Sector-wide Evaluation

Evaluation of ADB's Support for Health in Asia and the Pacific

Independent Evaluation ADB

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NOTE

In this report, "$" refers to United States dollars.

Director General	Emmanuel Jimenez, Independent Evaluation Department (IED)
Director	Andrew Brubaker, Thematic and Country Division, IED
Team leader	Eungji Kim, Senior Evaluation Specialist, IED
Team members	Nassreena Baddiri, Senior Evaluation Specialist, IED Myrna Fortu, Associate Evaluation Officer, IED Neeta Goel, Senior Evaluation Specialist, IED Maya Vijayaraghavan, Principal Evaluation Specialist, IED Sergio Villena, Senior Evaluation Officer, IED

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In preparing any evaluation report, or by making any designation of or reference to a particular territory or geographic area in this document, the Independent Evaluation Department does not intend to make any judgments as to the legal or other status of any territory or area.

Abbreviations

ADB	–	Asian Development Bank
AfDB	–	African Development Bank
AIIB	–	Asian Infrastructure Investment Bank
ANR	–	agriculture, natural resources, and rural development
APDRF	–	Asia Pacific Disaster Response Fund
APVAX	–	Asia Pacific Vaccine Access Facility
COVID-19	–	coronavirus disease
CPRO	–	COVID-19 Pandemic Response Option
CPS	–	country partnership strategy
DMC	–	developing member country
HSDG	–	Health Sector Directional Guide
IDB	–	Inter-American Development Bank
IED	–	Independent Evaluation Department
MDB	–	multilateral development bank
MTR	–	midterm review
NSO	–	nonsovereign operations
PBL	–	policy-based loan
RBL	–	results-based loan
SDGs	–	Sustainable Development Goals
TA	–	technical assistance
UHC	–	universal health coverage
WBG	–	World Bank Group
WHO	–	World Health Organization

Contents

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Foreword

Health is a fundamental human right and a cornerstone of sustainable and inclusive development. As the 2030 target for Sustainable Development Goal (SDG) 3—ensuring healthy lives and promoting well-being for all—draws near, countries across Asia and the Pacific have made notable progress in improving health outcomes. Expanded immunization, improved access to health care, and public health campaigns have lowered child mortality rates and improved maternal health, while disease control programs for HIV/AIDS, tuberculosis, and malaria have improved quality of life for the most vulnerable. Some countries have even started moving toward universal health care and have increased their focus on disease prevention and treatment.

Despite these gains, the nature of health risks in the region has continued to evolve—driven by rapidly aging populations and a rise in noncommunicable diseases such as diabetes, cardiovascular disease, and cancer—even as consumer expectations for access to convenient and affordable health care have risen. Equity remains a major issue as health care has not sufficiently reached the poor and marginalized groups in most developing member countries. More recently, the coronavirus disease (COVID-19) pandemic laid bare these vulnerabilities in health systems, widened disparities, and strained existing resources. Advances are at risk of being reversed, and achieving the SDG 3 targets remains a distant goal.

This evaluation offers an in-depth assessment of Asian Development Bank (ADB) support for health from 2011 to 2024, focusing on the relevance of ADB strategies, the adequacy of its commitments, the effectiveness of its implementation, and the coherence of its institutional capacities and partnerships. ADB's rapid response during the COVID-19 pandemic and its commitment to strengthening health systems and expanding universal health coverage have provided a strong foundation as it transitions to a more strategic and integrated model that can deliver measurable results and build long-term resilience in the region.

The evaluation highlights the limitations of ADB's legacy health policy, which does not reflect the complexity of current and emerging health challenges, including changing demographics and behaviors, epidemiological transitions, and rising consumer expectations. The evaluation finds that ADB has struggled to implement its two-track approach of direct support for the health sector and investment in other sectors that can contribute to health outcomes.

This evaluation presents timely and actionable insights to guide ADB's growing role in the health sector. With a new, focused, strategic, and inclusive approach, ADB can strengthen support for its developing member countries to improve health outcomes and achieve its broader development goals.

Emmanuel Jimenez
Director General
Independent Evaluation

Executive Summary

The Asia and Pacific region has made significant strides in health. Countries have increased life expectancy, reduced child and maternal mortality, and controlled communicable diseases. However, the nature of health risks in the region has changed. Health needs in Asia and the Pacific have evolved significantly in recent decades, driven by shifting demographic profiles, changing behaviors, epidemiological transitions, and rising consumer expectations. The failure of publicly financed health care to reach the poor in almost all developing countries has contributed to growing disparities in health outcomes among and within countries.

The role of health within the development agenda is complex and has been a persistent challenge for multilateral development banks and other international agencies. As with education, health is both an outcome and a catalyst of economic growth and development. Some key determinants of health outcomes lie outside the health sector.

