategy 2 as highly relevant, Strategy 3 as relevant, Strategy 4 as relevant, and Strategy 5 as highly relevant.

147. The Policy's strength is its focus on poverty and disadvantaged groups, which is in harmony with ADB's poverty reduction strategy and the LTSF. There is a broad consensus that achieving health goals as a means of reducing poverty within a fixed timeframe represents a basis for collaboration with other multilateral and bilateral donors, UN agencies, DMCs, and parts of the private sector and civil society. There is a greater commitment to the control of TB, malaria, vaccine-preventable diseases, and HIV/AIDS. Commitments made under ADF VII reaffirmed the Policy's priorities. Promoting rigorous evaluation is in line with the LTSF and ADB's approach to managing for development results, which reinforces performance benchmarks, systematic evaluation, and use of the feedback. The Policy corresponds to global efforts to improve aid effectiveness and improve public service delivery, finance, management, and organization.

B. Adherence and Implementation

148. ADB has generally adhered to and implemented the Policy's strategic priorities and incorporated its priorities into its post-Policy health-related operations, as shown in the assessments of HNP operations by comparing those that were approved 5 years before and 5 years after the Policy was adopted. In general, increases were demonstrated under all five priority strategies. Hence, ADB's adherence to and implementation of the Policy are considered satisfactory.

C. Impact of the Policy

149. The Policy had a positive impact in changing the way ADB operates in the health sector. Important positive trends included a large increase in the number of loans using specific health-outcome indicators, the incorporation of cost-benefit and/or economic sustainability analysis in all projects approved since 2001, and the inclusion of economic internal rate of return calculations in most of these projects (Table 8).

150. The Policy stresses the need to improve the quality of loans at entry and during their implementation, which will lead to technically sound health activities, implementation oversight, and participatory design and approaches in line with ADB's overall goal to promote good governance. The Policy's emphasis on coordination with other donors is in line with the LTSF, the Paris declaration on aid effectiveness—in particular the need for ADB to play a "catalytic" role, seeking strategic alliances, promoting advocacy and dialogue on social sector priorities, and working more broadly with a range of development partners. Despite this, the Policy did not result in changes that led to a substantial increase in health lending. Many clients do not wish to borrow OCR from ADB for the health sector and the sector remains a small and declining proportion of ADB's operations. Many DMCs do not view the health sector as one of ADB's competitive strengths. This issue reflects broader ADB policies, strategies, and products than can be addressed in a single sector policy study.

D. Issues to be Considered in Revising Asian Development Bank's Health Policy

151. The SES supports ADB's plan to update the Policy and make it a strategy that encompasses HNP and other related social sectors. The Strategy, to be completed by 2006, should draw on the findings of this SES.

152. Adopting separate policies for HNP would be likely to result in some confusion, conflicting objectives, and goal congestion. Moreover, health operations generally cover nutrition and population issues, which are usually covered by the same agency in most DMCs. A strategy would be a more flexible way of responding to country demands for HNP operations, and emphasize implementation and interpretation. The 1999 policy for the health sector promotes similar principles and strategies to those in the 1994 population policy. The SES of selected ADB interventions on nutrition and food fortification concluded that a separate ADB policy for nutrition was not required. Rather, the lessons, findings, outputs, and recommendations of ADB's nutrition-related operations should be used as inputs for the nutrition section in the Strategy. Relevant strategies of the population policy, lessons derived from ADB population-related operations, and updated population issues—including urbanization and migration—should be a part of the population section of the Strategy. Cross-cutting issues, such as water and sanitation, environmental and occupational health, and emerging communicable diseases should also be included. The Strategy must be based on full consultation with DMCs to ensure that it takes into account the regional and country priorities and needs.

153. The decision on what ADB wishes to achieve in HNP will influence the levels and types of technical expertise and staffing, how the Strategy will be implemented, and costs and savings in implementing it. These need to be analyzed in the Strategy. The Strategy should clearly set out the staffing and cost requirements of different options. Unfunded mandates and differences between aspirations and commitments to staffing raise false expectations and can affect portfolio quality and development impact. The strategic options for ADB's HNP panel to consider in preparing the Strategy are outlined below.

154. ADB, with the guidance of the HNP panel/committee, should develop short- and medium-term implementation strategies. The vision, purpose, and objectives should be clearly set out in the Strategy. They should be in accordance with the regional burden of disease, the needs articulated by DMCs, ADB's organizational strengths, the results of the ADF IX negotiations, the LTSF, the Paris declaration on aid effectiveness, the availability of such trust funds as the water and HIV/AIDS funds, other sources of external aid, and other ways of mobilizing concessional funds for HNP. The Strategy should address public goods with cross-border health significance and mobilize private sector resources as well.

155. In preparing the Strategy, the HNP panel should include both internal and external experts. External experts could consist of international, regional, and in-country academics, and HNP program implementers, specialized technical agencies, and representatives of civil society experienced in HNP delivery services. ADB should conduct a technical peer review process for loans and TA projects in HNP by nominating specialists to the project team. In the field, peer review by specialized UN agencies, other organizations, and/or civil society working in the HNP sector of, for example, HNP sector-wide approach programs and health-related disaster mitigation initiatives, will help to ensure that new products fit within a broader sectoral framework and maximize stakeholder input.

156. ADB should develop a niche as a high-profile advocate of the importance of increasing investment in the health sector. It should undertake sound economic research to provide a basis

for encouraging DMCs to place a higher priority on the health sector. An institutional commitment that extends far beyond ADB's health professionals is necessary for ADB to play this role. Major inputs from the country economists, ERD, the ADB Institute, and resident missions will be needed.

157. ADB should continue using its strength as a regional organization to address public health infrastructure, particularly on issues of cross-border significance. Communicable disease surveillance is one example. ADB's work during the SARS and avian flu events was appreciated and could serve as a model. Systematically addressing disease surveillance would require ADB to continue strengthening its relationships with UN agencies—particularly WHO—and other specialized agencies, and to promote compatible systems at the country level. ADB should build on its solid track record and continue playing the role of a catalyst in nutrition and food fortification development efforts in the region.

158. ADB could promote PHC by building on its strengths and supporting "upstream" approaches that emphasize structural changes for good governance and incentives for governments to take on the health functions of a modern bureaucracy. For example, governments need to establish sustainable channeling mechanisms for funds and human resource deployment to deliver a basic service package. This would entail much-needed institutional capacity to establish variable indicators, manage the process, and conduct mid-term corrections if necessary. To be successful, good governance is essential.

159. Within the context of ADB's overall initiative of fighting corruption and improving governance in each DMC, strategies for good governance and for preventing corruption in the HNP sector should be identified in the Strategy. The coverage of these issues in the Strategy may contribute to ADB's effort to address governance and corruption in its health sector operations.

160. Health should be considered a cross-cutting priority and ADB should look for ways to integrate health considerations into the nonhealth sector. More coordination within ADB is needed to integrate HIV/AIDS, other communicable and noncommunicable diseases, environmental health, occupational health, and water and sanitation into support for this larger "sector." To be effective, this cannot rely solely on individual initiatives. Staff will need to be appropriately recognized and rewarded for providing input and adding value to nonhealth sector loans. Care must be taken to ensure that such initiatives do not overly complicate project design or unduly raise transaction costs, from a DMC perspective, of doing business with ADB.

161. The Policy discouraged ADB from supporting investments in infrastructure and equipment in the health sector. This restriction should be removed in the Strategy. While policy reform, capacity building, PHC services, and rural health care are all important, so is health infrastructure, such as equipment and hospitals, particularly within the decentralized health system. The Strategy should allow for a full range of interventions. The priority for ADB's interventions would be determined by sound diagnostics and the priorities of the DMC.

162. Staffing types, levels, and incentives need to be examined from a long-term perspective. Implementing one or a set of health-related MDGs may require staff time to be shared across regions and the provision of more administrative support to health specialists, particularly in resident missions. Additional staff may be needed at ADB headquarters and/or in resident missions. ADB's current health sector specialists are diverse and few. They are located in a number of divisions and resident missions. There must be appropriate mechanisms and rewards to encourage more formal and informal collaboration among them. At present ADB does not

have good mechanisms in place to share staff across regions and divisions. It is clear from the evaluation findings that, from the perspective of some DMCs, ADB financing mechanisms are not appropriate for health interventions. This is particularly the case for some large OCR borrowers. Unless this issue is resolved, ADB will play only a minor and inconsequential role in the health sector in those countries. The Strategy must address the issue of financing modalities for the health sector. This SES has identified several options to be considered (para. 54). There may be other options. However, this issue must be addressed in the Strategy to arrest the expected decline in ADB's health sector lending.

E. Recommendations

163. The SES recommends that the Strategy be completed by 2006. It has identified many issues that should be considered in the formulation of the Strategy. It would not be appropriate to cover all these issues by explicit recommendations. However, some issues are, in the view of OED, particularly important. The following explicit recommendations are made. The Strategy should

(i) be a strategy covering HNP and other related social sectors;
(ii) identify innovative loan and grant products that will facilitate greater ADB involvement in the health sector;
(iii) cover governance and corruption in the context of ADB's overall initiative of fighting corruption in each DMC to provide guidance on how ADB staff should address these difficult issues;
(iv) allow ADB to finance health infrastructure and equipment;
(v) place more emphasis in developing partnerships with other donors, the private sector, and civil society; and
(vi) analyze the staffing implications associated with different options considered in the Strategy so that the Board and Management understand the trade-offs between strategic options and resource implications.

MILLENNIUM DEVELOPMENT GOALS

Goals	Targets
Goal 1	**Target 1**
Eradicate extreme poverty and hunger[a]	Halve, between 1990 and 2015, the proportion of people whose income is less than $1 a day
	Target 2
	Halve, between 1990 and 2015, the proportion of people who suffer from hunger
Goal 2	**Target 3**
Achieve universal primary education	Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling
Goal 3	**Target 4**
Promote gender equality and empower women	Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015
Goal 4	**Target 5**
Reduce child mortality[a]	Reduce by two thirds, between 1990 and 2015, the under-five mortality rate[a]
Goal 5	**Target 6**
Improve maternal health[a]	Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio
Goal 6	**Target 7**
Combat HIV/AIDS, malaria and other diseases[a]	Have halted by 2015 and begun to reverse the spread of HIV/AIDS[a,b]
	Target 8
	Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases[a]
Goal 7	**Target 9**
Ensure environmental sustainability[a]	Integrate the principles of sustainable development into country policies and programs and reverse the loss of environmental resources
	Target 10
	Halve by 2015 the proportion of people without sustainable access to safe drinking water and basic sanitation[a]
	Target 11
	By 2020 have achieved a significant improvement in the lives of at least 100 million slum dwellers
Goal 8	**Target 12**
Develop a global partnership for development	Develop further an open, rule-based, predictable, nondiscriminatory trading and financial system (including a commitment to good governance, development, and poverty reduction—both nationally and internationally)
	Target 13
	Address the special needs of the least developing countries (including tariff- and quota-free access for least developed countries' exports, an enhanced program of debt relief for heavily indebted poor countries and cancellation of official bilateral debt,

Goals	Targets
	and more generous official development assistance for countries committed to poverty reduction)
	Target 14
	Address the special needs of landlocked countries and small island developing states (through the Program of Action for the Sustainable Development of Small Island Developing States and 22nd General Assembly provisions)
	Target 15
	Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term
	Target 16
	In cooperation with developing countries, develop and implement strategies for decent and productive work for youth
	Target 17
	In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries[a]
	Target 18
	In cooperation with the private sector, make available the benefits of new technologies, especially information and communications technologies

[a] Goals and targets related to health and nutrition.
[b] Human immunodeficiency virus/acquired immunodeficiency syndrome.
Source: Sachs, Jeffrey. 2005. *Investing in Development: A Practical Plan to Achieve the Millennium Development Goals*. New York.

ECONOMIC AND SOCIAL DEVELOPMENTS AFFECTING THE HEALTH SECTOR

A. Basic Economic Conditions

1. The economies in most of the Asia and Pacific region have performed quite well in recent years, despite the threat of terrorism, high oil prices, severe acute respiratory syndrome, the Asian financial crisis, and slow economic growth in industrial countries. Economic growth was 6.3% in 2003[1] and the Asia and Pacific region remains the most dynamic economy in the world, although this masks significant differences in country economic performance. Generally, economic performance was strong in East Asia, South Asia, and Central Asia, moderate in Southeast Asia, and fragile in the Pacific.

2. In its 2003 triennial review of the least developed countries, the United Nations Economic and Social Commission for Asia and the Pacific Committee for Development Policy based its identification of least developed countries on the three dimensions of a country's state of development: (i) income level, (ii) stock of human assets, and (iii) economic vulnerability. Of the 49 least developed countries in the world, 13 are located in the Asia and Pacific region: Afghanistan, Bangladesh, Bhutan, Cambodia, Kiribati, Lao People's Democratic Republic, Maldives, Myanmar, Nepal, Samoa, Solomon Islands, Tuvalu, and Vanuatu. Timor-Leste was recommended for inclusion in the list by the Committee for Development Policy in 2003.

3. Least developed countries benefited from specific advantages under the Generalized System of Preferences of the General Agreement on Tariffs and Trade and the World Trade Organization. A developed country can grant nonreciprocal duty concessions to imports from developing countries. Some developed countries extend Generalized System of Preferences benefits to all products originating from least developed countries. In the Brussels Declaration adopted at the Third United Nations Conference on the Least Developed Countries, donors agreed "to meet expeditiously the targets of 0.15% or 0.20% of gross national income as official development assistance[2] to least developed countries as agreed." In addition, governments undertook to improve aid effectiveness and to implement an Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee recommendation to untie all ODA to least developed countries.

B. Demographic Changes

4. About 59% of the global population lives in the Asia and Pacific region.[3] Among the five subregions (East and Central Asia, Mekong, Pacific, South Asia, and Southeast Asia), South Asia is the largest with 1.4 billion people. Five of the 10 most populous countries in the world are in the Asia and Pacific region. These countries are projected to account for 45% of global population growth between 2002 and 2050.[4] Regional averages are dominated by trends in these five countries: Bangladesh, India, Indonesia, Pakistan, and People's Republic of China (PRC). Sex bias has led to "missing" women, estimated at between 89 and 100 million globally. The problem is most severe in South Asia and the PRC.[5] Lower access to nutrition and health

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[1] ADB. 2004. *Asian Development Outlook 2004*. Manila.

[2] Official development assistance is defined as concessional flows (a grant element of at least 25%) to developing countries provided by official agencies, including state and local governments, or by their executing agencies to promote economic development and welfare. GNI is gross national income.

[3] Population Reference Bureau. 2004. *World Population Data Sheet 2004*. Washington, DC.

[4] Population Reference Bureau. 2004. *Country Profiles for Population and Reproductive Health: Asia and the Pacific 2004*. Washington, DC.

[5] Also North Africa. See Amartya Sen. 2003. Missing Women-Revisited. *British Medical Journal.* 327:1297–1298.

care for girls in South Asia has been documented.[6] Although illegal, evidence of sex-selective abortions exists in the PRC and India, given the availability of ultrasound. Sex ratio imbalances at birth and in mortality among children have been reported in the Republic of Korea, Nepal, and Pakistan.[7]

5. A shift from high to lower mortality and fertility started during the mid-1990s in many developing member countries (DMCs), although patterns vary widely among and within countries. In Asia as a whole, fertility declined from an average of 5.9 to 2.6 children per woman between 1950 and 2000.[8] The region, however, is characterized by countries that have experienced moderate declines in mortality and fertility (such as Bangladesh, India, Indonesia, and Pakistan) in contrast to the PRC, where the total fertility ratio (TFR)[9] is below the 2.0 replacement level. Regions with the highest fertility levels are the Pacific island countries (TFR 3.3–4.8) and South Asia (TFR 2.0–6.8). Migration and urbanization are accelerating the demographic transition throughout the region. It is estimated that Asia's urban population will increase from 1.5 billion (24% of total population) to 2.6 billion (32% of total population) between 2000 and 2030,[10] putting pressure on the urban environment (especially with regard to water, air, and sanitation). Much of this growth will occur in Asia's largest countries. In the PRC alone, 7 million to 10 million new migrants leave rural areas each year,[11] and one half of the PRC's population will be living in urban areas by 2030.[12]

6. In the less developed world as a whole, life expectancy at birth increased from 41 years in 1950 to 63.5 years in 2000. This has increased the proportion of working age adults, which, in turn, has raised gross national product per capita and economic growth over the long term.[13] Longer life expectancy also increases the noncommunicable disease burden. However, a large proportion of morbidity and mortality from noncommunicable conditions and injuries among children and working age adults can be prevented by limiting risk and exposure to tobacco, alcohol, pollution, poor nutrition, and obesity; and improving road safety.

C. Other Changes Affecting the Health Sector

7. The rapid transition in the early 1990s from centrally planned to market economies in a number of DMCs resulted in fundamental changes in governance. The transition itself has been linked to declines in health as a result of system collapse associated with economic hardship, particularly in the Central Asian republics.[14] With this transition, financial support for public health and basic services declined in several DMCs. Reductions in quality and access to basic medical services, together with excessive consumption of drugs and alcohol, played an important role in declining health outcomes in Central Asian republics. The introduction of market reforms in the PRC resulted in the dissolution of rural health insurance, in addition to

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[6] Osmani, S., and Amartya Sen. 2003. The Hidden Penalties of Gender Inequality. *Economics and Human Biology*. 105–121.

[7] Banister, J. 2003. *Shortage of Girls in China Today: Causes, Consequences, International Comparisons and Solutions*. Washington, DC: Population Reference Bureau.

[8] Population Reference Bureau. 2004. *Transitions in World Population*. Washington, DC.

[9] The total fertility ratio is the average number of children per woman assuming constant age-specific fertility rates.

[10] McGee, T. 2001. *Urbanization Takes on New Dimensions in Asia's Population Giants.* Washington, DC: Population Reference Bureau.

[11] Yardley, J. 2004. In a Tidal Wave, China's Masses Pour from Farm to City. *The New York Times.* 12 September.

[12] Earth trends, from UN population Division. Available: http://earthtrends.wri.org/text/theme4vars.htm

[13] Bloom, David, D. Canning, and B. Graham. 2001. *Health Longevity, and Life Cycle Savings, Working Paper for Report of the Commission on Macroeconomics and Health*. Geneva: WHO.

[14] World Bank. 1996. Is Transition a Killer? *1996 World Development Report: From Plan to Market*. Washington, DC.

declines in the utilization of basic services, such as immunization, after the imposition of service fees.[15] Restructuring of state-owned enterprises has left large parts of the urban population without health insurance or health services. In Indonesia, declines in the quality of the public sector occurred in the mid-1990s, resulting from a zero growth policy with regard to civil service recruitment and a reduction in support for the health sector. Ministries of health are struggling with the internal reorganization and skills required to take on the functions of a modern bureaucracy, and are strengthening central government regulatory functions, legislation, and health mandates; and protection of public interests, as well as separating service financing and provision.