The strategic priorities and approaches to health of the Asian Development Bank (ADB) have shifted over time. ADB has had a Policy for the Health Sector since 1999, but in its Strategy 2020 corporate document (published in 2008) ADB took a decision to step away from working directly in health, instead stating that it would pursue a multisector approach by working primarily in other sectors that can impact health outcomes. However, in 2014, the midterm review (MTR) of Strategy 2020 recognized the limitations of this approach and the need for ADB to become more directly engaged in the health sector. In 2018, a new corporate document, Strategy 2030, strengthened ADB's commitment to reengage in the health sector. This approach received an external boost from ADB's emergency response to the coronavirus disease (COVID-19) pandemic. Since then, ADB has deepened and articulated its support for the health sector, embodied in the Strategy 2030 Health Sector Directional Guide, released in 2022.

Evaluation Scope and Objectives

This evaluation covers 2011–2024, providing an opportunity to assess the shifts in ADB's support to health, which have been driven both by ADB's corporate strategies and by spikes in demand from its developing member countries. The evaluation covers ADB's portfolio of core health projects (tier 1), multisector projects with health subcomponents (tier 2), and other projects that may contribute to health outcomes (tier 3).

The evaluation's overall objective is to assess how well ADB is positioned to deliver improved health outcomes and well-being for people in Asia and the Pacific. A key evaluation objective is understanding the extent to which ADB has moved the needle on health outcomes through its investments in other sectors. The evaluation also assesses ADB's effectiveness and responsiveness to client needs and the extent to which it has provided critical knowledge and mobilized partnerships to support its client countries.

Key Findings

The 2008 shift in ADB's strategic priorities and approaches away from direct health support to a multisector approach was in line with its comparative strengths, particularly in infrastructure. ADB infrastructure projects in other sectors, such as water and other urban infrastructure and services, could be leveraged to address critical social and environmental determinants of health. ADB had access to multiple sources and types of financing as well as the mandate and capacity to work in and across sectors that support health. This allowed it to take a more programmatic approach. However, an absence of clear operational guidance, monitoring frameworks,

and institutional incentives undermined the effectiveness of ADB's health support.

In response to country demand, ADB sought to reengage directly in health operations while maintaining its multisector approach through the 2014 MTR of Strategy 2020. While this may have been appropriate, ADB's fluctuating priorities and shortcomings posed challenges for the clarity and coherence of its vision, approach, and support for health in Asia and the Pacific and its ability to position itself as a consistent and influential development partner in the sector.

Indeed, it has proved difficult to adapt the policy in response to complex and emerging health challenges, including noncommunicable diseases, pandemics, aging populations, equity, and universal health coverage. ADB's strategic shifts and the COVID-19 pandemic were the two most significant factors impacting ADB's approach to health and its portfolio during 2011–2024. Although ADB's efforts to leverage its infrastructure-centric advantage to support health was well intentioned, its health-related portfolio remained limited in scale and scope before COVID-19. The pandemic underscored ADB's institutional advantage: ADB was one of the only development agencies with the mandate, operational capacity, and financial resources to coordinate rapidly across sectors and modalities to address emergency needs.

Health benefits from ADB's multisector projects and COVID-19 response are difficult to measure or attribute because of inadequate monitoring and evaluation systems and the complex nature of these interventions. ADB's investments in nonsovereign operations in the health sector increased during the pandemic, but this expansion also showed that ADB needs to take a more strategic approach to guide its medium- to long-term private sector engagement in health.

ADB's institutional resources, structure, and capacity are inadequate given the scale and complexity of its evolving health goals. Health is a complex sector because of its multisectoral nature, the wide range of stakeholders, the need to balance preventive and curative services, and the requirement to optimize public and private contributions, including financing. A range of technical skills are needed to address key health issues effectively. Although it has more than tripled its in-house health expertise since publication of the Strategy 2020 midterm review, sustaining this rapid growth in capacity will require strong strategic backing.

ADB's new operating model reshaped ADB's organizational structure and its internal collaboration dynamics, presenting both opportunities and challenges to the multisector approach to health. Under the new operating model, health specialists are consolidated in the Human and Social Development Sector Office. This offers an opportunity for ADB to utilize its internal expertise more effectively, align itself with consultant networks, and form partnerships with other technical agencies, think tanks, and academia.

An increase in the number of health indicators and objectives in ADB country partnership strategies is an encouraging sign of the greater priority developing member countries are placing on strengthening health systems. However, ADB needs to conduct more country-specific analytical work to deepen its engagement and ensure future support is based on needs and contributes to countries' national development. Such work can be sector specific or cater more broadly to ADB's cross-sector developmental objectives, such as equity, innovation, and private sector engagement.

Recommendations

This evaluation makes the following recommendations:

Recommendation 1. ADB should update its health strategic framework to provide a clear vision and mandate in meeting the rising health needs in Asia and the Pacific.

Recommendation 2. In implementing its updated health strategic framework, ADB should provide clear guidance and incentivization on how to operationalize the health and multisector approach for better health outcomes.

Recommendation 3. ADB should develop and implement a strategic staffing and resource plan aligned with the updated health strategic framework.

Recommendation 4. ADB should strengthen country-focused diagnostic work and knowledge management to complement its demand-driven approach to health.

Links Between Findings and Recommendations

Recommendations	Findings, Issues, and References
1. ADB should update its health strategic framework to provide a clear vision and mandate in meeting the rising health needs in Asia and the Pacific.	- The Policy for the Health Sector (1999) remains ADB's most recent Board-approved, mandatory policy governing its engagement in health. Although the policy may have been forward-looking at the time of its adoption, it has not been revised in more than 2 decades, despite substantial shifts in regional health dynamics and global development paradigms. (*para. 13*). - The absence of an updated health policy limited institutional preparedness and hindered ADB's ability to deploy resources strategically across sectors. The situation worsened with the introduction of Strategy 2020 and Strategy 2030, as according to the 2024 ADB policy architecture, "there is no practice for retiring old policies after a new or revised policy is introduced, leading to a situation where there is no single coherent set of policy provisions". The policy architecture noted this shortcoming as a common issue in ADB's board document life cycle management. (*para. 14*) - The absence of an updated health policy has resulted in a disconnect between institutional guidance and operational practice, particularly in responding to emerging health challenges while aligning with the corporate priorities articulated in Strategy 2030. (*para. 15*) - Despite articulating these important aspirations, the Health Sector Directional Guide (HSDG) took the form of a guiding document, meaning that its recommendations were neither binding nor mandatory for staff. This limited the HSDG's effectiveness in driving institutional accountability and cross-sector engagement. (*para. 20*) - During the evaluation period, ADB's health sector operations were not guided by a current policy, corporate-level strategy, or goal that could have united its efforts or interventions. As a result, although individual operations were successfully implemented, they did not contribute to high-level or corporate-level outcomes or impacts. (*para. 71*)
2. In implementing its updated health strategic framework, ADB should provide clear guidance and incentivization on how to operationalize the health and multisector approach for better health outcomes.	- While the HSDG expanded on Strategy 2030 by presenting high-level descriptions of how multisector projects could be designed, the design and monitoring framework failed to articulate how they would ultimately contribute to health outcomes. It also failed to provide guidance on how progress or success on the delivery of health outcomes would be monitored or evaluated. (*para. 20*) - Despite the strategic intent and vision of Strategy 2030, the renewed corporate emphasis on achieving health outcomes through the multisector approach has still not been underpinned by a coherent theory of change or effective mechanisms to monitor and evaluate progress. (*para. 33*) - This suggests a broader lack of internal operational support, which has limited the capacity of project teams to integrate health indicators into multisector projects in a systematic way. ADB has limited evidence of success from the multisector approach, due in large part to the absence of dedicated monitoring frameworks to capture health outcomes within ADB multisector projects and investments led by other sectors. (*para. 60*) - Without strong cross-sector governance, robust monitoring systems, and mechanisms to ensure accountability for health outcomes, the link between nonsovereign infrastructure investments and tangible health benefits could be weakened. For ADB to continue pushing for health outcomes via its nonsovereign operations in other sectors, more explicit commitments on the integration and monitoring of health outcomes through non-health sectors will be needed. (*para. 66*) - Operationally, the new operating model (NOM) has reshaped internal collaboration dynamics, presenting opportunities as well as challenges to the multisector approach to health. The NOM rollout has broken down regional silos while establishing links across sectors and modalities within ADB. (*para. 83*) - ADB's comparative advantage in infrastructure has not been translated into a significant increase in health support, as staff outside the health sector receive limited incentives to pursue multisector collaboration. The NOM and the One ADB approach offer the potential for ADB to enhance internal collaboration and cross-sector integration, but it is still too early to assess their impact. (*para. 87*)