8. Several DMCs are reexamining the appropriate role and functions of the government in promoting health. The process of decentralization is underway in many DMCs. The decentralization of authority for health service delivery with insufficient central allocations for funding basic public health functions and a minimum package of service delivery is common in these countries, and the situation was made worse by the Asian financial crisis. It is important to identify sustainable financing mechanisms to increase the amount of resources for basic health services and public functions over the long term. Because the health sector accounts for a significant proportion of the government budget in many countries, improving the financing of the health sector is often linked to broader fiscal reform measures.

[15] Health Situation Assessment, PRC. Draft, September 2004. Ministry of Health, PRC, and the United Nations Theme Group on Health (UNTGH).

MAIN STRATEGIES OF ADB'S POLICY FOR THE HEALTH SECTOR

Five Strategic Considerations

1. The Asian Development Bank (ADB) will work to improve the health of the poor, women, children, and indigenous peoples by (i) increasing its lending for the health sector and maintaining its current emphasis on primary health care (including reproductive health, family planning, and selected nutrition interventions); and (ii) focusing on vulnerable groups with particular attention to women, and measuring the extent to which the poor, women, and indigenous peoples have access to health services.

2. ADB will maintain a focus on achieving tangible, measurable results by (i) further strengthening monitoring and evaluation of all health sector activities, (ii) emphasizing interventions with strong evidence of effectiveness, (iii) improving the quality of loans at entry, and (iv) improving implementation of health sector activities.

3. ADB will support the testing of innovative approaches and the rapid deployment of effective and affordable new technologies through (i) financing pilot tests of new approaches to health care financing, organization, and management; and (ii) helping support the deployment of new technologies, particularly new vaccines.

4. ADB will play a significant role in health sector reform by encouraging developing member country (DMC) governments to take an appropriate and activist role in the health sector. This will involve engaging in policy dialogue to encourage the DMCs to (i) increase their budgetary allocations for primary health care; (ii) diversify their sources of health care financing; (iii) collaborate more extensively with the private sector; and (iv) increase support for public goods, such as research, health education, and regulation.

5. ADB will increase the efficiency of its health sector investments by (i) helping to strengthen management capacity of the public sector in the DMCs, (ii) improving its economic and sector work and strengthening links with other sectors, and (iii) further strengthening its collaboration with partner institutions in the health sector.

HEALTH SECTOR POLICY MATRIX

Strategic Objectives	Operational Objectives	Specific Recommendations
Work to improve • health of vulnerable groups • poor health status among the poor • lack of progress in improving women's health status • services not reaching vulnerable groups	Maintain emphasis on PHC	ADB will work with DMCs to ensure universal access to essential health services of proven benefit, cost effectiveness, and affordability. ADB will continue to emphasize lending for PHC.
		ADB will encourage DMCs to emphasize PHC and to shift away from financing activities with low cost–benefit ratios, such as tertiary hospitals and specialist training.
	Focus on vulnerable groups and measure benefits obtained by the poor, women, children, and indigenous peoples.	ADB health projects and programs will employ methods to measure access to basic services by the poor, women, children, and indigenous peoples.
		ADB will pay particular attention to the needs of women in the design and implementation of projects. Where appropriate, loans targeted at women's health, including reproductive health, will be developed.
Focus on achieving tangible, measurable results • Inadequate attention to M&E • Little consideration given to quality of evidence supporting interventions; weaknesses in project design may have interfered with impact	Further strengthen M&E	ADB health loans will list objective indicators, set aside budgets for data collection and analysis, have clear plans for measuring results—including use of comparison areas and collection of baseline data—and develop a plan for building the capacity of DMCs to conduct M&E.
	Focus on interventions with strong evidence of effectiveness	ADB will prioritize technical interventions that have strong scientific evidence of effectiveness. Where such evidence does not exist, ADB will be cautious and support the rigorous testing of such technical and programmatic interventions.
	Improve the quality of health sector loans	ADB will implement a technical peer review process for health sector loans.
		Health sector loans will employ and explicitly describe participatory approaches in design and implementation.
		Flexibility in project design through the use of process, rather than blueprint approaches, will be encouraged to reduce risks. ADB will adopt a realistic approach to local cost financing.
	Improve implementation of health sector loans	Supervision of health sector loans will be strengthened. Procurement and disbursement procedures will take into account the special needs of the health sector.

Strategic Objectives	Operational Objectives	Specific Recommendations
Support testing of innovations and deployment of effective new technologies • Epidemiological and demographic transitions and emerging threats are impetus for continuing innovation • Slow deployment of technological advances	Support rigorous testing of new approaches to health care financing and health system management and organization	ADB will encourage pilot testing of innovations and ensure that they are implemented on a reasonable scale, utilize a replicable level of investment per beneficiary, and employ rigorous evaluation methods.
	Help finance deployment of new and emerging technologies, such as vaccines	ADB will assist the widespread use of new vaccines through the region.
Encourage DMC governments to take an appropriate and activist role in the health sector • Low level of public investment in health sector • Governments have been ignoring private sector • Little attention paid to public goods in the health sector • Emerging threats, such as tobacco, pollution, HIV/AIDS	Encourage DMCs to increase their budgetary allocations for health services, particularly PHC	In the context of commitments made at the World Summit for Social Development, ADB will encourage DMCs to increase their budgetary allocations for PHC.
		ADB activities aimed at reforming public finances, decreasing subsidies, and privatizing state-owned enterprises will attempt to divert some of the resultant savings to the financing of PHC.
	Assist DMC governments to diversify their health care financing	ADB will promote carefully designed social health insurance schemes among the DMCs with the long-term goal of achieving universal coverage.
		ADB will be cautious in promoting cost-recovery for PHC services, but will encourage it more widely for hospital care.
	Facilitate government collaboration with private sector partners, including NGOs	ADB will facilitate public–private partnerships in the provision of health care with special emphasis on the role of NGOs.
	Increase support for public goods such as research, health education, and regulation.	ADB will increase the loan and technical assistance resources used to support applied, noncommercial research in the health sector, especially for health problems of the poor.
		To combat emerging threats, ADB will support research and pilot testing of activities that are cost-effective and that can be implemented through PHC approaches.

Strategic Objectives	Operational Objectives	Specific Recommendations
		Through policy dialogue, ADB will encourage DMC governments to adopt a regulatory environment that is conducive to good health, and aims at decreasing tobacco use, fortifying food, and improving traffic safety.
Increase the efficiency of investments in the health sector • Low public sector management capacity • Inadequate sector work	Invest in strengthening technical and managerial capacity	ADB will help improve management of health care systems. Capacity-building activities will be based on careful institutional analyses. Success will be defined in terms of improving coverage and quality of care, where data are derived from strengthened management information systems that contain data on households, health facilities, client satisfactory surveys, and disease surveillance activities.
	Strengthen economic and sector work, and strengthen the linkages with other sectors	Project and program department staff will ensure that the critical linkages between the health sector and ADB's medium-term strategic objectives, including economic growth, poverty, and improving the status of women are properly reflected in the country operational strategy study and the country assistance plan.
		ADB will strengthen the linkages between the health sector and other sectors that affect health, such as environment and education.
		ADB will further strengthen the collaboration with partner institutions operating in the health sector, including multilateral and bilateral agencies. The Bank will maintain close cooperation with and utilize the technical expertise of United Nations agencies, including UNFPA, UNICEF, and WHO.

ADB = Asian Development Bank, HIV/AIDS = human immunodeficiency virus/acquired immunodeficiency syndrome, DMC = developing member country, M&E = monitoring and evaluation, NGO = nongovernment organization, PHC = primary health care, UNFPA = United Nations Population Fund, UNICEF = United Nations Children's Fund, WHO = World Health Organization.

PERCENT OF UNDERWEIGHT CHILDREN BELOW 5-YEARS OLD

Countries	Percent
East Asia	
People's Republic of China	10.0
Hong Kong, China	—
Republic of Korea	27.9
Mongolia	12.7
Taipei, China	—
Southeast Asia	
Cambodia	45.2
Indonesia	27.3
Lao People's Democratic Republic	40.0
Malaysia	20.1
Myanmar	35.3
Philippines	31.8
Singapore	2.9
Thailand	17.6
Viet Nam	33.8
South Asia	
Afghanistan	49.3
Bangladesh	47.7
Bhutan	18.7
India	46.7
Maldives	45.0
Nepal	48.3
Pakistan	37.4
Sri Lanka	32.9
Central Asia	
Azerbaijan	16.8
Kazakhstan	4.2
Kyrgyz Republic	11.0
Tajikistan	—
Turkmenistan	12.0
Uzbekistan	18.8
Pacific	
Cook Islands	—
Fiji Islands	7.9
Kiribati	12.9
Marshall Islands	—
Federated States of Micronesia	—
Nauru	—
Papua New Guinea	29.9
Samoa	—
Solomon Islands	21.3
Timor-Leste	42.6
Tonga	—
Tuvalu	—
Vanuatu	19.7

— = not available.

Source: WHO. 2002. *Statistical Annex to the World Health Report 2002*. Geneva. Available: http://www.who.int/whr/ 2002/annex/en/

GLOBAL INDICATORS OF INFANT AND MATERNAL MORTALITY

Table A5.1: Countries that Contribute the Largest Number of Child Deaths to the Global Burden, 2000

Country	Annual Number of Child Deaths
India	2,402,000
Nigeria	834,000
People's Republic of China	784,000
Pakistan	565,000
Democratic Republic of Congo	484,000
Ethiopia	472,000
Bangladesh	343,000
Afghanistan	251,000
Tanzania	223,000
Indonesia	218,000

Source: Black, R., S. Morris, and J. Bryce. 2003. Where and why are 10 million children dying every year? *The Lancet*. 361: 2226-34. Available: http://thelancet.com/journal/vol361/iss9376/full/llan.361.9376.child_survival.26233.1

Table A5.2: Under-5 Mortality Rates, Infant Mortality Rates, and the Proportion of 1-Year Olds Immunized Against Measles, by United Nations Region

Region	Under-5 Mortality Rate		Infant Mortality Rate		Percent of 1-year olds Immunized Against Measles	
	1990	2002	1990	2002	1990	2003
East Asia	48	38	37	30	98	85
South Asia	126	93	87	67	58	69
Southeast Asia	78	48	54	36	72	79
West Asia	68	61	53	49	80	84
Oceania	86	78	63	59	70	57
Commonwealth of Independent States (includes developing states in Asia and Europe)	41	44	34	35	—	97

— = not available, UN = United Nations.

Source: UN General Assembly. 2004. *Implementation of the UN Millennium Declaration: Report of the UN Secretary-General.* 27 August 2004. A/59/282. Available: http://www.eldis.org/fulltext/N0446540.pdf

Table A5.3: Change in the Maternal Mortality Ratio and Number of Maternal Deaths 1995–2000, by United Nations Region

	1995		2000	
Region	Maternal Mortality Ratio	Number of Maternal Deaths	Maternal Mortality Ratio	Number of Maternal Deaths
Asia	280	217,000	330	253,000
East	55	13,000	55	11,000
South Central	410	158,000	520	207,000
Southeast	300	35,000	210	25,000
West	230	11,000	190	9,800
Oceania	260	600	240	530
Developing Regions	440	512,000	440	527,000
Developed Regions	21	2,800	20	2,500

Source: UNFPA. 2000. *Maternal mortality in 2000. Estimates developed by WHO, UNICEF, and UNFPA*. New York. Available: http://www.unfpa.org/upload/lib_pub_file/237_filename_maternal_mortality 2000.pdf

Table A5.4: Change in Proportion of Presence of Women with Skilled Attendance at Birth, 1990–2000, by United Nations Region

	Deliveries with Skilled Attendant		Deliveries with a Doctor	
Region	1990	2000	1990	2000
Asia				
East	53	72	—	—
South Central	27	35	16	28
Southeast	36	59	9	13
West	59	64	26	36
Developing Regions	42	52	15	23

— = not available.

Source: United Nations Statistics Division. 2003. *Millennium Indicators Database: World and regional trends*. New York. Based on data December 2003 provided by United Nations Children's Fund and World Health Organization. Available: http://millenniumindicators.un.org

PREVALENCE OF HIV/AIDS AND TUBERCULOSIS

Table A6.1: HIV/AIDS Prevalence, by United Nations Region

Region	HIV/AIDS Prevalence (percentage of the population aged 15–49 living with HIV/AIDS)	
	2001	2003
East Asia	<0.1	0.1
South Asia	0.5	0.7
Southeast Asia	0.5	0.5
West Asia	<0.1	0.1
Oceania	0.4	0.5
Commonwealth of Independent States (Asia)	<0.1	0.1

HIV/AIDS = human immunodeficiency virus/acquired immunodeficiency syndrome, UN = United Nations.

Source: UN General Assembly. 2004. *Implementation of the UN Millennium Declaration: Report of the UN Secretary-General.* 27 August 2004. A/59/282. Available: http://www.eldis.org/fulltext/ N0446540.pdf

Table A6.2: Knowledge of HIV among Women in Selected Developing Member Countries

Developing Member Country	Women with Correct Knowledge of HIV/AIDS (%)	Women Who Know that a Healthy-looking Person Can Transmit HIV (%)
Tajikistan	5	8
Azerbaijan	11	30
Turkmenistan	21	42
Uzbekistan	22	41
Indonesia	23	32

HIV/AIDS = human immunodeficiency virus/acquired immunodeficiency syndrome.

Source: Percentage of women who know that a person can protect herself from HIV by consistent condom use, 1996/2001. *Progress Toward the MDGs*. United Nations Statistical Division. Available: http://millenniumindicators.un.org/unsd/mi/mi_coverfinal.htm

Table A6.3: Estimated Tuberculosis (TB) Incidence and Mortality, 2002, by WHO Region

	Number of cases ('000)		Cases per 100,000		Deaths from TB (including TB deaths in people infected with HIV)	
WHO Region	**All Forms**	**Smear-positive**	**All Forms**	**Smear-positive**	**Number** ('000)	**Per 100,000**
Europe	472	211	54	24	73	8
Southeast Asia	2,890	1,294	182	81	625	39
Western Pacific	2,090	939	122	55	373	22
Global	8,797	3,887	141	63	1823	29

HIV = human immunodeficiency virus, TB = tuberculosis, WHO = World Health Organization.
Source: WHO. 2004. *Global TB Control Report*. Geneva. Available: www.who.int/tb/publications/global_report/en/

Table A6.4: New TB Cases Detected and Successfully Treated Under Directly Observed Treatment, Short-Course, by UN Region

	TB cases detected (%)		TB cases successfully treated (%)	
UN Region	**2000**	**2002**	**2000**	**2001**
East Asia	28	28	94	96
South Asia	14	30	83	85
Southeast Asia	39	50	86	86
West Asia	26	25	81	83
Oceania	13	20	76	76
Commonwealth of Independent States (Asia)	37	47	78	77

TB = tuberculosis, UN = United Nations.
Source: Treatment success based on cohorts in 2000 and 2001.

INFANT MORTALITY RATE, MATERNAL MORTALITY RATIO, INCOME, AND GOVERNANCE

1. This appendix reports the results of some regression estimates of (i) infant mortality rate (IMR), gross domestic product (GDP) per capita and governance; and (ii) maternal mortality ratio (MMR), GDP per capita, and governance.[16]

2. The regression estimate on the IMR is summarized in Table A7.1, which shows that the estimated parameters a, b, and c are all significant at 1% level. In particular, it indicates that b, which is the elasticity of IMR with respect to GDP per capita, is about 0.58. That is, a 1% increase in GDP per capita leads to 0.58% decrease in IMR. On the other hand, c, which is the semi-elasticity of IMR with respect to governance, is about 0.16%. This implies that a 1% improvement in governance indicators translates to about 0.16 percentage point improvement in IMR. The range of the governance index varies from -3.3 to 4.9, the lowest score going to the worst-performing country and the highest to the best-performing country.

3. The partial scatters between IMR and governance are provided in Figure A7.1. It shows the relationship between IMR and governance controlling for other regressors. The plot shows that there is a statistically significant negative relationship between IMR and governance.

4. The corresponding regression results and the scatter plot are indicated by Table A7.2 and Figure A7.2 for maternal mortality, GDP per capita, and governance. The regression and interpretation of the results with respect to MMR is similar to that for the IMR. A 1% increase in GDP per capita leads to a 0.8% decrease in MMR. The relationship between governance and MMR is also weaker. A 1% improvement in governance results in a 0.23 percentage point reduction in MMR. There is a statistically significant negative relationship between MMR and governance. The important message that comes from this analysis is that, quantitatively, income seems to be the most important determinant of infant and maternal mortality rates, and, while governance plays a role, its quantitative significance is smaller.

5. The results of this analysis, which is mainly intended to test the role of governance in the determination of these Millennium Development Goals, should be treated as only suggestive. The analysis was not intended to identify all the factors that influence these outcomes. Available empirical studies suggest that many economic and social factors other than those identified above can be important. The extent of poverty and inequality, public health expenditures (their composition, allocation, and efficient use), housing and sanitation, maternal education, cultural factors (such as ethno-linguistic fractionalization), and social capital can have a bearing on the outcomes relating to infant and maternal mortality.

[16] The regression equations that are estimated here are the following: (i) (IMR) = a + b (GDP per capita) + c (governance); and (ii) (MMR) a* + b* (GDP per capita) +c*(governance), where a, b, c plus a*, b*, c* are the estimated parameters. These regression estimates were developed by M. G. Quibria, advisor in OED.

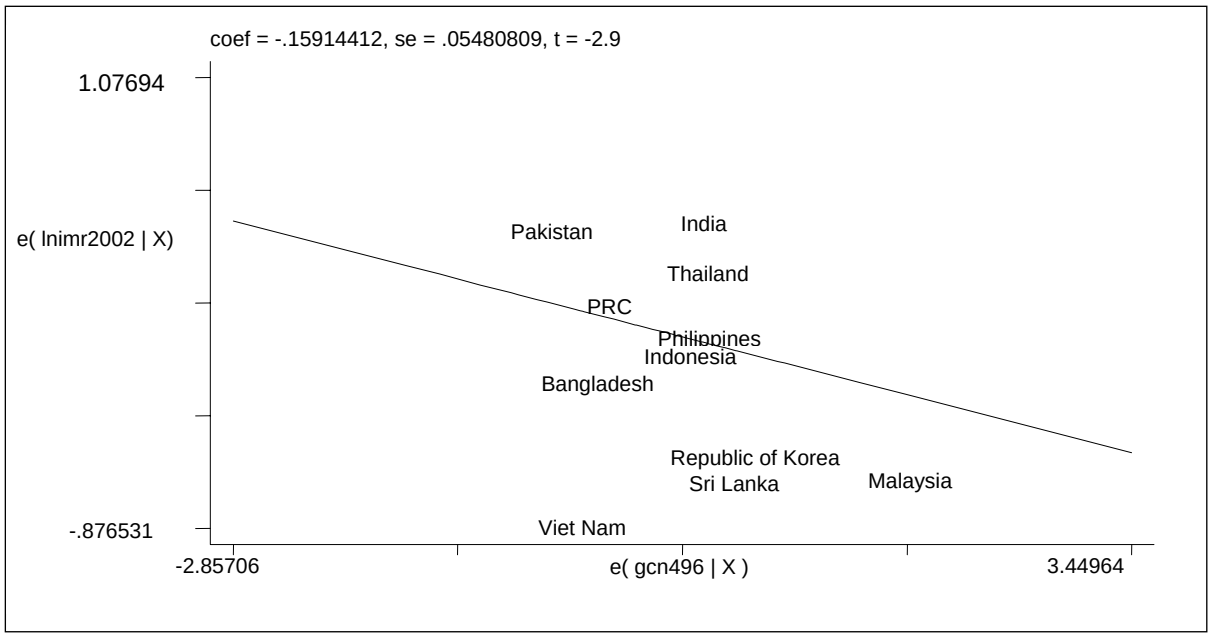
Table A7.1: Regression Equation
Dependent Variable: ln (Infant Mortality Rate[a])

Item	Equation	t-statistic
Variable	Coefficient	
ln (GDP per capita[b])	-0.5837	-5.71*
Governance[c]	-0.1591	-2.90*
Constant	8.2263	10.03*
R-squared	0.8012	
Adjusted R-squared	0.7915	

GDP = gross domestic product, R = regression.
* Significant at the 1% level of significance.
[a] Infant mortality rate refers to the mortality rate of children between 0 and 1 year per 1,000 live births. The data are based on United Nations Children's Fund estimates.
[b] GDP per capita refers to GDP per capita at purchasing power parity (constant 1995 dollars).
[c] Governance data used here are derived from Kaufmann, Kraay, and Zoido-Lobaton (KKZ) (1999)—see sources, below. The KKZ dataset provides six governance indicators, namely: (i) voice and accountability, (ii) political stability, (iii) government effectiveness, (iv) regulatory quality, (v) rule of law, and (vi) control of corruption. The quality of governance index used here is based on four of the six KKZ governance indicators—namely, control of corruption, government effectiveness, regulatory quality, and rule of law. This new index, which relies on the principal components approach, condenses the information contained in the four governance indicators into a single measure. This new measure, which retains the character and nature of the original indicators, helps to attenuate the problems associated with high correlations among the governance indicators. The governance data refer to 1996 and cover 44 countries. While this is one of the most comprehensive data sets available, the authors acknowledge that there are errors of estimate associated with the data.