Recommendations	Findings, Issues, and References
3. ADB should develop and implement a strategic staffing and resource plan aligned with the updated health strategic framework.	- Another constraint was loss of institutional knowledge because of the departure of many ADB health experts starting in the early 2000s after ADB deprioritized health. (*para. 9*) - Acknowledging that ADB cannot be the lead health sector partner for all of its developing member countries (DMCs), the guide emphasized the critical importance of strategic partnerships with other development agencies, particularly in contexts where technical and financial capacity for health system strengthening is limited. (*para.19*) - Although ADB has made progress in mobilizing private sector investment in health, its approach along this continuum remains fragmented and characterized by persistent operational challenges. These include difficulties in sourcing bankable projects with measurable health outcomes, the limited technical capacity of private sponsors in frontier markets, and shortages of staff and sector expertise within ADB (e.g., only one international staff covers nonsovereign operations in all of Southeast Asia). These constraints have limited both the visibility and the sourcing of nonsovereign opportunities. (*para. 62*) - The evaluation team found that the in-country presence of ADB health staff with deep knowledge of national systems and sector dynamics had played a significant role in the success, sustainability, and growth of several country health portfolios, as exemplified by the Mongolia Resident Mission, where a highly experienced national health officer contributed to a robust health portfolio and provided critical support for policy dialogue. (*para. 78*) - To meet the sudden surge in demand from DMCs amid the COVID-19 pandemic, more international staff were brought onboard, with the total peaking at 21 international and 4 national or local staff in 2023. However, this increase has proved insufficient to meet the long-term demands of DMCs for health sector support. ADB will need to recruit more health specialists (including health economists and administrators) if it is to translate the boost in DMCs' health sector demands post-COVID into long-term project pipelines. (*para. 79*) - The evaluation team's discussions with government officials from five of the largest borrowing countries found that the officials were concerned about the adequacy of ADB's staffing for the health sector. Senior government leaders expressed strong appreciation for ADB's support during the COVID-19 response and noted the flexibility demonstrated by ADB staff, but they also questioned whether ADB staff were sufficient in number or had the required technical skills. (*para. 80*)
4. ADB should strengthen country-focused diagnostic work and knowledge management to complement its demand-driven approach to health.	- Despite the absence of a strong institutional mandate for health from ADB, some DMCs have identified health as a priority in their national development plans and have actively sought ADB's continued engagement in the health sector. Evolving corporate priorities within ADB and the health sector needs of its DMCs are reflected in ADB country partnership strategies (CPSs). (*para. 25*) - Although such technical assistance (TA) is essential to effective collaboration and to the implementation of ADB projects, the ADB TA program would have been better balanced if it had supported more policy and advisory and research and development TA projects, which together accounted for only 21% of TA projects by number and 9% of TA by volume. Such TA can offer greater mid- to long-term impact by providing in-depth country-specific knowledge and policy reform direction. (*para. 52*) - ADB has undertaken extensive knowledge work in the health sector aimed at informing policy, guiding investments, and supporting countries to achieve universal health coverage. (*para. 73*) - Despite the breadth and depth of ADB's knowledge work in the health sector, much of it may not be reaching its intended audiences, particularly policymakers, implementers, and private sector actors in low- and middle-income countries. ADB has produced text-heavy technical publications that assume a high degree of familiarity with development finance and health systems, and may not resonate with time-constrained or non-specialist readers. (para. 74) - ADB's lack of structured, publicly accessible data on its health portfolio significantly undermines efforts to evaluate the effectiveness of its investments in the sector. Without a consistent framework for reporting project outcomes, disbursement progress, and measurable health indicators, it is difficult to assess whether projects—collectively or individually—have achieved their intended impact or offered value for money. (*para. 75*)

CHAPTER 1

Supporting Evolving Health Needs in the Region

A. Health Needs in Asia and the Pacific

1. The Asia and Pacific region has seen health outcomes improve significantly, particularly in reducing child and maternal mortality and controlling communicable diseases. Expanded immunization, better access to health care, and public health campaigns have lowered child mortality and improved maternal health. The region has also carried out effective disease control programs for HIV/AIDS, tuberculosis, and malaria. Some countries are moving toward universal health care and have increased their focus on disease prevention and treatment.

2. Despite these gains, the nature of health risks in the region is changing. Health needs in Asia and the Pacific have evolved significantly since the 1990s, driven by rapidly aging populations; a rise in noncommunicable diseases, including diabetes, cardiovascular diseases, and cancer; and rising consumer expectations for access to convenient and affordable health care. Equity in health remains a major issue. The failure of publicly financed health care to reach poor and marginalized groups in almost all Asian Development Bank (ADB) developing member countries (DMCs) has compromised health outcomes. Even in countries with advanced health systems, the poor tend to be more vulnerable than the wealthy.[1]

3. Three global transitions—demographic, epidemiological, and nutritional—directly influence health outcomes in Asia and the Pacific, and they will require DMCs to adapt how their health systems are organized and financed.[2] Communicable diseases pose a visible and significant health threat, causing millions of deaths during periodic outbreaks, with the heaviest toll on countries with underdeveloped health systems. The coronavirus disease (COVID-19) pandemic was one such flare-up, as were severe acute respiratory syndrome (SARS) and avian influenza before it. Greater global connectivity, growing trade, and the rapid rise of international travel have increased the risk of communicable diseases becoming pandemics, with huge detrimental impacts on both global health and trade. Over time, disease burdens have transitioned from communicable to noncommunicable diseases, from young populations to aging populations, and from undernutrition to overnutrition. Modern health systems need to adapt to this transition while also preparing for future outbreaks of communicable diseases. The recent experience with COVID-19 spotlighted the increasingly critical role of modern health systems for safeguarding the health and economic well-being of populations.