Sources: World Bank. 2003. *World Development Indicators*. Washington, DC. Available: http://info.worldbank.org/governance/kkz2002/tables.asp; United Nations. 2004. *UN Millennium Indicators Database*. UN Statistics Division. Available: http://milleniumindicators.un.org/unsd/mi/mi_goals.asp; and Kaufmann, D., A. Kraay, and P. Zoido-Lobaton. 1999. Aggregating Governance Indicators. *Policy Research Working Paper* 2195. Washington, DC: World Bank. Available: http://econ.worldbank.org/docs/918.pdf

Figure A7.1: Partial Scatters of IMR Against Governance



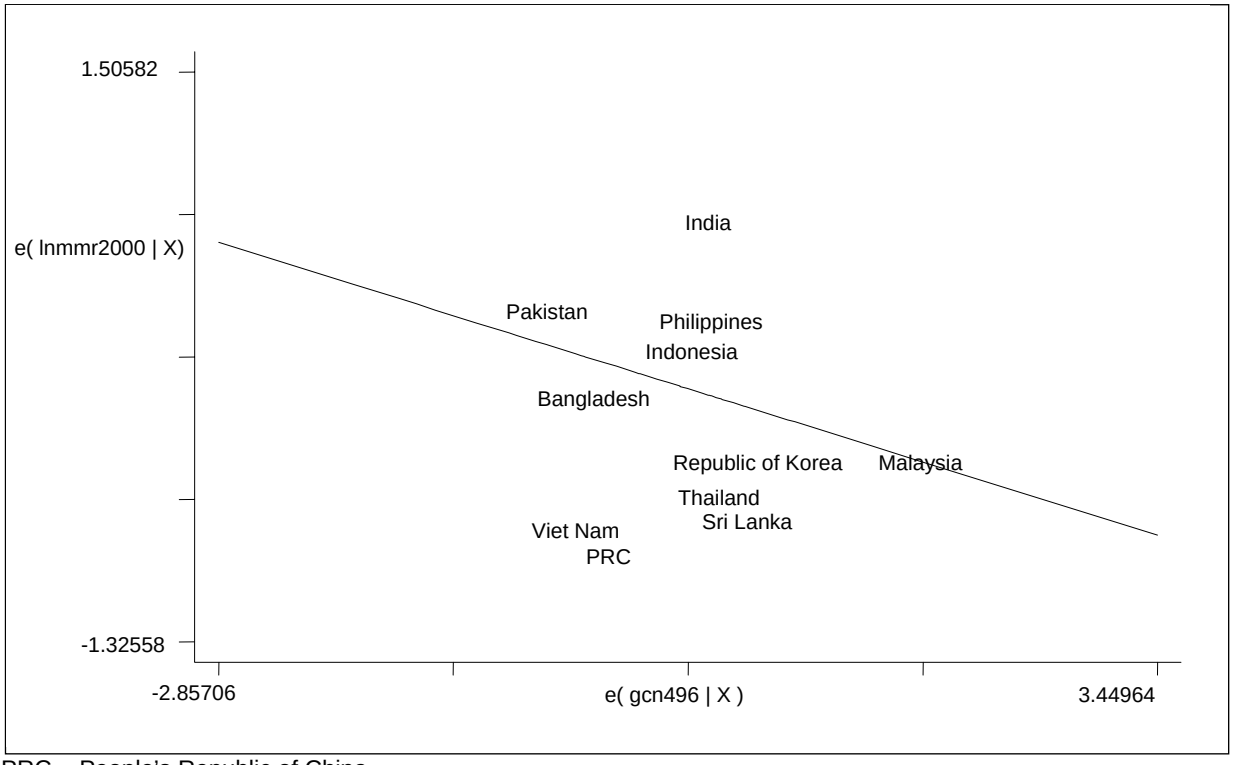
IMR = infant mortality rate, PRC = People's Republic of China.
Source: Author's estimates.

Table A7.2: Regression Equation
Dependent Variable: ln (Maternal Mortality Ratio[a])

Item	Equation	t-statistic
Variable	Coefficient	
ln GDP per capita[b]	-0.8000	(-5.03)*
Governance [c]	-0.2306	(-2.71)*
Constant	11.6846	(9.17)*
R-squared	0.7648	
Adjusted R-squared	0.7533	

GDP = gross domestic product.
* = Significant at the 1% level of significance.
[a] Maternal mortality ratio refers to the mortality ratio of mothers per 100,000 live births. The data, which refer to 2000, are based on World Health Organization, United Nations Children's Fund, and United Nations Population Fund estimates.
[b] GDP per capita refers to GDP per capita in 2002 measured in terms of purchasing power parity (in constant 1995 dollars).
[c] Governance refers to an index derived using the principal components analysis. The governance data refer to 1996 and cover 44 countries.
Sources: World Bank. 2003. *World Development Indicators*. Available: http://info.worldbank.org/governance/kkz2002/tables.asp; United Nations. 2004. *UN Millennium Indicators Database*. UN Statistics Division. Available: http://milleniumindicators.un.org/unsd/mi/mi_goals.asp, and Kaufmann, D., A. Kraay, and P. Zoido-Lobaton. 1999. Aggregating Governance Indicators. *Policy Research Working Paper* 2195. Washington, DC: World Bank. Available: http://econ.worldbank.org/docs/918.pdf

Figure A7.2: Partial Scatters of Maternal Mortality Against Governance



PRC = People's Republic of China.
Source: Author's estimates.

CORRUPTION RELATED TO THE HEALTH SECTOR

1. Transparency International has developed "national integrity system"[1] country studies to provide a detailed assessment of anticorruption systems at the country level. During 2001–2004, 19 developing member countries of the Asian Development Bank were included in these studies: Bangladesh, Cook Islands, Fiji Islands, India, Kazakhstan, Kiribati, Marshall Islands, Mongolia, Nauru, Nepal, Pakistan, Palau, Papua New Guinea, Samoa, Solomon Islands, Sri Lanka, Tonga, Tuvalu, and Vanuatu. The studies were based on Transparency International's national integrity concept, which encompasses the interrelated elements necessary to promote accountability and integrity in a society. Of these studies, five indicated corruption issues related to the health sector. A summary of the findings related to health is provided below (Table A8.1).

Table A8.1: National Integrity System Country Studies

Country, Year	Remarks
Bangladesh, 2003	The study noted that corruption is a massive systemic problem in Bangladesh, affecting every sector of service delivery, including the police, health care, education, land administration, tax collection, journalism, municipal services, public transport, and telephone services.
India, 2003	There have been a number of financial and political scandals. At the state level, these included the (i) fodder scandal (The Central Bureau of Investigation has registered cases against the two former chief ministers and officials for embezzling funds intended for the purchase of fodder, medicines, instruments, etc., for cattle on the basis of alleged fake letters and nonexistent suppliers); and (ii) a drug purchase scandal (misappropriation of funds in the purchase of drugs, appliances, and instruments) in the Health Department of the state of Bihar, involving many thousand million rupees.
Pakistan, 2003	In seven major government sectors, the average bribery expenditure per consumer in each sector was: judiciary (34%), land administration (21%), education (17%), tax department (14%), police (8%), power (4%), and health (3%). Bribes are routinely paid or other influence brought to bear—either via coercion or collusion—to be relieved of a traffic fine, get a utilities connection, reduce a tax bill, get a case to be heard by a favored judge, get access to medical care, settle a land dispute, fix an exam result, or be exonerated from an investigation or audit query.
Papua New Guinea, 2003	Under the guise of bringing development, elected leaders commit a great deal of funds to the building and maintenance of roads and bridges, rural health centers, and schools. Although this is justified by the deteriorating or virtually nonexistent infrastructure, together with the isolation of most people living in rural areas, many investments are misused and diverted to private accounts or to fund bogus companies and projects.
Samoa, 2004	There are a number of concerns related to corruption, one of which is the issue of gift-giving in the public domain, where administrative systems are supposedly governed by legal-rational principles. In the Customs

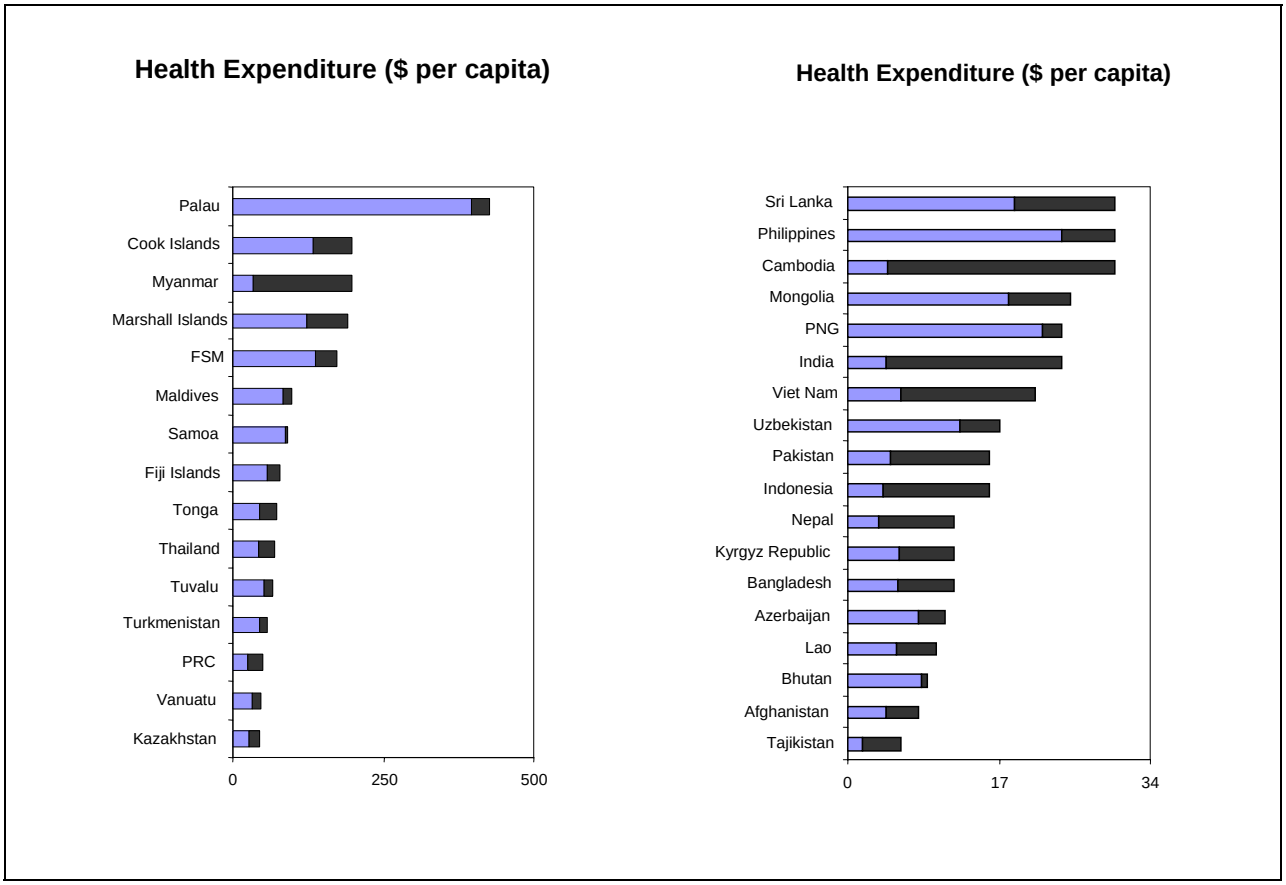
[1] The national integrity system (NIS) is the sum total of the laws, institutions, and practices in a country that maintain accountability and integrity of public, private, and civil society organizations. The NIS is concerned with combating corruption as part of the larger struggle against misconduct and misappropriation, and with creating an efficient and effective government working in the public interest, supported by a vital, transparent civil society and private sector. Available: www.transparency.org

Country, Year	Remarks
	Department, for example some of its officers were part of a ring that accepted bribes for preferential treatment by certain members of the traveling public. There is an ongoing investigation by the Government into the embezzlement of funds amounting to over $373,800 at the Ministry of Health. Some public servants, including senior public servants, are implicated.

Source: National Integrity Systems country studies.

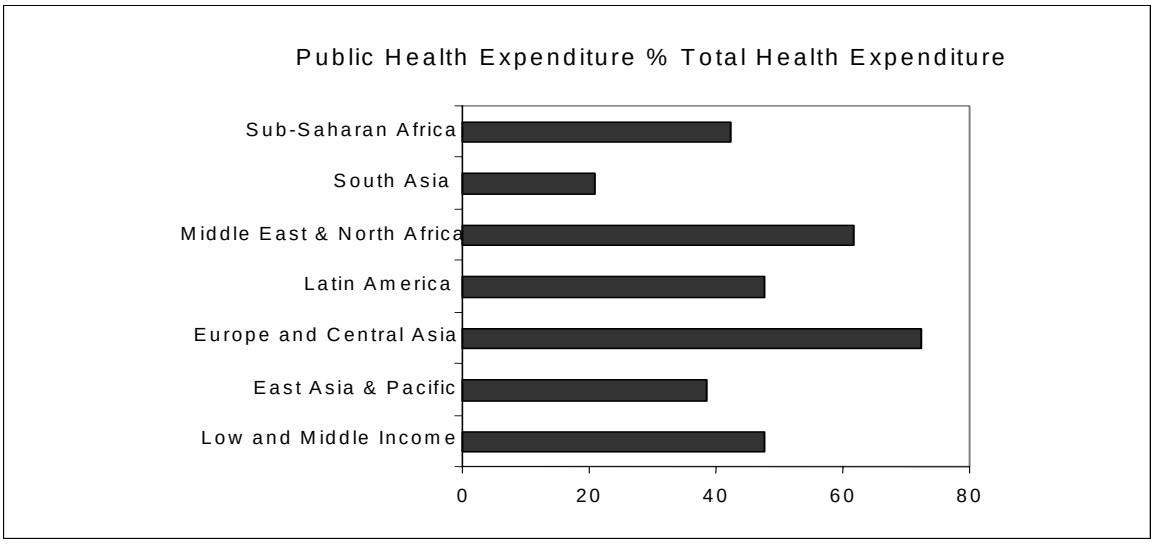
HEALTH FINANCING

Figure A9.1: Total Health Care and Out- of-Pocket Health Expenditures Per Capita, 2001



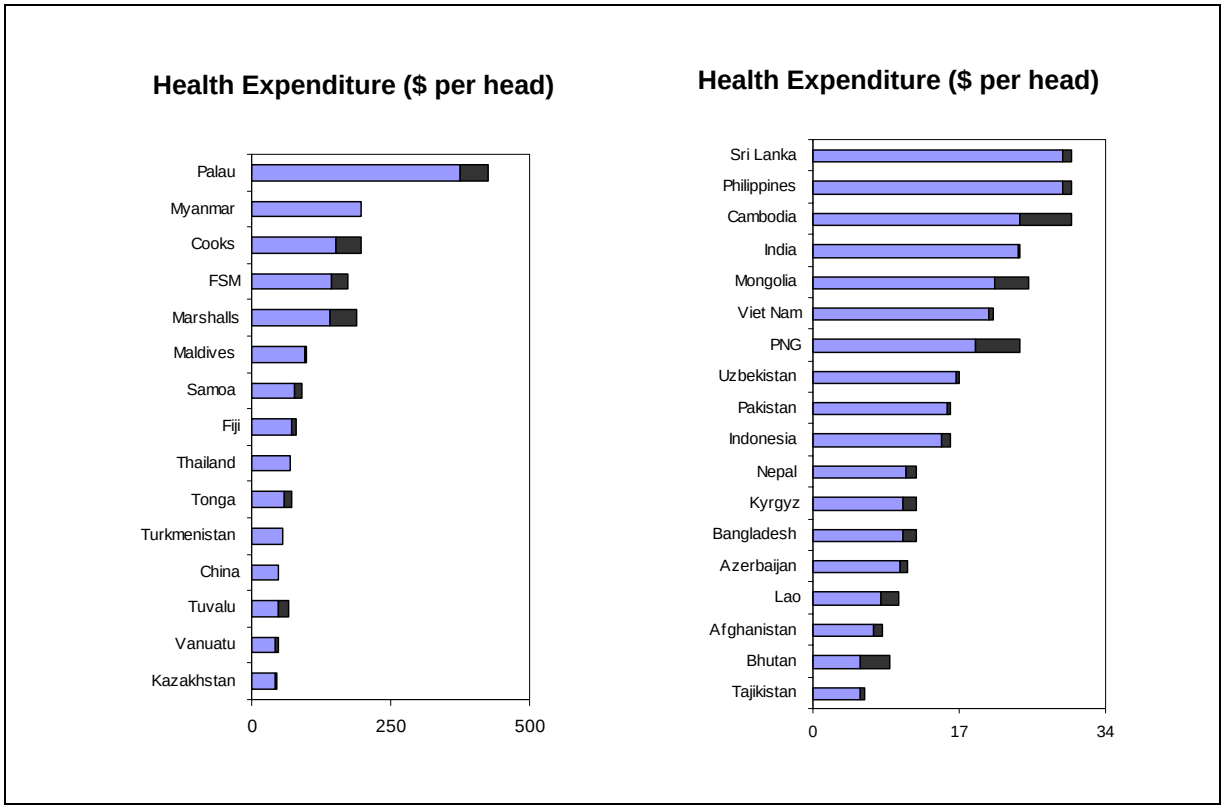
FSM = Federated States of Micronesia, PNG = Papua New Guinea, PRC = People's Republic of China.
Note: Shading = out-of-pocket, blue = other.
Source: WHO. 2004. *World Health Year Book*. Geneva.

Figure A9.2: Government Contribution to Total Health Expenditures



Source: World Bank. 2003. Health Expenditure, Services and Uses. *World Development Indicators 2003*. Washington, DC.

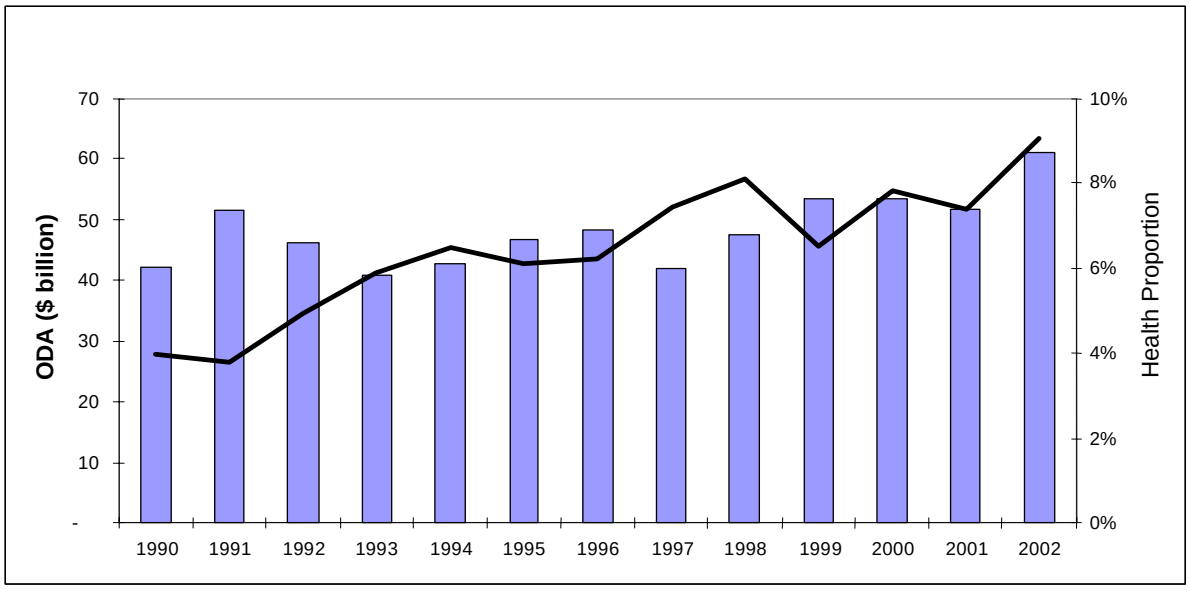
Figure A9.3: Health Expenditure Per Capita and External Assistance (black = shaded) in 2001 (WHO, 2004)



FSM = Federated States of Micronesia, PNG = Papua New Guinea, PRC = China, People's Republic of.
Source: WHO. 2004. *World Health Year Book*. Geneva.

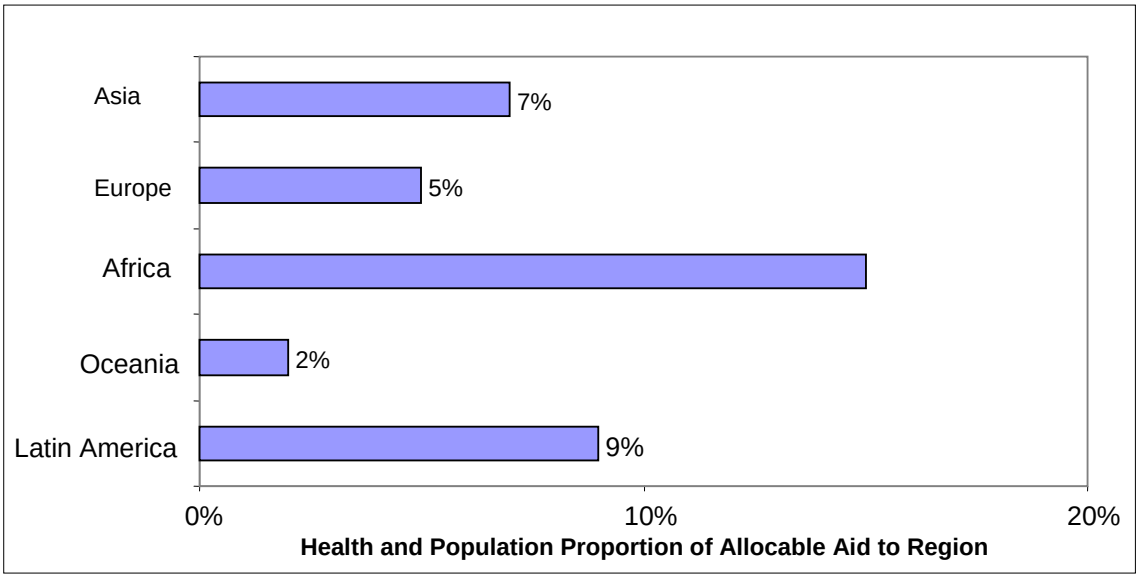
AID IN HEALTH

Figure A10.1: Overall ODA and Health Allocation



ODA = official development assistance.
Note: Blue bar = nominal flow; Black line = health allocation.
Source: Organisation for Economic Co-operation and Development database.

Figure A10.2: Health Aid as a Percentage of Total Assistance, by Region, 2002



Source: White, H. 2003. Trends in the Volume and Allocation of Official Flows from Donor Countries. *International Review of Economics and Finance*. 13: 233–244.

AVERAGE ANNUAL COMMITMENT AND TOTAL SECTOR ALLOCATION, 1996–2002[a]

	$ million			% of Donor Total[b]		
Countries	**1996–1998**	**1999–2000**	**2001–2002**	**1996–1998**	**1999–2000**	**2001–2001**
Australia	83	136	83	11	18	15
Austria	23	57	33	11	22	14
Belgium	56	65	97	19	21	18
Canada	36	61	92	6	11	14
Denmark	90	68	37	13	10	9
Finland	13	12	30	8	10	14
France	100	65	118	5	4	7
Germany	163	127	147	7	4	4
Greece	6	4	5	22	6	4
Ireland	16	15	44	22	19	29
Italy	26	45	26	10	14	10
Japan	242	162	142	2	2	2
Luxembourg	15	16		31	24	
Netherlands	140	150	178	11	15	12
New Zealand	5	5	4	7	7	7
Norway	42	64	135	10	10	16
Portugal	9	7	8	12	5	5
Spain	117	104	79	22	15	10
Sweden	73	89	73	10	17	11
Switzerland	30	36	48	9	8	10
United Kingdom	233	591	586	16	22	29
United States	733	1045	1605	25	17	24
TOTAL DAC	**2,252**	**2,924**	**3,569**	**9**	**10**	**13**
AfDF	59	75	78	11	12	14
ADF	45	42	70	3	3	6
EC (EDF)	83	153	143	8	11	8
IDA	893	586	457	16	11	8
IDB Sp.Fund	42	23	2	8	5	0
Multilateral	**1122**	**879**	**749**	**12**	**9**	**7**
TOTAL	**3,374**	**3,802**	**4,319**	**10**	**10**	**12**

ADF = Asian Development Fund, AfDF = African Development Fund, DAC = Development Assistance Committee, EC = European Commission, EDF = European Development Fund, IDA = International Development Association, IDB = Inter-American Development Bank, Sp. = special.

[a] The definition of aid to health excludes aid to other sectors, which may have direct or indirect effects on health status, e.g., water and sanitation. Medical assistance in natural disasters and other emergency situations is also excluded. At least 25% of financing needs to have a grant component to qualify as aid (i.e., ADF in the case of ADB).

[b] Contributions not susceptible to allocation by sector (e.g., structural adjustment, balance-of-payments support, action relating to debt, emergency assistance, internal transactions in the donor country) are excluded from the denominator in order to reflect better the sector focus of donors' programs.

THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS, AND MALARIA GRANTS: PROGRESS DETAILS

		Approved Proposals							Grant Agreements and Disbursements					
Country (1)	Local Fund Agent (2)	Rnd	Disease Component	Source	Total Yr. 1 & 2 Budgets ($) (3)	Total Lifetime Budgets ($)	Principal Recipient	PR Type	Grant Number	Grant Signature Date	Grant Amount ($)	Amount Disbursed to Date ($)	Date of Most Recent Disbursement	Status (4)
Region: East Asia and the Pacific														
CAM	KPMG	1	HIV/AIDS	CCM	11,242,538 (G)	15,945,803	The Ministry of Health of CAM	Government: Ministry of Health	CAM-102-G01-H-00	27-Jan-03	11,242,538	6,824,100	28-Jan-05	Disbursement 6[b]
		2	HIV/AIDS	CCM	5,370,564 (G)	14,877,295	The Ministry of Health of CAM	Government: Ministry of Health	CAM-202-G02-H-00	14-Oct-03	5,370,564	2,537,143	28-Jan-05	Disbursement 4[b]
		2	Malaria	CCM	5,013,262 (G)	9,998,371	The Ministry of Health CAM	Government: Ministry of Health	CAM-202-G03-M-00	14-Oct-03	5,013,262	2,779,988	12-Jan-05	Disbursement 4[b]
		2	Tuberculosis	CCM	2,505,255 (G)	6,639,001	The Ministry of Health of CAM	Government: Ministry of Health	CAM-202-G04-T-00	14-Oct-03	2,505,255	1,412,598	12-Jan-05	Disbursement 4[b]
		4	HIV/AIDS	CCM	8,794,984 (T)	36,546,136			Not signed yet					TRP Clarification Completed[e]
		4	Malaria	CCM	5,221,242 (T)	9,870,565			Not signed yet					TRP Clarification Completed[e]
PRC	United Nations Office for Project Services	1	Malaria	CCM	3,523,662 (G)	6,406,659	The Chinese Centre for Disease Control and Prevention of the PRC	Government: Other	CHN-102-G02-M-00	30-Jan-03	3,523,662	3,523,662	17-Dec-04	Disbursement 6[b]
		1	Tuberculosis	CCM	25,370,000 (G)	48,070,000	The Chinese Centre for Disease Control and Prevention of PRC	Government: Other	CHN-102-G01-T-00	30-Jan-03	25,370,000	25,370,000	02-Dec-04	Disbursement 6[b]
		3	HIV/AIDS	CCM	32,122,550 (G)	97,888,170	The Chinese Centre for Disease Control and Prevention of PRC	Government: Other	CHN-304-G03-H	18-Aug-04	32,122,550	13,966,823	21-Mar-05	Disbursement 2[b]
		4	HIV/AIDS	CCM	23,936,918 (T)	63,742,277			Not signed yet					TRP Clarification Completed[e]
		4	Tuberculosis	CCM	27,890,000 (T)	56,140,000			Not signed yet					TRP Clarification Completed[e]
East Timor	Pricewaterhouse Coopers	2	Malaria	CCM	2,300,744 (G)	2,963,723	Ministry of Health, Timor-Leste	Government: Ministry of Health	TMP-202-G01-M-00	25-Jun-03	2,300,744	1,364,450	15-Dec-04	Disbursement 5[b]
		3	Tuberculosis	CCM	967,650 (G)	2,299,659	The Ministry of Health of the Government of Timor-Leste	Government: Ministry of Health	TMP-304-G02-T	01-Nov-04	967,650	250,885	24-Feb-05	Disbursement 1[b]

Approved Proposals								Grant Agreements and Disbursements					
Country (1)	Local Fund Agent (2)	Rnd	Disease Component	Source	Total Yr. 1 & 2 Budgets ($) (3)	Total Lifetime Budgets ($)	Principal Recipient	PR Type	Grant Number	Grant Signature Date	Grant Amount ($)	Amount Disbursed to Date ($)	Date of Most Recent Disbursement	Status (4)
INO	Pricewaterhouse Coopers	1	HIV/AIDS	CCM	6,924,971 (G)	15,960,103	Directorate of Directly Transmitted Disease Control of the Ministry of Health of INO	Government: Ministry of Health	IND-102-G03-H-00	11-Jun-03	6,924,971	3,312,198	07-Feb-05	Disbursement 5[b]
		1	Malaria	CCM	8,254,947 (G)	23,704,947	Directorate of Vector Borne Disease Control of the Ministry of Health of INO	Government: Ministry of Health	IND-102-G02-M-00	11-Jun-03	8,254,947	7,488,677	17-Mar-05	Disbursement 4[b]
		1	Tuberculosis	CCM	21,612,265 (G)	70,653,837	Directorate of Directly Transmitted Disease Control of the Ministry of Health of INO	Government: Ministry of Health	IND-102-G01-T-00	27-Jan-03	21,612,265	18,858,281	01-Feb-05	Disbursement 6[b]
		4	HIV/AIDS	CCM	31,129,618 (G)	65,035,569	Directorate of Directly Transmitted Disease Control of the Ministry of Health of INO	Government: Ministry of Health	IND-404-G04-H	26-Jan-05	31,129,618			TRP Clarification Completed[e]
Lao PDR	KPMG	1	HIV/AIDS	CCM	1,307,664 (G)	3,407,664	The Ministry of Health of Lao PDR	Government: Ministry of Health	LAO-102-G01-H-00	05-Feb-03	1,307,664	1,307,655	24-Feb-05	Disbursement 5[b]
		1	Malaria	CCM	3,155,152 (G)	12,709,087	The Ministry of Health of Lao PDR	Government: Ministry of Health	LAO-102-G02-M-00	05-Feb-03	3,155,152	2,728,630	18-Jan-05	Disbursement 5[b]
		2	Tuberculosis	CCM	1,524,338 (G)	3,530,391	The Ministry of Health of Lao PDR	Government: Ministry of Health	LAO-202-G03-T-00	03-Jul-03	1,524,338	1,100,024	15-Dec-04	Disbursement 3[b]
		4	HIV/AIDS	CCM	3,014,946 (T)	7,747,873			Not signed yet					TRP Clarification Completed[e]
		4	Malaria	CCM	3,292,689 (T)	14,515,720			Not signed yet					TRP Clarification Completed[e]
		4	Tuberculosis	CCM	1,175,826 (T)	3,617,781			Not signed yet					TRP Clarification Completed[e]

Approved Proposals									Grant Agreements and Disbursements					
Country (1)	Local Fund Agent (2)	Rnd	Disease Component	Source	Total Yr. 1 & 2 Budgets ($) (3)		Total Lifetime Budgets ($)	Principal Recipient	PR Type	Grant Number	Grant Signature Date	Grant Amount ($)	Amount Disbursed to Date ($)	Date of Most Recent Disbursement	Status (4)
MON	United Nations Office for Project Services	1	Tuberculosis	CCM	644,000	(G)	1,730,000	The Ministry of Health of MON	Government: Ministry of Health	MON-102-G01-T-00	05-Feb-03	644,000	641,369	12-Nov-04	Disbursement 7[b]
		2	HIV/AIDS	CCM	1,271,623	(G)	2,997,103	The Ministry of Health of MON	Government: Ministry of Health	MON-202-G02-H-00	01-Jul-03	1,271,623	1,271,623	16-Feb-05	Disbursement 7[b]
		4	Tuberculosis	CCM	1,958,259	(T)	4,083,764			Not signed yet					TRP Clarification Completed[e]
MWP	KPMG	2	HIV/AIDS	Reg. CCM	3,036,000	(G)	6,304,000	The Secretariat of the Pacific Community	Government: Other	MWP-202-G01-H-00	27-Jun-03	3,036,000	1,953,925	06-Sep-04	Disbursement 2.1[b]
		2	Malaria	Reg. CCM	2,416,850	(G)	4,897,650	The Secretariat of the Pacific Community	Government: Other	MWP-202-G02-M-00	27-Jun-03	2,416,850	2,217,488	22-Dec-04	Disbursement 3[b]
		2	Tuberculosis	Reg. CCM	1,699,100	(G)	3,089,010	The Secretariat of the Pacific Community	Government: Other	MWP-202-G03-T-00	27-Jun-03	1,699,100	1,220,806	22-Dec-04	Disbursement 3[b]
MYN	KPMG	2	Tuberculosis	CCM	6,997,137	(G)	17,121,370	The United Nations Development Programme	Multilateral Organization: UNDP	MYN-202-G01-T-00	13-Aug-04	6,997,137	2,404,656	14-Sep-04	Disbursement 1[b]
		3	HIV/AIDS	CCM	19,221,525	(G)	54,300,034	The United Nations Development	Multilateral Organization: UNDP	MYN-305-G02-H	14-Jan-05	19,221,525			Grant Agreement Signed[c]
		3	Malaria	CCM	9,462,062	(G)	27,050,046	The United Nations Development	Multilateral Organization: UNDP	MYN-305-G03-M	14-Jan-05	9,462,062			Grant Agreement Signed[c]
PNG	KPMG	3	Malaria	CCM	6,106,557	(G)	20,105,689	The Department of Health of the Government of PNG	Government: Ministry of Health	PNG-304-G01-M	07-Jul-04	6,106,557	2,185,723	09-Aug-04	Disbursement 1[b]
		4	HIV/AIDS	CCM	8,492,245	(T)	29,957,420			Not signed yet					TRP Clarification Completed[e]
PHI	Pricewaterhouse Coopers	2	Malaria	CCM	7,244,762	(G)	11,829,545	Tropical Disease Foundation, Inc.	Civil Society/ Private Sector: Private Sector	PHL-202-G01-M-00	11-Jun-03	7,244,762	5,901,349	12-Nov-04	Disbursement 4[b]
		2	Tuberculosis	CCM	3,434,487	(G)	11,438,064	Tropical Disease Foundation, Inc.	Civil Society/ Private Sector: Private Sector	PHL-202-G02-T-00	11-Jun-03	3,434,487	2,631,460	12-Nov-04	Disbursement 4[b]
		3	HIV/AIDS	CCM	3,496,865	(G)	5,528,825	Tropical Disease Foundation, Inc.	Civil Society/ Private Sector: Private Sector	PHL-304-G03-H	27-Jun-04	3,496,865	1,506,042	09-Jul-04	Disbursement 1[b]