4. The complex and evolving relationship among health, health systems, and economic development have posed challenges for governments and the development agencies that support them (Box 1). This evaluation considers how ADB has approached health since 2011 and its commonalities with other multilateral development banks (MDBs). First, all MDBs have adopted,

[1] A. Wagstaff. Poverty and Health Sector Inequalities. 2002. *Bulletin of the World Health Organization*. 80(2). pp. 97–105.

[2] International organizations define the term "health system" differently depending on their mandate, focus areas, and development philosophy. For this evaluation, “health system” is defined as “collective institutions, infrastructure, policies, and human resources that deliver health services,” based on ADB’s operational plans and guidance documents.

as an organizational principle, the objective of universal health coverage (UHC) as established by the United Nations. This means that investment in the health sector should increase access to—and use of—life-saving health services. Second, progress toward UHC requires the DMCs to address income, gender, and ethnic inequities that are barriers to physical and financial access to services. Third, realizing UHC necessitates a whole-of-sector approach that acknowledges the existence of large private health sectors in most countries. Policy-focused engagement between the public and private sectors is needed, as is direct investment in the private sector. Finally, given the importance of health outcome determinants outside the health sector, a whole-of-government approach is needed to ensure that investment in other sectors promotes health outcomes.

Box 1: Strategic Shift in the Role of Health in Economic Development

The relationship of health and education to economic development has evolved substantially since the 1950s when high rates of illiteracy, malnutrition, and communicable diseases were regarded as the product of arrested economic development. Since multilateral development banks have tended to focus on infrastructure, their involvement in health has largely taken the form of investments in hospitals and schools. It was not until the late 1970s that the development community began to appreciate that a bricks-and-mortar approach to the social sectors was not producing the expected outcomes because it ignored the critical importance of sector policies and knowledge-based adaptable systems. During the 1990s and 2000s, multilateral development banks shifted their focus in health and education to systems and policies. Rapid growth in the economies of the Asian Tigers—namely Hong Kong, China; the Republic of Korea; Singapore; and Taipei,China—illustrated how investments in health and education can precede or lead to economic growth in developing countries and how they can drive economic growth through human capital improvements.

For the health sector, additional complicating factors face countries and the development agencies that support them. First, many of the determinants of health outcomes reside outside the health sector. These include access to clean water, adequate sanitation, safe transportation, housing, gender equity, education, and income security. Another complication is a lack of consensus among members of the Organisation for Economic Co-operation and Development on how health systems should be organized and financed. In the late 2010s, both the International Monetary Fund and the World Health Organization issued reports showing that health spending was increasing faster than economic growth globally—possibly increasing the risk of health services becoming accessible only to those who can afford them.

Source: Asian Development Bank (Independent Evaluation Department); D. Bloom, D. Canning, and J. Sevilla. 2004. The Effect of Health on Economic Growth: A Production Function Approach. *World Development*. 32(1). pp. 1–13. https://doi.org/10.1016/j.worlddev.2003.07.002.

B. Evaluating ADB's Health Support

1. Nature of the Evaluation

5. This evaluation provides an independent assessment of ADB's approach to health. It considers the COVID-19 pandemic and evolving contexts in Asia and the Pacific since the formulation of ADB's Policy for the Health Sector in 1999, Strategy 2020, Strategy 2030, and the Health Sector Directional Guide (HSDG).[3] This is the first independent evaluation of ADB's support for health since 2005 and comes at the critical midpoint of Strategy 2030 implementation. It provides an opportunity to reflect on ADB's evolving approach to health, assess its performance to date, and offer findings and recommendations to inform future enhancements to ADB's policy,

[3] ADB. 1999. *Policy for the Health Sector*; ADB. 2008. *Strategy 2020: Working for an Asia and Pacific Free of Poverty*; ADB. 2018. *Strategy 2030: Achieving a Prosperous, Inclusive, Resilient, and Sustainable Asia and the Pacific*; ADB. 2022. *Strategy 2030 Health Sector Directional Guide*.

strategy, and operations in the sector. It examines the period 2011–2024, focusing on the scope set out in the theory of change (Appendix 1).

6. The evaluation examines ADB's performance in achieving the objectives of the Policy for the Health Sector and subsequent ADB-wide strategic changes and guidance related to health from 2008 to 2022. The evaluation also assesses whether ADB's strategy and approach in the health sector have been relevant and effective in addressing the needs and development agendas of ADB DMCs. The evaluation applies a classification system that identified operations as health projects (tier 1), projects that included health components or financing (tier 2), or other projects with potential health outcomes (tier 3) (Box 2). These have been assessed through country case studies.

Box 2: Classifying ADB's Support for Health

The evaluation team developed a classification scheme for the different types of projects that ADB utilizes to support health. Tier 1 contains projects that are primarily classified under the health sector. Tier 2 contains multisector projects that are primarily classified under other sectors but include health tags or subcomponents. Tier 1 and 2 projects could be identified through these tags or subcomponents in ADB's project management systems.