		Approved Proposals							Grant Agreements and Disbursements					
Country (1)	Local Fund Agent	Rnd	Disease Component	Source	Total Yr. 1 & 2 Budgets ($) (3)	Total Lifetime Budgets ($)	Principal Recipient	PR Type	Grant Number	Grant Signature Date	Grant Amount ($)	Amount Disbursed to Date ($)	Date of Most Recent Disbursement	Status (4)
THA	KPMG	1	HIV/AIDS	CCM	30,933,204 (G)	109,505,316	The Department of Disease Control, Ministry of Public Health of THA	Government: Ministry of Health	THA-102-G01-H-00	18-May-03	30,933,204	27,289,779	15-Dec-04	Disbursement 4[b]
		2	HIV/AIDS	CCM	20,073,183 (G)	81,348,535	Raks Thai Foundation	Civil Society/ Private Sector: NGO	THA-202-G03-H-00	01-Jul-03	5,993,913	3,522,181	22-Dec-04	Disbursement 3[b]
							The Ministry of Public Health of the THA	Government: Ministry of Health	THA-202-G04-H-00	03-Sep-03	14,079,270	2,565,976	22-Feb-05	Disbursement 2[b]
VIE	KPMG	1	HIV/AIDS	CCM	7,500,000 (G)	12,000,000	The Ministry of Health of VIE	Government: Ministry of Health	VTN-102-G01-H-00	05-Sep-03	7,500,000	6,298,383	07-Mar-05	Disbursement 4[b]
		1	Tuberculosis	CCM	2,500,000 (G)	10,000,000	The Ministry of Health of VIE	Government: Ministry of Health	VTN-102-G02-T-00	15-Oct-03	2,500,000	630,948	17-Feb-05	Disbursement 2[b]
		3	Malaria	CCM	13,388,402 (G)	22,787,909	Central Project Management Unit "To consolidate and sustain the achievement of the last decade and to decisively roll back malaria in the remaining high risk areas"	Government: Ministry of Health	VTN-304-G03-M	24-Aug-04	13,388,402	3,218,217	21-Dec-04	Disbursement 1[b]
Totals for East Asia & the Pacific					395,718,938	1,048,497,609					311,941,829	162,555,869		
Region: Eastern Europe & Central Asia														
ARM	KPMG	2	HIV/AIDS	CCM	3,166,641 (G)	7,249,981	World Vision International - Armenia Branch	Civil Society/ Private Sector: NGO	ARM-202-G01-H-00	14-Jul-03	3,166,641	2,684,323	18-Jan-05	Disbursement 3[b]
AZE		4	HIV/AIDS	CCM	6,553,600 (T)	11,750,550			Not signed yet					TRP Clarification Completed[e]
BLR	KPMG	3	HIV/AIDS	CCM	6,818,796 (G)	17,369,100	UNDP	Multilateral Organization: UNDP	BLR-304-G01-H	29-Jun-04	6,818,796	1,254,445	05-Oct-04	Disbursement 1[b]
BUL	KPMG	2	HIV/AIDS	CCM	6,894,270 (G)	15,711,884	The Ministry of Health of the Republic of BUL	Government: Ministry of Health	BUL-202-G01-H-00	06-Jun-03	6,894,270	5,793,017	07-Mar-05	Disbursement 4[b]

Approved Proposals									Grant Agreements and Disbursements					
Country	Local Fund Agent (2)	Rnd	Disease Component	Source	Total Yr. 1 & 2 Budgets ($) (3)	Total Lifetime Budgets ($)	Principal Recipient	PR Type	Grant Number	Grant Signature Date	Grant Amount ($)	Amount Disbursed to Date ($)	Date of Most Recent Disbursement	Status (4)
Croatia	KPMG	2	HIV/AIDS	CCM	3,363,974 (G)	4,945,192	The Ministry of Health and Social Welfare of the Republic of Croatia	Government: Ministry of Health	HRV-202-G01-H-00	21-Jul-03	3,363,974	2,052,638	18-Jan-05	Disbursement 3[b]
EST	Pricewaterhouse Coopers	2	HIV/AIDS	CCM	3,908,952 (G)	10,246,580	The National Institute for Health Development of the Ministry of Social Affaires of EST	Government: Ministry of Health	EST-202-G01-H-00	25-Sep-03	3,908,952	3,001,436	03-Mar-05	Disbursement 4[b]
GEO	KPMG	2	HIV/AIDS	CCM	4,018,332 (G)	12,125,644	The Georgia Health and Social Projects Implementation Center	Government: Other	GEO-202-G01-H-00	14-Jul-03	4,018,332	1,711,409	18-Mar-05	Disbursement 2[b]
		3	Malaria	CCM	645,700 (G)	806,300	The Georgia Health and Social Projects Implementation Center	Government: Other	GEO-304-G02-M	29-Apr-04	645,700	360,950	11-Jun-04	Disbursement 1[b]
		4	Tuberculosis	CCM	1,829,218 (G)	5,536,965	The Georgia Health and Social Projects Implementation Center	Government: Other	GEO-405-G03-T	25-Jan-05	1,829,218	421,753	03-Mar-05	Disbursement 1[b]
Global (LWF)	DTT Emerging Markets	1	HIV/AIDS	NGO	485,000 (G)	700,000	The Lutheran World Federation	Civil Society/ Private Sector: Faith-Based Organization	WRL-102-G01-H-00	29-Jan-03	485,000	348,000	07-Apr-04	Disbursement 2[b]
KAZ	KPMG	2	HIV/AIDS	CCM	6,502,000 (G)	22,360,000	The Republican Center for Prophylactics and Control of AIDS of KAZ	Government: Other	KAZ-202-G01-H-00	04-Aug-03	6,502,000	5,258,929	10-Mar-05	Disbursement 5[b]
KGZ	Pricewaterhouse Coopers	2	HIV/AIDS	CCM	4,958,038 (G)	17,073,306	The National AIDS Center of KZG	Government: Other	KGZ-202-G01-H-00	04-Aug-03	4,958,038	3,288,378	10-Jan-05	Disbursement 3[b]
		2	Tuberculosis	CCM	1,212,835 (G)	2,771,082	National Center of Phtisiology of KGZ	Government: Other	KGZ-202-G02-T-00	04-Aug-03	1,212,835	1,102,678	15-Mar-05	Disbursement 3[b]
MKD	United Nations Office for Project Services	3	HIV/AIDS	CCM	4,348,599 (G)	6,309,972	The Ministry of Health of the Government of MKD	Government: Ministry of Health	MKD-304-G01-H	16-Sep-04	4,348,599	1,240,413	02-Nov-04	Disbursement 1[b]

		Approved Proposals							Grant Agreements and Disbursements					
Country (1)	Local Fund Agent (2)	Rnd	Disease Component	Source	Total Yr. 1 & 2 Budgets ($) (3)	Total Lifetime Budgets ($)	Principal Recipient	PR Type	Grant Number	Grant Signature Date	Grant Amount ($)	Amount Disbursed to Date ($)	Date of Most Recent Disbursement	Status (4)
MOL	Pricewaterhouse Coopers	1	HIV/TB	CCM	5,257,941 (G)	11,719,047	The Project Coordination, Implementation and Monitoring Unit of the Ministry of Health of MOL	Government: Ministry of Health	MOL-102-G01-C-00	24-Mar-03	5,257,941	5,026,861	17-Mar-05	Disbursement 8[b]
ROM	KPMG	2	HIV/AIDS	CCM	21,801,000 (G)	28,192,395	The Ministry of Health and Family of ROM	Government: Ministry of Health	ROM-202-G01-H-00	06-Jun-03	21,801,000	12,797,397	18-Jan-05	Disbursement 4[b]
		2	Tuberculosis	CCM	16,870,000 (G)	18,633,167	The Ministry of Health and Family of ROM	Government: Ministry of Health	ROM-202-G02-T-00	06-Jun-03	16,870,000	10,018,505	19-Nov-04	Disbursement 3[b]
RUS	Pricewaterhouse Coopers	3	HIV/AIDS	NGO	31,596,307 (G)	88,742,354	The Open Health Institute	Civil Society/ Private Sector: NGO	RUS-304-G01-H	25-Jun-04	31,596,307	10,900,000	27-Aug-04	Disbursement 1[b]
		3	Tuberculosis	Sub-CCM	6,306,869 (G)	10,766,486	Partners In Health	Civil Society/ Private Sector: NGO	RUS-304-G02-T	14-Oct-04	6,306,869	1,761,235	01-Dec-04	Disbursement 1[b]
		4	HIV/AIDS	CCM	34,176,931 (T)	120,543,828			Not signed yet					TRP Clarification Completed[e]
		4	Tuberculosis	CCM	53,534,157 (B)	92,263,589			Not signed yet					Board Approved[a]
SER	United Nations Office for Project Services	1	HIV/AIDS	CCM	2,718,714 (G)	3,575,512	The Economics Institute in Belgrade	Civil Society/ Private Sector: Private Sector	SER-102-G01-H-00	16-Apr-03	2,718,714	2,136,166	10-Mar-05	Disbursement 5[b]
		3	Tuberculosis	CCM	2,428,986 (G)	4,087,979	The Ministry of Health of the Republic of Serbia of SER	Government: Ministry of Health	SER-304-G02-T	04-Oct-04	2,428,986	368,549	12-Nov-04	Disbursement 1[b]
SER (Kosovo)		4	Tuberculosis	CCM	2,122,441 (T)	3,952,491			Not signed yet					TRP Clarification Completed[e]
TAJ	Pricewaterhouse Coopers	1	HIV/AIDS	CCM	1,474,520 (G)	2,425,245	UNDP	Multilateral Organization: UNDP	TAJ-102-G01-H-00	30-Mar-03	1,474,520	1,474,520	21-Dec-04	Disbursement 4[b]
		3	Tuberculosis	CCM	1,301,485 (G)	2,553,595	Project HOPE	Civil Society/ Private Sector: NGO	TAJ-304-G02-T	27-Sep-04	1,301,485	340,148	18-Oct-04	Disbursement 1[b]
		4	HIV/AIDS	CCM	2,508,720 (G)	8,128,972	UNDP	Multilateral Organization: UNDP	TAJ-404-G03-H	04-Nov-04	2,508,720	1,719,565	01-Dec-04	Disbursement 1[b]
Turkey		4	HIV/AIDS	CCM	3,891,762 (T)	3,891,762			Not signed yet					TRP Clarification Completed[e]
UKR	Pricewaterhouse Coopers	1	HIV/AIDS	CCM	24,970,211 (G)	92,152,744	The International HIV/AIDS Alliance	Civil Society/ Private Sector: NGO	UKR-102-A04-H-00	09-Mar-04	300,000	300,000	10-Mar-04	Disbursement 1[b]

		Approved Proposals							Grant Agreements and Disbursements					
Country (1)	Local Fund Agent (2)	Rnd	Disease Component	Source	Total Yr. 1 & 2 Budgets ($) (3)	Total Lifetime Budgets ($)	Principal Recipient	PR Type	Grant Number	Grant Signature Date	Grant Amount ($)	Amount Disbursed to Date ($)	Date of Most Recent Disbursement	Status (4)
							The Ukrainian Fund to Fight HIV Infection and AIDS	Government: Other	UKR-102-G01-H-00	22-Mar-03	311,889	311,889	22-Jul-03	Grant Suspended
							The Ministry of Health of UKR	Government: Ministry of Health	UKR-102-G02-H-00	29-Jan-03	541,682	541,682	19-Sep-03	Grant Suspended
							UNDP	Multilateral Organization: UNDP	UKR-102-G03-H-00	17-Feb-03	462,525	462,525	23-May-03	Grant Suspended
							The International HIV/AIDS Alliance	Civil Society/ Private Sector: NGO	UKR-102-G04-H-00	15-Mar-04	23,354,116	15,680,503	21-Dec-04	Disbursement 4[b]
UZB	Pricewaterhouse Coopers	3	HIV/AIDS	CCM	4,760,755 (G)	24,075,843	The National AIDS Center of the Ministry of Health of UZB	Government: Ministry of Health	UZB-304-G01-H	28-Sep-04	4,760,755	407,181	29-Oct-04	Disbursement 1[b]
		4	Malaria	CCM	1,343,466 (G)	2,482,572	The Republican Center of State Sanitary-Epidemiological Surveillance	Government: Other	UZB-405-G02-M	11-Feb-05	1,343,466	450,290	15-Mar-05	Disbursement 1[b]
		4	Tuberculosis	CCM	6,056,522 (G)	13,797,676	The Republican DOTS Center of UZB	Government: Ministry of Health	UZB-405-G03-T	09-Feb-05	6,056,522	1,078,706	10-Mar-05	Disbursement 1[b]
Totals for Eastern Europe & Central Asia					277,826,743	666,941,812					177,547,851	94,294,090		
Region: South Asia														
AFG	Pricewaterhouse Coopers	2	Integrated	CCM	3,125,605 (G)	3,125,605	The Ministry of Health of AFG	Government: Ministry of Health	AFG-202-G01-I-00	25-Oct-04	3,125,605	1,687,514	19-Nov-04	Disbursement 1[b]
		4	Tuberculosis	CCM	2,344,390 (T)	3,453,840			Not signed yet					TRP Clarification Completed[e]
BAN	DTT Emerging Markets	2	HIV/AIDS	CCM	6,010,140 (G)	19,711,030	The Economic Relations Division, Ministry of Finance, BAN	Government: Ministry of Finance	BAN-202-G01-H-00	28-Aug-03	6,010,140	2,420,010	19-Aug-04	Disbursement 2[b]
		3	Tuberculosis	CCM	16,643,074 (G)	42,466,601	Bangladesh Rural Advancement Committee (BRAC)	Civil Society/ Private Sector: Nongovernment Organization	BAN-304-G02-T	07-Jul-04	11,172,846	6,795,061	21-Mar-05	Disbursement 2[b]
							The Economic Relations Division, Ministry of Finance, BAN	Government: Ministry of Finance	BAN-304-G03-T	24-Aug-04	5,470,228	2,393,374	30-Sep-04	Disbursement 1[b]

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Country (1)	Local Fund Agent (2)	Rnd	Disease Component	Source	Total Yr. 1 & 2 Budgets (USD) (3)	Total Lifetime Budgets ($)	Principal Recipient	PR Type	Grant Number	Grant Signature Date	Grant Amount ($)	Amount Disbursed to Date ($)	Date of Most Recent Disbursement	Status (4)
BHU	KPMG	4	Malaria	CCM	1,000,957 (G)	1,737,190	The Department of Aid and Debt Management of the Ministry of Finance of BHU	Government: Ministry of Finance	BTN-405-G01-M	07-Jan-05	1,000,957	503,587	16-Feb-05	Disbursement 1[b]
		4	Tuberculosis	CCM	560,568 (G)	994,298	The Department of Aid and Debt Management of the Ministry of Finance of BHU	Government: Ministry of Finance	BTN-405-G02-T	07-Jan-05	560,568	196,216	16-Feb-05	Disbursement 1[b]
IND	The World Bank	1	Tuberculosis	CCM	5,650,999 (G)	8,784,999	The Department of Economic Affairs of IND	Government: Other	IDA-102-G01-T-00	30-Jan-03	5,650,999	4,313,840	17-Dec-04	Disbursement 3[b]
	United Nations Office for Project Services	2	HIV/AIDS	CCM	26,116,000 (G)	100,081,000	The Department of Economic Affairs of IND	Government: Other	IDA-202-G02-H-00	16-Feb-04	26,116,000	4,766,000	21-Dec-04	Disbursement 2[b]
		2	Tuberculosis	CCM	7,080,000 (G)	29,110,000	The Department of Economic Affairs of IND	Government: Other	IDA-202-G03-T-00	12-Feb-04	7,080,000	1,921,000	17-Dec-04	Disbursement 2[b]
		3	HIV/TB	CCM	2,667,346 (G)	14,819,773	The Department of Economic Affairs of IND	Government: Other	IDA-304-G04-C	15-Oct-04	2,667,346	165,428	23-Dec-04	Disbursement 1[b]
		2	Tuberculosis	CCM	7,080,000 (G)	29,110,000	The Department of Economic Affairs of IND	Government: Other	IDA-202-G03-T-00	12-Feb-04	7,080,000	1,921,000	17-Dec-04	Disbursement 2[b]
		4	HIV/AIDS	CCM	4,158,465 (G)	140,878,119	The Population Foundation of IND	Civil Society/Private Sector:	IDA-405-G05-H	10-Mar-05	4,158,465	827,493	15-Mar-05	Disbursement 1[b]
		4	Malaria	CCM	30,167,781 (T)	69,053,902			Not signed yet					TRP Clarification Completed
		4	Tuberculosis	CCM	6,819,000 (G)	26,545,000	The Department of Economic Affairs of IND	Government: Other	IDA-405-G08-T	09-Feb-05	6,819,000	397,000	15-Mar-05	Disbursement 1[b]
IRN	KPMG	2	HIV/AIDS	CCM	5,698,000 (G)	15,922,855	UNDP	Multilateral Organization: UNDP	IRN-202-G01-H-00	11-Mar-05	5,698,000			Grant Agreement Signed[c]
NEP	Pricewaterhouse Coopers	2	HIV/AIDS	CCM	4,365,996 (G)	11,173,542	The Ministry of Health, NEP	Government: Ministry of Health	NEP-202-G01-H-00	13-Aug-03	4,365,996	303,855	21-Dec-04	Disbursement 2[b]
		2	Malaria	CCM	2,622,929 (G)	7,624,668	The Ministry of Health, NEP	Government: Ministry of Health	NEP-202-G02-M-00	13-Aug-03	2,622,929	644,658	21-Dec-04	Disbursement 2[b]
		4	Tuberculosis	CCM	3,354,080 (T)	10,126,706			Not signed yet					TRP Clarification Completed

Approved Proposals									Grant Agreements and Disbursements					
Country (1)	Local Fund Agent (2)	Rnd	Disease Component	Source	Total Yr. 1 & 2 Budgets ($) (3)	Total Lifetime Budgets ($)	Principal Recipient	PR Type	Grant Number	Grant Signature Date	Grant Amount ($)	Amount Disbursed to Date ($)	Date of Most Recent Disbursement	Status (4)
PAK	KPMG	2	HIV/AIDS	CCM	3,822,700 (G)	8,312,200	The National AIDS Control Programme on the Behalf of the Ministry of Health of PAK	Government: Ministry of Health	PKS-202-G01-H-00	06-Aug-03	3,822,700	2,266,161	01-Feb-05	Disbursement 3[b]
		2	Malaria	CCM	4,407,000 (G)	7,719,800	The National AIDS Control Programme on the Behalf of the Ministry of Health of PAK	Government: Ministry of Health	PKS-202-G02-M-00	06-Aug-03	4,407,000	1,875,482	01-Feb-05	Disbursement 3[b]
		2	Tuberculosis	CCM	2,248,800 (G)	4,042,900	The National AIDS Control Programme on the Behalf of the Ministry of Health of PAK	Government: Ministry of Health	PKS-202-G03-T-00	06-Aug-03	2,248,800	922,808	01-Feb-05	Disbursement 3[b]
		3	Malaria	CCM	1,548,636 (G)	1,548,636	The National AIDS Control Programme on the Behalf of the Ministry of Health of PAK	Government: Ministry of Health	PKS-304-G04-M	12-Oct-04	1,548,636	454,800	24-Nov-04	Disbursement 1[b]
		3	Tuberculosis	CCM	5,605,431 (G)	13,085,948	The National AIDS Control Programme on the Behalf of the Ministry of Health of PAK	Government: Ministry of Health	PKS-304-G05-T	12-Oct-04	5,605,431	1,846,726	24-Nov-04	Disbursement 1[b]
SRI	Pricewaterhouse Coopers	1	Malaria	CCM	5,197,620 (G)	8,345,200	The Ministry of Health, SRI	Government: Ministry of Health	SRL-102-G01-M-00	19-Dec-02	730,140	607,773	03-Mar-05	Disbursement 2[b]
							Lanka Jatika Sarvodaya Shramadana Sangamaya	Civil Society/ Private Sector: NGO	SRL-102-G02-M-00	19-Dec-02	4,467,480	3,680,162	30-Jul-04	Disbursement 4[b]
		1	Tuberculosis	CCM	2,860,000 (G)	6,160,000	The Ministry of Health, SRI	Government: Ministry of Health	SRL-102-G03-T-00	19-Dec-02	2,384,980	1,709,265	03-Mar-05	Disbursement 2[b]
							Lanka Jatika Sarvodaya Shramadana Sangamaya	Civil Society/ Private Sector: NGO	SRL-102-G04-T-00	19-Dec-02	475,020	268,292	01-Oct-04	Disbursement 4[b]

		Approved Proposals						Grant Agreements and Disbursements					
Country (1)	Local Fund Agent (2)	Rnd	Disease Component	Source	Total Yr. 1 & 2 Budgets ($) (3)	Total Lifetime Budgets ($)	Principal Recipient	PR Type	Grant Number	Grant Signature Date	Grant Amount ($)	Amount Disbursed to Date ($)	Date of Most Recent Disbursement	Status (4)
		4	Malaria	CCM	2,203,520 (T)	3,781,268			Not signed yet					TRP Clarification Completed
Totals for South Asia					156,279,037	558,605,080					118,209,266	40,966,505		
GRAND TOTALS					**829,824,718**	**2,274,044,501**					**607,698,946**	**297,816,464**		

AFG = Afghanistan, ARM = Armenia, AZE = Azerbaijan, BAN = Bangladesh, BLR = Belarus, BHU = Bhutan, BUL = Bulgaria, CAM = Cambodia, CCM = country coordinating mechanism, DTT = Deloitte Touch Tohmatsu, EST = Estonia, G = final grant budget, GEO = Georgia, HIV/AIDS = human immunodeficiency virus/acquired immunodeficiency disease syndrome, IND = India, INO = Indonesia, IRN = Islamic Republic of Iran, KAZ = Kazakhstan, KPMG = Keiner Prueft Mehr Geisau, KGZ = Kyrgyz Republic, Lao PDR = Lao People's Democratic Republic, LWF = Lutheran World Federation, MKD = Macedonia, Former Yugoslav Republic, MOL = Moldova, MWP = Multi-country Western Pacific, MYN = Myanmar, NEP = Nepal, NGO = nongovernment organization, PAK = Pakistan, PNG = Papua New Guinea, PRC = People's Republic of China, PHI = Philippines, PR = principal recipient, ROM = Romania, RUS = Russian Republic, SER = Serbia and Montenegro, SRI = Sri Lanka, TAJ = Tajikistan, THA = Thailand, T = TRP clarification completed, budget pending grant negotiations, TB = tuberculosis, TRP = technical review panel, UKR = Ukraine, UNDP = United Nations Development Programme, UZB = Uzbekistan, VIE = Viet Nam.

[a] Board Approved = Board approved, pending TRP clarification and grant negotiations.

[b] Disbursement 1, 2, 3, … = Number of disbursements made to Principal Recipient.

[c] Grant Agreement Signed = The Grant Agreement between the Global Fund and the Principal Recipient has been signed.

[e] TRP Clarification Completed = Grant proposal clarifications completed as requested by the Global Fund's Technical Review Panel.

Note: An LFA is listed only if a grant agreement has been signed in country; LFA listings are current as of the report run date.

Source: The Global Fund to Fight AIDS, Tuberculosis and Malaria website. Available: www.theglobalfund.org

Table A13.1: Health, Nutrition, Population & Early Childhood Development Sector Loans
As of 31 December 2004

	Year of Approval	Country	Loan No.	Project Title	Approval Date	Closing Date	Loan Amount ($ million) OCR	ADF	Total	Status	Rating[a] PCR	PPAR
Public Sector												
1.	1978	HKG	354	Sha Tin Hospital	14-Sep-78	19-Dec-83	19.500	0.000	19.500	completed	NR	GS
2.	1978	SIN	386	Kent Ridge Hospital-Polyclinic	20-Dec-78	22-May-84	19.000	0.000	19.000	completed	NR	GS
3.	1980	BAN	504	Public Health Program	22-Dec-80	06-Apr-87	0.000	15.600	15.600	completed	NR	PS
4.	1981	MAL	511	Health and Population	21-Apr-81	31-Jan-91	25.800	0.000	25.800	completed	NR	PS
5.	1981	MYA	553	Upgrading of Hospitals	03-Dec-81	11-Oct-90	0.000	18.500	18.500	completed	NR	PS
6.	1981	PAK	562	Health and Population	15-Dec-81	22-Oct-90	0.000	15.000	15.000	completed	NR	PS
7.	1982	PNG	586	Rural Health Services	30-Sep-82	18-May-89	12.000	0.000	12.000	completed	NR	PS
8.	1982	SRI	576	Health and Population	22-Jul-82	16-Aug-90	0.000	9.300	9.300	completed	NR	GS
9.	1983	BAN	672	Health and Family Planning Services	14-Dec-83	23-Jun-92	0.000	27.500	27.500	completed	NR	PS
10.	1983	MYA	665	Rangoon General Hospitals	08-Dec-83	12-Oct-92	0.000	44.600	44.600	completed	NR	—
11.	1984	PAK	710	Second Health and Population	29-Nov-84	29-Apr-94	0.000	16.000	16.000	completed	NR	PS
12.	1985	INO	743	Health and Population	17-Oct-85	06-Jun-94	41.600	0.000	41.600	completed	GS	PS
13.	1985	PNG	746/747	Second Rural Health Services	24-Oct-85	13-Dec-91	5.400	8.500	13.900	completed	NR	PS
14.	1986	MAL	815	Health Services Development (Sector)	09-Dec-86	29-Sep-93	50.730	0.000	50.730	completed	GS	GS
15.	1987	PAK	850	Third Health	29-Oct-87	08-Aug-96	0.000	30.400	30.400	completed	PS	S
16.	1988	INO	926	Second and Health Population	29-Nov-88	12-Jul-95	39.300	0.000	39.300	completed	GS	—
17.	1989	MAL	980	Third Health (Sector)	31-Oct-89	24-Dec-97	105.000	0.000	105.000	completed	GS	S
18.	1990	PNG	1054[b]	Special Interventions	27-Nov-90	31-Dec-93	0.000	6.800	6.800	completed	PS	—
19.	1991	BAN	1074	Second Health and Family Planning Services	10-Jan-91	26-Jan-99	0.000	51.000	51.000	completed	PS	—
20.	1991	PNG	1097	Third Rural Health Services	05-Sep-91	15-Aug-00	0.000	21.000	21.000	completed	US	—
21.	1992	PAK	1200	Health Care Development	01-Dec-92	30-Apr-00	0.000	60.000	60.000	completed	PS	—
22.	1992	SRI	1189	Second Health and Population	17-Nov-92	27-Dec-99	0.000	26.100	26.100	completed	GS	S
23.	1993	PAK	1277	Population	02-Dec-93	08-Jun-00	0.000	25.000	25.000	completed	S	S
24.	1993	PNG	1225	Population and Family Planning	01-Apr-93	31-May-01	0.000	7.110	7.110	completed	PS	—
				Subtotal			**318.330**	**382.410**	**700.740**			
25.	1994	INO	1299	Rural Health and Population	26-May-94	15-Jun-01	40.000	0.000	40.000	completed	S	—
26.	1994	PHI	1331	Women's Health and Safe Motherhood	10-Nov-94	16-Oct-02	0.000	54.000	54.000	completed	S	—
27.	1994	RMI	1316	Health and Population	22-Sep-94	30-Jul-02	0.000	5.700	5.700	completed	S	—
28.	1995	LAO	1348	Primary Health Care	19-Jan-95	06-Dec-01	0.000	5.000	5.000	completed	S	S
29.	1995	CAM	1368	Basic Skills	30-Aug-95	14-Feb-03	0.000	16.200	16.200	completed	S	S
30.	1995	PHI	1396	Integrated Community Health	17-Oct-95	31-Dec-03	0.000	25.910	25.910	completed	—	—
30.	1996	CAM	1447	Basic Health Services	20-Jun-96	31-Mar-03	0.000	20.000	20.000	completed	S	—
31.	1996	CAM	1447	Basic Health Services	20-Jun-96	31-Mar-03	0.000	20.000	20.000	completed	S	—
32.	1996	INO	1471	Family Health and Nutrition	27-Sep-96	31-Dec-03	45.000	0.000	45.000	completed	—	—

	Year of Approval	Country	Loan No.	Project Title	Approval Date	Closing Date	Loan Amount ($ million) OCR	ADF	Total	Status	Rating PCR	PPAR
33.	1996	VIE	1460	Population and Family Health	19-Sep-96	30-Jun-03	0.000	43.000	43.000	completed	S	—
34.	1997	BAN	1538	Urban Primary Health Care	16-Sep-97	31-Dec-04	0.000	40.000	40.000	ongoing	—	—
35.	1997	INO	1523	Intensified Communicable Disease Control	19-Jun-97	31-Mar-04	87.400	0.000	87.400	ongoing	—	—
36.	1997	MON	1568	Health Sector Development Program	04-Nov-97	18-Jun-01	0.000	4.000	4.000	completed	S	—
37.	1997	MON	1569	Health Sector Development Project	04-Nov-97	30-Sep-03	0.000	11.922	11.922	completed	S	—
38.	1997	PNG	1516/17	Health Sector Development	20-Mar-97	08-Dec-99	45.000	5.000	50.000	completed	PS	—
39.	1997	PNG	1518	Health Sector Investment Project	20-Mar-97	30-Sep-03	0.000	10.000	10.000	completed	—	—
40.	1998	INO	1622 [c]	Social Protection Sector Development Program	09-Jul-98	31-Dec-99	100.000	0.000	100.000	completed	S	—
41.	1998	INO	1623 [b]	Social Protection Project	09-Jul-98	31-Jan-01	66.160	0.000	66.160	completed	S	—
42.	1998	KGZ	1645 [b]	Social Services Delivery and Finance	27-Nov-98	30-Jun-04	0.000	4.100	4.100	ongoing	—	—
43.	1998	PHI	1606/07	Early Childhood Development	27-Jan-98	31-Jan-05	15.700	8.800	24.500	ongoing	—	—
44.	1998	THA	1611 [b]	Social Sector Program	12-Mar-98	31-Mar-00	83.340	-	83.340	completed	S	—
				Subtotal			**482.600**	**273.632**	**756.232**			
45.	1999	INO	1675	Health and Nutrition Sector Development Program - Policy	25-Mar-99	22-Dec-00	100.000	0.000	100.000	completed	S	—
46.	1999	INO	1676	Health and Nutrition Sector Development Program - Project	25-Mar-99	31-Dec-03	200.000	0.000	200.000	completed	S	—
47.	1999	PAK	1671	Women's Health	16-Mar-99	31-Dec-05	0.000	47.000	47.000	ongoing	—	—
48.	1999	TAJ	1705 [b]	Social Sector Rehabilitation	16-Oct-99	31-Dec-03	0.000	7.860	7.860	ongoing	—	—
49.	2000	BHU	1762	Health Care Reform Program	21-Sep-00	27-Sep-02	0.000	10.000	10.000	completed	—	—
50.	2000	FSM	1816 [b]	Basic Social Services	20-Dec-00	30-Jun-07	0.000	3.885	3.885	ongoing	—	—
51.	2000	INO	1810	Decentralized Health Services	14-Dec-00	30-Sep-06	0.000	65.000	65.000	ongoing	—	—
52.	2000	LAO	1749	Primary Health Care Expansion	24-Aug-00	30-Jun-07	0.000	20.000	20.000	ongoing	—	—
53.	2000	VIE	1777	Rural Health	09-Nov-00	31-Dec-06	0.000	68.300	68.300	ongoing	—	—
54.	2001	MON	1836 [c]	Social Security Sector Development Project	28-Aug-01	30-Apr-07	0.000	4.108	4.108	ongoing	—	—
55.	2001	MON	1837 [c]	Social Security Sector Development Program	28-Aug-01	31-Oct-05	0.000	8.216	8.216	ongoing	—	—
56.	2001	PAK	1900	Reproductive Health	20-Dec-01	30-Jun-08	0.000	36.000	36.000	ongoing	—	—
57.	2002	CAM	1940	Health Sector Support	21-Nov-02	30-Jun-08	0.000	20.000	20.000	ongoing	—	—
58.	2003	INO	2074/75	Second Decentralized Health Services	19-Dec-03	31-Dec-10	64.800	35.200	100.000	ongoing	—	—
59.	2003	KGZ	2007	Community-Based Early Childhood Development	29-Sep-03	30-Jun-09	0.000	10.500	10.500	ongoing	—	—

	Year of Approval	Country	Loan No.	Project Title	Approval Date	Closing Date	Loan Amount ($ million) OCR	ADF	Total	Status	Rating PCR	PPAR
60.	2003	MON	1998	Second Health Sector Development	05-Jun-03	31-Dec-08	0.000	14.000	14.000	ongoing	—	—
61.	2003	TAJ	2054	Health Sector Reform	17-Dec-03	30-Jun-09	0.000	7.500	7.500	ongoing	—	—
62.	2004	VIE	2076	Health Care in the Central Highlands	09-Jan-04	30-Jun-10	0.000	20.000	20.000	ongoing	—	—
				Subtotal			**364.800**	**377.569**	**742.369**			
63.	2004	UZB	2090	Woman and Child Health Development	23-Sep-04	30-Jun-10	40.000	0.000	40.000	ongoing	—	—
64.	2004	PHI	2136	Health Sector Development Program	15-Dec-04	30-Jun-07	200.000	0.000	200.000	ongoing	—	—
65.	2004	PHI	2137	Health Sector Development Project	15-Dec-04	31-Dec-11	13.000	0.000	13.000	ongoing	—	—
				Subtotal			**253.000**	**-**	**253.000**			
				TOTAL - PUBLIC			**1,418.730**	**1,033.611**	**2,452.341**			

— = not available; ADF = Asian Development Fund; BAN = Bangladesh; BHU = Bhutan; CAM = Cambodia; FSM = Federated States of Micronesia; GS = generally successful; HKG = Hong Kong, China; INO = Indonesia; KGZ = Kyrgyz Republic; LAO = Lao People's Democratic Republic; MAL = Malaysia; MON = Mongolia; MYA = Myanmar; NR = no rating; OCR = ordinary capital resources; PAK = Pakistan; PCR = project completion report; PHI = Philippines; PNG = Papua New Guinea; PPAR = project performance audit report; PS = partly successful; RMI = Republic of the Marshall Islands; S = successful; SIN = Singapore; SRI = Sri Lanka; TAJ = Tajikistan; THA = Thailand; US = unsuccessful; UZB = Uzbekistan; VIE = Viet Nam.

[a] There were three assessment categories prior to 2000: generally successful, partly successful, and unsuccessful. With the *Guidelines for the Preparation of Project Performance Audit Reports* in October 2000, the rating categories were revised to highly successful, successful, partly successful, and unsuccessful.

[b] The total loan amount indicated for these multisector projects refers to the health-related component only.

[c] Portion for the health-related component cannot be determined from the report and recommendation of the President.

Sources: Loan Financial Information System, Postevaluation Information System, Project Performance Information System, and reports and recommendations of the President.

Table A13.2: Technical Assistance to the Health, Nutrition, Population, and Early Childhood Development Sector as of 31 December 2004

	Year of Approval	DMC	TA No.	Project Title	Approval Date	Completion Date	Type	Amount ($'000)	Status
1.	1979	NEP	304	Malaria Control	06-Sep-79	30-Jun-81	PPTA	80.00	completed
2.	1979	PAK	312	Upgrading of Hospital	13-Nov-79	31-Jul-81	PPTA	170.00	completed
3.	1980	BAN	380	Thana/Union Health Centers Development	09-Dec-80	31-Oct-82	PPTA	134.00	completed
4.	1980	INO	358	Production and Distribution of Essential Drugs	01-Jul-80	30-Apr-81	PPTA	170.00	completed
5.	1980	MYA	349	Upgrading of Hospital	22-Apr-80	31-May-84	PPTA	350.00	completed
6.	1980	PNG	394	Rural Health Services	31-Dec-80	30-Apr-82	PPTA	170.00	completed
7.	1982	INO	485	Health and Population Sector Study	04-Oct-82	31-Dec-87	PPTA	50.00	completed
8.	1982	MYA	502	Rangoon General Hospital	23-Dec-82	31-Dec-87	PPTA	150.00	completed
9.	1983	INO	552	Health and Population	17-Nov-83	31-Dec-87	PPTA	250.00	completed
10.	1983	PAK	538	Second Health and Population	12-Sep-83	28-Feb-85	PPTA	50.00	completed
11.	1984	MAL	622	Health Services Financing Study	29-Aug-84	30-Jun-88	ADTA	250.00	completed
12.	1984	PAK	639	Maintenance and Repair of Medical Equipment	29-Nov-84	30-Jun-92	ADTA	500.00	completed
13.	1984	PNG	594	Second Rural Health Services	12-Apr-84	31-Dec-87	PPTA	150.00	completed
14.	1985	MAL	735	Health Services Development	26-Dec-85	31-Dec-87	PPTA	220.00	completed
15.	1986	MAL	829	Study of National Health Security Fund	09-Dec-86	31-Dec-92	ADTA	430.00	completed
16.	1986	PAK	766	Third Health and Population	15-May-86	31-Dec-87	PPTA	236.00	completed
17.	1987	INO	932	Second Health and Population	07-Dec-87	31-Mar-94	PPTA	335.00	completed
18.	1987	PAK	913	Health Manpower and Training	29-Oct-87	31-Dec-90	ADTA	383.00	completed
19.	1987	PNG	852	Hospital Services	29-Jan-87	31-Mar-94	PPTA	304.00	completed
20.	1988	BAN	975	Institutional Strengthening of Procurement of Medical Supplies	09-May-88	30-Nov-89	ADTA	75.00	completed
21.	1988	MAL	1079	Third Health Sector	02-Dec-88	31-Dec-90	PPTA	100.00	completed
22.	1988	PNG	1091	Health Sector Financing	21-Dec-88	30-Dec-90	ADTA	361.00	completed
23.	1989	BAN	1264	Second Health and Family Planning Services	26-Dec-89	31-Mar-91	PPTA	250.00	completed
24.	1989	MAL	1214	National Health Plan Study	31-Oct-89	31-Mar-94	ADTA	600.00	completed
25.	1989	PHI	1121	National Hospital Services Development	06-Feb-89	31-Mar-94	ADTA	470.00	completed
26.	1990	PAK	1314	Fourth Health and Population (Manpower)	01-Jun-90	31-Dec-91	PPTA	100.00	completed
27.	1990	PNG	1333	Third Rural Health Services	06-Jul-90	30-Sep-92	PPTA	250.00	completed
28.	1990	SRI	1291	Second Health and Population	18-Apr-90	31-Aug-90	PPTA	100.00	completed
29.	1991	BAN	1463	Strengthening the Management and Maintenance Capabilities of NEMEW and its Regional Workshops	10-Jan-91	31-Dec-95	ADTA	240.00	completed