Projects classified as Tier 3 could potentially contribute to health outcomes, but lacked health subsector tags or subcomponents. These projects were often found in the education, energy, transport, and water and other urban infrastructure and services sectors. The evaluation identified Tier 3 projects using a health-related keyword search of the design and monitoring frameworks for all ADB projects approved since 2011 (Appendix 6).

Source: Independent Evaluation Department. 2024. *Evaluation of ADB's Support for Health in Asia and the Pacific, Evaluation Approach Paper*. Asian Development Bank.

2. Evaluation Approach

7. This evaluation uses a mix of qualitative and quantitative methods to answer the overarching evaluation question: how well positioned is ADB to deliver improved health outcomes and well-being for people in Asia and the Pacific? Four subquestions support the overarching evaluation question:

(i) How relevant has ADB support been to DMCs' health needs and priorities?
(ii) How effective have ADB operations been in contributing to DMCs' key health outcomes?
(iii) Have ADB's resources, organizational structure, and capacity been adequate to deliver on its health goals?
(iv) How coherent has ADB support for health at the country and regional levels been in bringing together financial support, technical assistance (TA), policy dialogue, and coordination and partnerships with other development partners?

8. The evaluation team consulted with ADB staff, employees of executing and implementing agencies, and contractors and suppliers through virtual interviews and in-person discussions. The team conducted country assessments in India, Mongolia, Papua New Guinea, the Philippines, and Uzbekistan to gauge the approach and impact of ADB support for health from 2011 to 2024.[4]

[4] These five countries were selected based on the following considerations: (i) potential to offer lessons from health sector operations and financing modalities (e.g., the blend of investment projects, policy-based lending, and results-

The team analyzed ADB's portfolio; assessed project data management systems; undertook a stakeholder perception survey; compared health sector policies, strategies, and approaches at other MDBs; and reviewed ADB corporate documents and project reports (Appendix 2).

3. Methodological Limitations

9. The evaluation's quantitative assessment of ADB's health sector performance was limited by the small size of the health portfolio,[5] and the absence of a comprehensive project performance management system to monitor health sector indicators. Complete data and information on health sector performance indicators were not readily accessible because of limitations in the project classification methodology and outdated data management systems. Although the evaluation team could identify tier 1 projects whose primary tag was "health" and tier 2 projects that had "health" subsector tags or that included health subcomponents, it could not easily identify tier 3 projects. Data collection was problematic, which may have led the evaluation team to underestimate ADB's health outcomes and impacts. Another constraint was loss of institutional knowledge because of the departure of many ADB health experts starting in the early 2000s after ADB deprioritized health.

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10. The report is structured to address the evaluation questions guiding this report (para. 7). Chapter 2 examines the relevance of ADB's support for health by exploring ADB's shifting strategic directions on health. Chapter 3 focuses on the adequacy of ADB's institutional support by assessing how its health strategies have been reflected in the volume and composition of ADB's health portfolio. Chapter 4 assesses the effectiveness of ADB's support by reviewing the performance of its engagement in DMCs. Chapter 5 explores the challenges that ADB faces in improving the coherence of ADB's support. Chapter 6 summarizes the key findings and recommendations for ADB in its support for health in Asia and the Pacific.

based lending); (ii) regional distribution; (iii) innovation, complexity, or comprehensiveness of interventions in the country, (iv) overall health portfolio volume; (v) share of nonsovereign operations; and (vi) inclusion of multisector projects.

[5] For the health sector, only 39 projects were completed and self-assessed during 2011–2024; of those, only 33 were validated by the Independent Evaluation Department—an average of fewer than three projects per year. By contrast, more than 980 projects were completed and self-assessed for other sectors during the same period, resulting in the health sector claiming a share of less than 4% of ADB's entire portfolio during the evaluation period.

CHAPTER 2

Shifts in ADB's Health Strategy

11. To assess the relevance of ADB support for health in the region, this chapter reviews shifts in ADB's strategy and approach to health during the evaluation period (2011–2024). Support for health and national health sectors was heavily influenced by ADB's fluctuating strategic choices and by the emergence of COVID-19. ADB's approach to health has gone through several iterations since it started financing the health sector in the early 1980s. Its early involvement in population projects was followed by a gradual expansion into basic health services and health infrastructure. It was only with the adoption of its Policy for the Health Sector in 1999 that ADB established a more comprehensive and structured approach to supporting health.[6]