	Year of Approval	DMC	TA No.	Project Title	Approval Date	Completion Date	Type	Amount ($'000)	Status
30.	1991	INO	1634	Preparation of Community Health Services Project	31-Dec-91	30-Apr-94	PPTA	480.00	completed
31.	1991	PNG	1557	Strengthening Monitoring of Health Service Delivery	05-Sep-91	28-Apr-93	ADTA	350.00	completed
32.	1992	PHI	1774	Devolution of Health Services to LGUs	30-Oct-92	31-Dec-93	ADTA	100.00	completed
33.	1992	RMI	1833	Preparation of a Health and Population Project	31-Dec-92	28-Feb-98	PPTA	250.00	completed
34.	1992	SRI	1786	Management Information System and Health Insurance Study	17-Nov-92	30-Sep-97	ADTA	425.00	completed
35.	1993	BAN	1898	Bangladesh Integrated Nutrition	01-Jun-93	30-Sep-97	ADTA	99.50	completed
36.	1993	LAO	1947	Essential Drugs	09-Sep-93	31-Aug-98	PPTA	250.00	completed
37.	1993	PAK	2005	Institutional Development of the MPW	02-Dec-93	31-Aug-99	ADTA	700.00	completed
38.	1993	PHI	1891	Integrated Community Health Services	19-May-93	30-Apr-95	PPTA	541.00	completed
39.	1993	PHI	1926	Women's Health and Safe Motherhood	16-Aug-93	30-Sep-94	PPTA	100.00	completed
40.	1993	PHI	1931	Implementation of the Local Government Code in the Health Sector	16-Aug-93	30-Apr-98	ADTA	300.00	completed
41.	1993	PHI	2044	Cebu Longitudinal Health and Nutrition Study	29-Dec-93	31-Dec-98	ADTA	100.00	completed
42.	1993	PNG	1875	Review of Health Services Delivery	28-Apr-93	31-Mar-94	ADTA	100.00	completed
43.	1994	CAM	2223	Basic Health Services	07-Dec-94	31-Dec-97	PPTA	300.00	completed
44.	1994	INO	2221	Resource Mobilization and Budgeting for Decentralized Health Services	05-Dec-94	30-Sep-96	ADTA	600.00	completed
45.	1994	MON	2252	Strengthening Social Insurance	20-Dec-94	30-Jun-95	ADTA	84.00	completed
46.	1994	MON	2279	Strengthening Health Insurance	29-Dec-94	31-May-98	ADTA	500.00	completed
47.	1994	PNG	2060	Human Resources Development Project in the Health Sector	09-Feb-94	31-Jul-99	PPTA	296.00	completed
48.	1994	PNG	2103	National Health Plan Development	16-Jun-94	30-Jul-96	ADTA	575.00	completed
49.	1994	RMI	2164	Health management Information System and Health Planning	22-Sep-94	31-Dec-98	ADTA	465.00	completed
50.	1994	SOL	2083	Population and Family Health Improvement	22-Apr-94	30-Sep-97	PPTA	350.00	completed
51.	1994	VAN	2259	Preparation of Population Policy and Action Plan	22-Dec-94	30-Nov-96	ADTA	50.00	completed
52.	1994	VIE	2135	Financing of Social Services	12-Aug-94	30-Apr-98	ADTA	575.00	completed
53.	1995	BAN	2413	Urban Primary Health Care	03-Oct-95	31-May-97	PPTA	450.00	completed
54.	1995	INO	2300	Communicable Disease Control	17-Feb-95	31-Jan-96	PPTA	800.00	completed
55.	1995	INO	2301	Family Health Nutrition	17-Feb-95	31-Jan-96	ADTA	600.00	completed
56.	1995	INO	2312	Enhancing the Quality of Reproductive Health Care	14-Mar-95	31-Mar-02	PPTA	840.00	completed

	Year of Approval	DMC	TA No.	Project Title	Approval Date	Completion Date	Type	Amount ($'000)	Status
57.	1995	KIR	2497	Sanitation and Public Health	21-Dec-95	31-Oct-96	PPTA	577.00	completed
58.	1995	LAO	2291	Strengthening the Ministry of Public Health	19-Jan-95	30-Nov-98	ADTA	800.00	completed
59.	1995	MON	2414	Health Sector Development	03-Oct-95	31-May-98	PPTA	600.00	completed
60.	1995	PHI	2323	Early Childhood Development	25-Apr-95	03-May-96	PPTA	600.00	completed
61.	1995	PHI	2354	Sustaining Health of the Working Age Population	30-Jun-95	30-Jun-02	ADTA	575.00	completed
62.	1995	PHI	2423	Strengthening Hospital Standards, Licensing and Regulation	17-Oct-95	30-Apr-98	ADTA	450.00	completed
63.	1995	SRI	2441	Study on Financing of Social Services	09-Nov-95	31-Oct-97	ADTA	350.00	completed
64.	1996	BAN	2584	Health Care Financing - National Health Accounts	10-Jun-96	28-Feb-99	ADTA	350.00	completed
65.	1996	CAM	2567	Managing Basic Health Services	08-May-96	30-Sep-00	ADTA	500.00	completed
66.	1996	KGZ	2688	Social Services Delivery and Finance	19-Nov-96	31-May-98	PPTA	1,100.00	completed
67.	1996	MON	2683	Strengthening the National Poverty Allevation Program	07-Nov-96	31-Dec-98	ADTA	422.00	completed
68.	1996	MON	2731	Health Sector Resources Development	23-Dec-96	28-Feb-97	PPTA	100.00	completed
69.	1996	PAK	2576	Public-Private Partnership in Health Study	31-May-96	30-Jun-98	ADTA	450.00	completed
70.	1996	PAK	2577	Women's Health	04-Jun-96	28-Apr-97	PPTA	500.00	completed
71.	1996	PNG	2561	Health Sector Program	26-Apr-96	31-Dec-96	PPTA	145.00	completed
72.	1997	BAN	2864	Strengthening the Management Capacity of the City Corporation Health Departments	12-Sep-97	30-Sep-00	ADTA	500.00	completed
73.	1997	INO	2814	Capacity Building of the Ministry of Health for Strategic Development	19-Jun-97	05-Mar-99	ADTA	800.00	completed
74.	1997	INO	2839	Reproductive Health Care	11-Aug-97	31-Mar-99	PPTA	500.00	completed
75.	1997	INO	2930	Early Childhood Development	09-Dec-97	30-Jun-02	PPTA	900.00	completed
76.	1997	MON	2907	Support for Decentralization Health Services	04-Nov-97	30-Jun-03	ADTA	600.00	completed
77.	1997	PHI	2843	Institutional Strengthening of the DSWD	15-Aug-97	31-May-99	ADTA	577.00	completed
78.	1997	PNG	2772	Strengthening Financial Management of the Health Sector	20-Mar-97	31-Jul-01	ADTA	786.00	completed
79.	1997	RMI	2844	Ebeye Hospital, Kwajalein Atoll	19-Aug-97	28-Feb-98	ADTA	90.00	completed
80.	1998	VIE	2348	Population and Family Health	15-Jun-98	30-Apr-98	PPTA	415.00	completed
81.	1998	LAO	3058	Primary Health Care Expansion	20-Aug-98	31-Aug-00	PPTA	700.00	completed
82.	1998	THA	2997	Health Management and Financing Study	12-Mar-98	31-Dec-99	ADTA	700.00	completed
83.	1998	VIE	3077	Rural Health	25-Sep-98	31-Jul-00	PPTA	598.43	completed
84.	1999	BHU	3186	Health Care Financing and Reform Program	16-Apr-99	31-May-00	PPTA	150.00	completed
85.	1999	FSM	3195	Human Resources Development Study	14-May-99	31-Oct-99	ADTA	150.00	completed
86.	1999	FSM	3342	Basic School Services Sector Development Program	16-Dec-99	31-May-00	PPTA	150.00	completed

	Year of Approval	DMC	TA No.	Project Title	Approval Date	Completion Date	Type	Amount ($'000)	Status
87.	1999	INO	3175	Monitoring and Evaluating the Health and Nutrition Sector Development Program	25-Mar-99	31-Dec-02	ADTA	2,000.00	completed
88.	1999	INO	3176	Capacity Building to Support Decentralized Health Services System	25-Mar-99	31-Dec-02	ADTA	1,000.00	completed
89.	1999	PAK	3386	Health Sector Reform NWFP	29-Dec-99	30-Apr-03	ADTA	500.00	completed
90.	1999	PAK	3387	Reproductive Health	29-Dec-99	31-Jul-01	PPTA	300.00	completed
91.	1999	SOL	3264	Population Policy and Services	24-Sep-99	30-Jun-00	PPTA	150.00	completed
92.	1999	VIE	3337	Capacity Building for Rural Health	14-Dec-99	31-Mar-04	ADTA	600.00	ongoing
93.	2000	CAM	3511	Capacity Building for HIV/AIDS Prevention and Control	03-Oct-00	31-Dec-03	ADTA	600.00	completed
94.	2000	INO	3448	Decentralized Health Services	26-May-00	31-Oct-01	PPTA	180.00	completed
95.	2000	INO	3579	Support for Health Sector Policy Reform	14-Dec-00	30-Apr-07	ADTA	1,857.40	ongoing
96.	2000	KGZ	3420	Community-Based Early Childhood Development	23-Mar-00	30-Apr-03	PPTA	700.00	completed
97.	2000	LAO	3478	Capacity Building for Primary Health Care	10-Aug-00	28-Feb-03	ADTA	800.00	completed
98.	2000	RMI	3611	Reviewing the Health Management Information System	21-Dec-00	30-Jun-02	ADTA	100.00	completed
99.	2000	VIE	3483	Capacity Building for Prevention of Food-Borne Diseases	29-Aug-00	31-Jan-03	ADTA	500.00	completed
100.	2001	CAM	3653	Second Basic Health Services	03-May-01	30-Apr-03	PPTA	700.00	completed
101.	2001	INO	3775	Second Decentralized Health Services	15-Nov-01	31-Oct-03	PPTA	1,000.00	completed
102.	2001	MON	3684	Improving Social Statistics	12-Jul-01	30-Sep-04	ADTA	500.00	completed
103.	2001	MON	3750	Second Health Sector	29-Oct-01	15-Sep-02	PPTA	600.00	completed
104.	2001	PNG	3660	Health Policy Support	30-May-01	31-Dec-03	ADTA	462.00	completed
105.	2001	PNG	3762	Health Sector Review	06-Nov-01	30-Jun-03	ADTA	250.00	completed
106.	2001	PNG	3827	Gender and Population	21-Dec-01	30-Jun-03	PPTA	500.00	ongoing
107.	2001	TUV	3709	Strengthening Policy for Social Security Reform	28-Aug-01	31-Dec-04	ADTA	600.00	ongoing
108.	2002	CAM	4016	Reaching the Rural Poor with Primary Health Care	06-Dec-02	30-Sep-03	ADTA	39.00	completed
109.	2002	PAK	3975	Early Childhood Development	05-Nov-02	15-Sep-03	PPTA	500.00	completed
110.	2002	PHI	4064	Health Sector Development	19-Dec-02	31-Mar-04	PPTA	600.00	completed
111.	2002	PNG	4057	Health Sector Development Program	21-May-02	30-Nov-03	PPTA	500.00	ongoing
112.	2002	PRC	3992	Strengthening National Public Nutrition Planning	20-Nov-02	30-Nov-05	ADTA	500.00	ongoing
113.	2002	VIE	3877	Making Health Care More Affordable for the Poor	07-Jun-02	31-Dec-04	ADTA	200.00	ongoing
114.	2003	AZE	4115	Early Childhood Development	14-May-03	31-Dec-05	PPTA	600.00	ongoing

	Year of Approval	DMC	TA No.	Project Title	Approval Date	Completion Date	Type	Amount ($'000)	Status
115.	2003	BAN	4085	Social Protection for Disadvantaged Women and Children	11-Feb-03	31-May-05	PPTA	500.00	ongoing
116.	2003	BAN	4165	Second Urban Primary Health Care	25-Aug-03	31-Oct-05	PPTA	400.00	ongoing
117.	2003	INO	4094	Public Health and Nutrition	11-Apr-03	30-Jun-04	ADTA	500.00	completed
118.	2003	INO	4124	Sustainable Social Protection	09-Jun-03	11-Nov-04	PPTA	800.00	ongoing
119.	2003	INO	4156	Second Decentralized Health Services	08-Aug-03	17-Oct-03	PPTA	100.00	completed
120.	2003	KGZ	4187	Institutional Strengthening for Community-Based Early Childhood Development	14-Oct-03	30-Jun-05	ADTA	500.00	ongoing
121.	2003	MON	4123	Health Sector Reform	05-Jun-03	30-Jun-05	ADTA	650.00	ongoing
122.	2003	NEP	4097	Social Protection Study	21-Apr-03	30-Apr-04	ADTA	250.00	completed
123.	2003	PNG	4208	Establishment of Pilot HIV/AIDS Care Centers	12-Dec-03	31-Mar-06	ADTA	450.00	ongoing
124.	2003	PRC	4118	Combating SARS in the Western Region	22-May-03	30-Jun-05	ADTA	2,000.00	ongoing
125.	2003	PRC	4142	Preventing HIV/AIDS on Road Projects in Yunnan Province	14-Jul-03	31-Jul-07	ADTA	800.00	ongoing
126.	2003	RMI	4219	Youth Social Services	10-Nov-03	30-Oct-05	PPTA	500.00	ongoing
127.	2003	TAJ	4268	Planning and Policy Dialogue for Health Reform	17-Dec-03	30-Sep-05	ADTA	300.00	ongoing
128.	2003	TAJ	4269	Drug Procurement and Distribution Strategy	17-Dec-03	31-Mar-05	ADTA	150.00	ongoing
129.	2003	UZB	4101	Woman and Child Health Development	28-Apr-03	31-Dec-04	PPTA	500.00	ongoing
130.	2003	VIE	4092	Health Care for the Poor in the Central Highlands	25-Mar-03	31-Dec-03	PPTA	150.00	completed
131.	2003	VIE	4102	Strengthening of Preventive Health Services	02-May-03	31-Dec-04	PPTA	500.00	ongoing
132.	2003	VIE	4205	Early Childhood Development for the Poor	24-Oct-03	31-Jul-05	ADTA	450.00	ongoing
133.	2004	VIE	4314	Health Care in the Central Highlands	09-Jan-04	30-Jun-10	ADTA	5,579.00	ongoing
134.	2004	VIE	4331	Support for Pro-Poor Health Policies	28-Apr-04	30-Jun-06	ADTA	500.00	ongoing
135.	2004	MON	4364	Awareness and Prevention of HIV/AIDS and Human Trafficking	22-Jul-04	31-Jul-09	ADTA	350.00	no contract
136.	2004	TAJ	9043	Community Participation and Public Information Campaign for Health Improvement	22-Jul-04	30-Jun-07	ADTA	1,000.00	ongoing
137.	2004	INO	4387	Urban Nutrition	08-Sep-04	31-Mar-05	PPTA	400.00	ongoing
138.	2004	UZB	4396	Capacity Building for Women and Child Health Development	23-Sep-04	31-Dec-05	ADTA	300.00	not effective
139.	2004	MON	9053	Information and Communication Technology for Improving Rural Health Services	02-Aug-04	28-Feb-07	ADTA	1,000.00	ongoing
140.	2004	KGZ	9056	Reducing Neonatal Mortality	08-Sep-04	31-Oct-08	ADTA	1,000.00	no contract yet

	Year of Approval	DMC	TA No.	Project Title	Approval Date	Completion Date	Type	Amount ($'000)	Status
141.	2004	CAM	9057	Health Care Financing for the Poor	15-Nov-04	31-Dec-08	ADTA	1,847.00	no contract yet
142.	2004	SRI	4442	Psychosocial Health in Conflict-Affected Areas	22-Nov-04	31-Dec-07	ADTA	400.00	not effective
143.	2004	KGZ	4445	Awareness and Prevention of HIV/AIDS, Sexually Transmitted Infections, and Human Trafficking	23-Nov-04	30-Jun-08	ADTA	500.00	no contract yet
144.	2004	VIE	4542	HIV/AIDS Prevention among Youth	23-Dec-04	31-Jul-05	PPTA	400.00	not effective
TOTAL								**71,958.33**	

ADTA = advisory technical assistance, AZE = Azerbaijan, BAN = Bangladesh, BHU = Bhutan, CAM = Cambodia, DMC = developing member country, DSWD = Department of Social Welfare and Development, FSM = Federated States of Micronesia, HIV/AIDS = human immunodeficiency virus/acquired immunodeficiency syndrome, INO = Indonesia, KIR = Kiribati, KGZ = Kygyz Republic, LAO = Lao People's Democratic Republic, MAL = Malaysia, MON = Mongolia, MYA = Myanmar, NEMEW = National Electromedical Equipment Maintenance Workshop and Training Center, NEP = Nepal, NWFP = North-West Frontier Province, PAK = Pakistan, PNG = Papua New Guinea, PPTA = project preparatory technical assistance, PRC = People's Republic of China, PHI = Philippines, PS = partly successful, RMI = Republic of the Marshall Islands, SARS = severe acute respiratory syndrome, SOL = Solomon Islands, SRI = Sri Lanka, TA = technical assistance, TAJ = Tajikistan, THA = Thailand, TUV = Tuvalu, UZB = Uzbekistan, VAN = Vanuatu, VIE = Viet Nam.
Source: Asian Development Bank Postevaluation Information System, Technical Assistance Information System.

Table A13.3: Regional Technical Assistance to the Health, Nutrition, Population, and Early Childhood Development Sector as of 31 December 2004

	Regional TA No.	Title	Type	Participating Countries	Date Approved	Amount ($'000)	Fund Source	Completion		Status
								Original	Revised	
1.	5181	Regional Seminar on the Use of Rural Health Services	Conference	BAN, IND, INO, KOR, MAL, MYA, PAK, PNG, PHI, SRI, THA	04-Jul-85	125.0	TASF	Jan-86	31-Dec-88	Closed in Dec 88.
		Supplementary			17-Feb-87	15.0				
2.	5228	Regional Seminar on Health Care Financing	Conference	BAN, PRC, IND, INO, KOR, MAL, MYA, PAK, PNG, PHI, SRI, THA	30-Oct-86	275.0	TASF	Jun-87	—	Closed in Mar 94.
3.	5294	Regional Study of the Health and Population Sector	Study	Not applicable	10-Jun-88	198.0	TASF	Nov-88	—	Closed in Mar 94.
4.	5318	Seminar on Health Insurance	Conference	General	24-Jan-89	30.0	TASF	—	30-Sep-89	Closed in Sep 89.
5.	5421	Regional Research Program on Priority Health and Population Issues	Research	PRC, FIJ, INO, NEP, PAK, PHI, SIN, SRI, THA	02-Jan-91	560.0	TASF	—	28-Apr-93	Closed in Aug 99.
6.	5523	Symposium on Population Policy and Economic Development: Lessons of Experience	Conference	General	11-Dec-92	95.0	JSF	—	—	Closed in Feb 94.
7.	5541	Study in the Economic Implications of the HIV/AIDS Epidemic in Selected DMCs	Study	PRC, INO, MYA, THA	20-Jul-93	300.0	TASF	Not mentioned	31-Mar-00	Closed in Aug 00.
8.	5601	Regional Conference on Health Sector Reform in Asia	Conference	General	02-Nov-94	100.0	TASF	—	31-May-98	Closed in Dec 99.
9.	5614	Issues Related to Private Sector Growth in the Health Sector in	Research	IND, INO, KOR, PHI, THA, VIE	27-Dec-94	550.0	JSF	May-96	—	TCR circulated 27 Dec 96, Closed in Apr 98.
10.	5629	Study of the Impact of Bank Assistance in the Health and Population Sector	Study	BAN, PAK, PNG, SRI	27-Apr-95	300.0	TASF	Jun-96	31-Dec-99	TCR circulated Dec 99, closed in Jul 99.
11.	5668	Study on Regional Health Policy Priorities	Study	BAN, PHI, VIE	09-Jan-96	600.0	TASF	Apr-97	31-Dec-99	TCR circulated 22 Jun 99. Closed in May 01.

	Regional TA No.	Title	Type	Participating Countries	Date Approved	Amount ($'000)	Fund Source	Completion Original	Completion Revised	Status
12.	5671	Reducing Child Malnutrition in Eight Asian Countries	Study	BAN, CAM, IND, PAK, PRC, SRI, VIE	29-Jan-96	750.0	TASF UNICEF	Mar-97	31-Dec-02	TCR circulated 11 Oct 99. Closed in May 03.
13.	5751	Cooperation in the Prevention and Control of HIV/AIDS in the GMS	Study	GMS countries	17-Sep-97	150.0	TASF	—	31-Dec-02	Completed.
14.	5752	Fourth International Congress on AIDS in Asia and the Pacific	Conference	General	26-Sep-97	100.0	TASF	—	29-Oct-97	Closed in Jul 99.
15.	5761	Strengthening of Capacity in Economic Analysis of Health Sector Projects in DMCs	Study	General	16-Dec-97	350.0	TASF	Jan-99	31-Jan-01	TCR circulated in Jul 2001, closed in Jul 01.
16.	5794	Study of Health and Education Needs of Ethnic Minorities in the GMS	Study	CAM, LAO, THA, VIE	30-Jun-98	800.0	TASF	Jun-00	30-Apr-02	TCR circulated 25-Sep-02.
17.	5824	Regional Study of Nutrition Trends, Policies and Strategies in Asia and the Pacific	Study	BAN, KGZ, PRC, FIJ, INO, SRI, VIE	23-Dec-98	750.0	JSF	Apr-00	30-Apr-02	TCR circulated 2-Oct-01. Closed in Aug 03.
		Supplementary			27-Apr-00	50.0				
18.	5825	Strengthening Safe Motherhood Programs	Study	BAN, CAM, INO, LAO, NEP, PAK, PNG	24-Dec-98	700.0	JSF	Mar-01	30-Apr-02	TCR circulated 4-Jul-03. Closed in Oct 03.
19.	5881	Preventing HIV/AIDS among Mobile Populations in the GMS	Study	CAM, LAO, MYA, VIE	16-Dec-99	450.0	JSF	Aug-01	31-Jul-02	TCR circulated 25-Sep-02.
		Supplementary			21-Dec-00	160.0				
20.	5914	Ninth International Congress of the World Federation of Public Health Association	Conference	General	11-May-00	50.0	TASF	Sep-00	06-Sep-00	Closed in Mar 2004.
21.	5944	Regional Initiative to Eliminate Micronutrient Malnutrition in Asia through Public-Private Partnership	Study	PRC, IND, INO, PAK, THA, VIE	17-Oct-00	1,100.0	JSF, DANIDA, ILSI	31-Mar-03	30-Oct-04	Closed in Jan 2005.
		Supplementary			01-Aug-02	200.0				

	Regional TA No.	Title	Type	Participating Countries	Date Approved	Amount ($'000)	Fund Source	Completion Original	Completion Revised	Status
22.	5958	Roll Back Malaria Initiative in the GMS	Others	GMS countries	07-Dec-00	600.0	JSF	Dec-02	31-Jul-04	Ongoing.
23.	5982	Support to the Sixth International Congress on AIDS in Asia and the Pacific	Conference	General	30-Mar-01	150.0	TASF	Oct-01	30-Jun-04	Completed.
24.	5970	Drug Eradication in the GMS	Study	GMS countries	21-Dec-00	150.0	TASF	30-Jun-01	31-Dec-03	Ongoing.
25.	9005	Asian Countries in Transition for Improving Nutrition for Poor Mothers and Children	Study	AZE, KAZ, KGZ, MON, TAJ, UZB	26-Apr-01	6,000.0	JFPR	31-Aug-02	30-Apr-05	Ongoing.
		Supplementary			23-Oct-01	850.0	JFPR			
26.	9006	Community Action for Preventing HIV/AIDS	Study	CAM, LAO, VIE	08-May-01	8,000.0	JFPR	Dec-03	31-May-05	Ongoing.
27.	6083	ICT AND HIV/AIDS Preventive Education in the Cross-Border Areas of the GMS	Training	GMS countries	19-Dec-03	1,000.0	TASF	Jun-04	31-Dec-04	Ongoing.
28.	6106	Financing Needs for HIV/AIDS Prevention and Care in Asia and the Pacific	Training	General	16-May-03	150.0	TASF	31-Dec-03	31-Dec-05	Ongoing.
29.	6108	Emergency Regional Support to Address the Outbreak of SARS	Others	AFG, BAN, BHU, CAM, PRC, ETM, IND, INO, KAZ, KGZ, LAO, MAL, MON, NEP, PAK, PNG, PHI, SRI, TAJ, THA, UZB, VIE	23-May-03	2,000.0	JSF	31-Dec-03	31-Dec-06	Ongoing.
		Supplementary			29-Sep-03	3,000.0				
		Supplementary			14-Jun-04	500.0	Taipei			
30.	6173	Strengthening the Response to HIV/AIDS in Asia and the Pacific	Study	General	21-May-04	150.0	TASF	31-Dec-04	31-Mar-05	Ongoing.
31.	9052	Sustainable Food Fortification	Poverty Reduction	KAZ, KGZ, MON, TAJ, UZB	22-Jul-04	2,000.0	JFPR	31-Aug-06	30-Apr-07	Ongoing.

	Regional TA No.	Title	Type	Participating Countries	Date Approved	Amount ($'000)	Fund Source	Completion Original	Completion Revised	Status
32.	6190	Preventing the Trafficking of Women and Children and Promoting Safe	Others	GMS countries	04-Oct-04	700.0	TASF	30-Jun-06	31-Dec-06	Ongoing.
33.	6194	GMS Regional Communicable Diseases Control	Study	GMS countries	20-Oct-04	600.0	JSF	30-Jun-05	—	Ongoing.
34.	6209	HIV/AIDS in the Pacific: ADB's Response	Research	Pacific DMCs	17-Dec-04	150.0	TASF	31-Aug-05	—	Ongoing.
	Total					**34,758.0**				

— = not available, ADB = Asian Development Bank, AFG = Afghanistan, AZE = Azerbaijan, BAN = Bangladesh, BHU = Bhutan, CAM = Cambodia, DANIDA = Danish International Development Agency, DMC = developing member country, ETM = Timor-Leste, FIJ = Fiji Islands, GMS = Greater Mekong Subregion, HIV/AIDS = human immunodeficiency virus/acquired immunodeficiency syndrome, ICT = information and communication technology, ILSI = International Life Sciences Institute, IND = India, INO = Indonesia, JPFR = Japan Fund for Poverty Reduction, JSF = Japan Special Fund, KAZ = Kazakhstan, KOR = Republic of Korea, KGZ = Kyrgyz Republic, LAO = Lao People's Democratic Republic, MAL = Malaysia, MON = Mongolia, MYA = Myanmar, NEP = Nepal, PAK = Pakistan, PNG = Papua New Guinea, PHI = Philippines, PRC = People's Republic of China, SARS = severe acute respiratory syndrome, SIN = Singapore, SRI = Sri Lanka, TA= technical assistance, TAJ = Tajikistan, TASF = Technical Assistance Special Fund, TCR = technical assistance completion report, THA = Thailand, UNICEF = United Nations Children's Fund, UZB = Uzbekistan, VIE = Viet Nam.

Source: Asian Development Bank Technical Assistance Information System.

Table A13.4: Assistance Pipeline for Lending Products in the Health, Nutrition, Population, and Early Childhood Development Sector, 2005–2008

Project/Program Name	Status	Year of PPTA	Cost ($ million)				
			Total	OCR	ADF	Govt	Others
2005							
1. INO: Community Water Services and Health	Approved on 7 Apr 2005	2002	86.8	34.1	30.6	22.1	5.6[a]
2. BAN: Second Urban Primary Health Care	Approved on 31 May 2005	2003	48.0	0.0	30.0	18.0	42[b]
3. VIE: Strengthening of Preventive Health Services	SRC completed	2003	38.0	0.0	38.0	TBD	TBD
2006							
1. AZE: Early Childhood Development	For fact-finding	2003	16.8	0.0	14.3	2.5	0.0
2. INO: Urban Nutrition and Health	For fact-finding	2004	50.0	20.0	30.0	TBD	0.0
3. PNG: Health Sector Development Program	For fact-finding	2002	24.0	0.0	10.0	4.0	10.0
4. LAO: Health Sector Development	For fact-finding	2005	15.0	0.0	15.0	TBD	0.0
2007							
1. PAK: Social Health Insurance	For fact-finding	2005	30.0	0.0	30.0	TBD	0.0
2. UZB: Second Woman and Child Health Development	For fact-finding	2006	40.0	40.0	0.0	TBD	0.0
2008							
1. MON: Third Health Sector Development	For fact-finding	2007	15.0	0.0	15.0	TBD	TBD
2. BAN: Urban Primary Health Care Sector Development	For fact-finding	2007	100.0	0.0	100.0	TBD	TBD
Total			**463.6**	**94.1**	**312.9**	**46.6**	**10.0**

ADF = Asian Development Fund, AZE = Azerbaijan, BAN = Bangladesh, Govt = government, INO = Indonesia, LAO = Lao People's Democratic Republic, MON = Mongolia, PAK = Pakistan, PNG = Papua New Guinea, OCR = ordinary capital resources, PPTA = project preparatory technical assistance, SRC = Staff Review Committee, TBD = to be determined, UZB = Uzbekistan, VIE = Viet Nam.

[a] Representing estimated contribution from project beneficiaries.

[b] Representing Asian Development Bank grant amounting to $10.0 million and contributions from the following cofinanciers: Department for International Development, $25.0 million; Swedish International Development Cooperation Agency, $5.0 million; and United Nations Population Fund, $2.0 million.

Source: Asian Development Bank Project Processing Information System.

ADB LOANS AND TECHNICAL ASSISTANCE WITH EMPHASIS ON SEXUALLY TRANSMITTED INFECTIONS, COMMUNICABLE DISEASES, HEALTHY LIFESTYLES, ENVIRONMENTAL HEALTH AND HEALTH EDUCATION

Table A14.1: Percentage of Loans and TA with Emphasis on Management and Control of STI and HIV/AIDS

	Loans		TA, RETA, JFPR Projects	
Infectious Diseases	**Pre-Policy**	**Post-Policy**	**Pre-Policy**	**Post-Policy**
Any RTIs, STI, HIV/AIDS	52.6	47.1	3.7	20.6
RTIs	21.1	11.8	0.0	0.0
STI, HIV/AIDS	47.4	47.1	3.7	20.6
STI	31.6	23.5	0.0	8.8
HIV/AIDS	31.6	41.2	3.7	17.6
Indicators:				
HIV Prevalence	0.0	5.9	0.0	11.8
Condom Use	0.0	0.0	0.0	5.9

HIV/AIDS = human immunodeficiency virus/acquired immunodeficiency disease syndrome, JFPR = Japan Fund for Poverty Reduction, RETA = regional technical assistance, RTI = reproductive tract infection, STI = sexually transmitted infections, TA = technical assistance.
Source: Asian Development Bank loan and TA documents.

Table A14.2: Percentage of Loans and TA with Emphasis on Management and Control of Communicable Diseases

Communicable	Loans		TA, RETA, JFPR Projects	
Diseases	**Pre-Policy**	**Post-Policy**	**Pre-Policy**	**Post-Policy**
Treatment of TB	52.6	52.9	3.7	2.9
Indicators:				
Any Indicator	52.6	52.9	0.0	2.9
TB Prevalence/Incidence	10.5	5.9	0.0	0.0
TB Detection	31.6	17.6	0.0	0.0
Malaria Prevention	42.1	29.4	3.7	11.8
Indicators:				
Any Indicator	42.1	29.4	0.0	11.8
Indicator:				
Incidence/Death	26.3	11.8	0.0	5.9
Indicator: Prevention	10.5	5.9	0.0	2.9
Schistosomiasis	5.3	0.0	3.7	0.0

JFPR = Japan Fund for Poverty Reduction, RETA = regional technical assistance, TA = technical assistance, TB = tuberculosis.
Source: Asian Development Bank loan and TA documents.

Table A14.3: Percentage of Loans and TA with Emphasis on Healthy Lifestyle

	Loans		TA, RETA, JFPR Projects	
Healthy Lifestyle	**Pre-Policy**	**Post-Policy**	**Pre-Policy**	**Post-Policy**
Healthy Lifestyle	21.1	35.3	0.0	0.0
Tobacco Reduction	5.3	17.6	0.0	0.0
Alcohol Reduction	5.3	5.9	0.0	0.0
Dietary Improvement	21.1	11.8	0.0	0.0

JFPR = Japan Fund for Poverty Reduction, RETA = regional technical assistance, TA = technical assistance.
Source: Asian Development Bank loan and TA documents.

Table A14.4: Percentage of Loans and TA with Emphasis on Environmental Health

	Loans		TA, RETA, JFPR Projects	
Environmental Health	**Pre-Policy**	**Post-Policy**	**Pre-Policy**	**Post-Policy**
Environmental Health and Sanitation	15.8	11.8	0.0	8.8
Any Indicator:	10.5	5.9	0.0	5.9
Hh Using Solid Fuel	0.0	0.0	0.0	0.0
Hh with Access to Safe Water	10.5	0.0	0.0	5.9
Hh with Access to Improved Sanitation	5.3	5.9	0.0	5.9

Hh = household, JFPR = Japan Fund for Poverty Reduction, RETA = regional technical assistance, TA = technical assistance.
Source: Asian Development Bank loan and TA documents.

Table A14.5: Percentage of Loans and TA with Emphasis on Health Education

Item	Loans		TA, RETA, JFPR Projects	
	Pre-Policy	**Post-Policy**	**Pre-Policy**	**Post-Policy**
Health Promo/Education	78.9	88.2	7.4	55.9

JFPR = Japan Fund for Poverty Reduction, RETA = regional technical assistance, TA = technical assistance.
Source: Asian Development Bank loan and TA documents.

PERCENTAGE OF ADB LOANS AND TA EMPHASIZING THE PROVISION OF PRIMARY HEALTH CARE SERVICES

	Loans		TA	
PHC Intervention	**Pre-Policy**	**Post-Policy**	**Pre-Policy**	**Post-Policy**
Total Loans/TAs	19	17	27	34
Immunization	68.4	58.8	0.0	2.9
Vitamin A Supplementation	36.8	11.8	0.0	5.9
Family Planning	57.9	47.1	3.7	2.9
Iodination of Salt or Water Supply	21.1	11.8	0.0	5.9
Treatment of TB	52.6	41.2	3.7	2.9
Treatment of STIs	31.6	23.5	3.7	8.8
ARI Case Management	42.1	35.3	0.0	2.9
HIV/AIDS	31.6	35.3	3.7	17.6
Management of Diarrhea	47.4	23.5	0.0	5.9
Malaria Prevention	36.8	17.6	3.7	5.9
Tobacco Use Reduction	5.3	11.8	0.0	0.0
Hygiene Education: Hand-washing	21.1	11.8	0.0	0.0

ADB = Asian Development Bank, ARI = acute respiratory tract infection, HIV/AIDS = human immunodeficiency virus/acquired immunodeficiency disease syndrome, STI = sexual transmitted infection, TA = technical assistance, TB = tuberculosis.

Source: Asian Development Bank loan and TA documents.

PERCENTAGE OF ADB LOANS SUPPORTING MAJOR COMPONENTS OF THE HEALTH SECTOR REFORMS

Project/Program Components	Loans		TAs	
	Pre-Policy	Post-Policy	Pre-Policy	Post-Policy
Policy	47.4	58.8	51.9	35.3
Planning/Strategy	26.3	58.8	51.9	58.8
Referral System	21.1	29.4	7.4	8.8
Hospital Rationalization	21.1	17.6	3.7	5.9
Regulations/Licensing	5.3	17.6	11.1	17.6
Health Insurance	0	35.3	11.1	11.8
Financial/Budget Management	26.3	58.8	11.1	23.5
Health Care Financing	47.4	41.2	18.5	14.7
Public-Private/NGO Partnership	63.2	41.2	25.9	29.4
Staff Training/Development	42.1	88.2	29.6	38.2
Supervision	26.3	29.4	7.4	5.9
HMIS	52.6	58.8	14.8	14.7
Monitoring/Evaluation	26.3	88.2	29.6	38.2
Surveillance	15.8	11.8	0.0	17.6
Community-based Initiatives	47.4	64.7	3.7	11.8
Health Education/ Health Promotion	78.9	88.2	7.4	55.9

HMIS = health management information system, NGO = nongovernment organization, TA = technical assistance.
Source: Asian Development Bank loan and TA documents.

FOCUS ON MILLENNIUM DEVELOPMENT GOALS

	Loans		TAs		
MDGs	**Pre-Policy**	**Post-Policy**	**Pre-Policy**	**Post-Policy**	**CSPUs**
Infant and Child Mortality	73.7	64.7	3.7	14.7	86.7
Prevalence of Underweight Children	15.8	17.6	0.0	2.9	70.0
Percent of 1-year olds Immunized Against Measles	68.4	47.1	0.0	2.9	3.3
Maternal Mortality Ratio	42.1	52.9	3.7	11.8	100.0
Contraceptive Prevalence Rate	42.1	47.1	3.7	2.9	40.0
Percent of Total Births Attended by Skilled Personnel	21.1	35.3	0.0	2.9	40.0
Prevalence of HIV	5.3	5.9	0.0	17.6	100.0
Condom Use Rate	0	0.0	0.0	5.9	0.0
Malaria Incidence/ Prevalence	10.5	5.9	0.0	8.8	93.3
Percent of Children Sleeping Under Insecticide Treated Bed Nets	10.5	5.9	0.0	2.9	0.0
Tuberculosis Prevalence	15.8	11.8	0.0	0.0	73.3
Percent of Tuberculosis Detected	26.3	5.9	0.0	2.9	6.7
Percent of Population Using Solid Fuel	0	0.0	0.0	0.0	0.0
Percent of People with Access to Improved Sanitation	5.3	0.0	0.0	5.9	42.0

CSPU = country strategy and program update, HIV = human immunodeficiency virus, MDG = Millennium Development Goal, TA = technical assistance.
Source: Asian Development Bank loan and TA documents.