12. Figure 1 illustrates the strategic shifts in ADB's engagement in health. Despite a special evaluation study in 2005 on ADB's Policy for the Health Sector, which provided recommendations designed to enhance ADB's support for health, the sector declined as a priority for ADB.[7] Under Strategy 2020, published in 2008, health was a supporting sector contributing to inclusive growth rather than a core operational area.[8] The midterm review (MTR) of Strategy 2020, conducted in 2014, raised the profile of health.[9] This was followed by an updated operational plan in 2015.[10] ADB's renewed emphasis on the health sector was consolidated under Strategy 2030, published in 2018, which elevated health within its operational priority 1, affirmed ADB's commitment to advancing health outcomes, and was operationalized through the HSDG in 2022.[11]

Figure 1: Timeline of ADB's Health-Related Policies, Strategies, Plans, and Reviews, 1999–2024

Note: According to ADB's policy architecture, operational plans and directional guides are not binding or mandatory.
Source: Asian Development Bank (Independent Evaluation Department).

[6] ADB. 1999. *Policy for the Health Sector*.
[7] Operations Evaluation Department. 2005. *Special Evaluation Study on ADB Policy for the Health Sector*. ADB.
[8] ADB. 2008. *Strategy 2020: The Long-Term Strategic Framework of the Asian Development Bank 2008–2020*.
[9] ADB. 2014. *Midterm Review of Strategy 2020: Meeting the Challenges of a Transforming Asia and Pacific*.
[10] ADB. 2015. *Health in Asia and the Pacific: A Focused Approach to Address the Health Needs of ADB Developing Member Countries—Operational Plan for Health, 2015–2020.*
[11] ADB. 2022. *Strategy 2030 Health Sector Directional Guide.*

A. Policy for the Health Sector

13. The Policy for the Health Sector (1999) remains ADB's most recent Board-approved, mandatory policy governing its engagement in health. Although the policy may have been forward-looking at the time of its adoption, it has not been revised in more than 2 decades, despite substantial shifts in regional health dynamics and global development paradigms. The policy focused on (i) improving the health of vulnerable groups (the poor, women, children, and indigenous people); (ii) achieving tangible results; (iii) testing innovations and deploying new technologies; (iv) encouraging DMC governments to take an active role in health; and (v) increasing the efficiency of health sector investments. The policy was grounded on the principle that health is essential to poverty reduction and economic growth. It encouraged partnerships with the private sector and other development actors and promoted selective engagement in areas where ADB held a comparative advantage, such as infrastructure development and health financing. The policy provided a strategic rationale for ADB's growing role in the social sectors, and its emphasis on pro-poor targeting, institutional sustainability, and technological innovation was aligned with contemporary global development thinking. However, many of its assumptions and operational frameworks are now outdated, as indicated by the 2005 special evaluation study, which noted that the scope of the original policy was insufficient and recommended that it be expanded to cover more aspects of health and facilitate greater ADB participation in the sector.[12]

14. The relevance of ADB's Policy for the Health Sector has diminished further since 2005 in light of modern health challenges. First, the policy predated major global health priorities such as UHC, pandemic preparedness, and the health impacts of climate change. It did not account for the rising burden of noncommunicable diseases, aging populations, or the demands of urban health systems—issues that now dominate health agendas across Asia and the Pacific. The policy also lacked any mention of digital health, health security, or resilience—concepts that have become central to the global and regional development discourse, particularly after the COVID-19 pandemic. ADB's response to COVID-19, while commendable in scope and speed, was not grounded in a coherent policy or strategic framework. The absence of an updated health policy limited institutional preparedness and hindered ADB's ability to deploy resources strategically across sectors. The situation worsened with the introduction of Strategy 2020 and Strategy 2030, as according to the 2024 ADB policy architecture, "there is no practice for retiring old policies after a new or revised policy is introduced, leading to a situation where there is no single coherent set of policy provisions". The policy architecture noted this shortcoming as a common issue in ADB's board document life cycle management.[13]

15. The Asia and Pacific region faces a complex health landscape marked by epidemiological transition, rapid urbanization, climate vulnerability, and increasing demand for equitable and inclusive health systems. The Policy for the Health Sector, conceived in a different era, did not provide guidance on integrating health with environmental sustainability, or addressing intersectional inequities such as gender gaps in access to services. It also lacked provisions for engaging with upper-middle-income DMCs, many of which now seek ADB support to expand health coverage and strengthen resilience. The absence of an updated health policy has resulted

[12] The 2005 study recommended that ADB formulate a new health strategy to cover (i) health, nutrition, and population and other related social sectors; (ii) innovative loan and grant products to facilitate greater ADB involvement; (iii) strengthening of governance to fight corruption; (iv) financing of health infrastructure and equipment; (v) development of partnerships with other donors, the private sector, and civil society; and (vi) analysis of staffing implications to better understand the trade-offs between strategic options and resource implications. Operations Evaluation Department. 2005. *Special Evaluation Study on ADB Policy for the Health Sector*. ADB.

[13] ADB. 2024. *Asian Development Bank's Policy Architecture*. p.5.

in a disconnect between institutional guidance and operational practice, particularly in responding to emerging health challenges while aligning with the corporate priorities articulated in Strategy 2030.

B. Infrastructure for Health Needs

16. The adoption of Strategy 2020 in 2008 marked a strategic shift toward infrastructure-focused investments, which resulted in a repositioning away from many elements of the Policy for the Health Sector and the special evaluation study's recommendations. The period following the adoption of Strategy 2020 marked a transitional phase in ADB's engagement with the health sector, during which its support for health remained largely stagnant. During 2011–2019, the health portfolio hovered well below its target of 3%–5% of total commitments, partly reflecting the 2008 decision under Strategy 2020 to deprioritize direct investment in the health sector in favor of a shift toward addressing health outcomes through investments in infrastructure-led sectors. ADB acknowledged the limitations of this strategic decision in 2014 during its Strategy 2020 MTR and subsequently adjusted course with the adoption of Strategy 2030. However, the share of health operations in total ADB commitments still lingered under 3%, until the boost in health support that came in response to the COVID-19 pandemic.[14]

17. ADB's Strategy 2020 justified the focus on investment in infrastructure as the core area of its operations by explaining that it is "fundamental to achieving poverty reduction and inclusive growth, and can also contribute to environmentally sustainable growth and regional integration."[15] Although ADB committed to continue supporting efforts to control and prevent the spread of communicable diseases in selected countries and regions, it began shifting away from direct investment in the health sector or tier 1 projects.[16] Instead, it opted to support health outcomes indirectly through tier 2 and 3 projects or "infrastructure projects such as water management and sanitation and through governance work that focuses on public expenditure management for cost-effective delivery of health programs and services to all population groups."[17]

18. By contrast, the Strategy 2020 MTR in 2014 recommended that ADB expand its health sector operations to 3%–5% of its annual approvals and emphasized that "reviving assistance to the sector is necessary to support inclusiveness, reduce vulnerabilities, and improve the preparedness of DMCs to face epidemics and infectious diseases" (footnote 9). The Strategy 2020 MTR highlighted the need for ADB to support DMCs in meeting their UHC goals, which was reaffirmed in Strategy 2030.

19. The HSDG, published in 2022 in response to COVID-19, reinforced ADB's alignment with Strategy 2030 and emphasized that its comparative strengths in infrastructure financing, policy-based lending, and regional collaboration should guide health sector operations to enhance delivery and impact. Acknowledging that ADB cannot be the lead health sector partner for all of its DMCs, the guide emphasized the critical importance of strategic partnerships with other development agencies, particularly in contexts where technical and financial capacity for health system strengthening is limited. In doing so, it positioned ADB to contribute meaningfully to UHC by integrating health outcomes into its broader investment portfolio. To operationalize this vision, the guide outlined five key focus areas to restore and accelerate progress toward UHC: (i) improving health governance, policy, and public goods; (ii) enhancing health financing and

[14] Footnote 11. p. 12.
[15] ADB. 2008. *Strategy 2020: Working for an Asia and Pacific Free of Poverty*. p.18.
[16] Refer to Box 2 for a detailed explanation of tiers 1, 2, and 3.
[17] Footnote 17. p. 21.

incentives; (iii) expanding health infrastructure and systems; (iv) strengthening the health workforce; and (v) enhancing pandemic preparedness and response.

20. The HSDG articulated broad strategic intentions for ADB's engagement in health, such as promoting UHC, strengthening health systems, and building resilience to health emergencies. It also updated and addressed key gaps in the Policy for the Health Sector. Despite articulating these important aspirations, the HSDG took the form of a guiding document, meaning that its recommendations were neither binding nor mandatory for staff.[18] This limited the HSDG's effectiveness in driving institutional accountability and cross-sector engagement. Thus, the HSDG provided general direction but offered few incentives for teams from other sectors to engage meaningfully with its principles. The shortcomings of the HSDG can be summarized as follows:

(i) As the HSDG presents a design and monitoring framework as its theory of change, many of its core components, such as inputs, outputs, and intended outcomes, were not clearly identified or logically linked to each other. While the HSDG expanded on Strategy 2030 by presenting high-level descriptions of how multisector projects could be designed, the design and monitoring framework failed to articulate how they would ultimately contribute to health outcomes. It also failed to provide guidance on how progress or success on the delivery of health outcomes would be monitored or evaluated.

(ii) A perception survey conducted for this evaluation (Appendix 3) revealed that the HSDG was not widely disseminated or actively promoted to staff outside those working on the health portfolio. Although the HSDG offered operational guidance on planning and implementing health sector interventions, it offered little clarify on how multisector projects should be designed and implemented. It also fell short in incentivizing staff to commit to supporting health outcomes across various sectors.

(iii) The HSDG did not clearly articulate how the enabling environment for the private sector would be strengthened and private sector lending expanded, although these are central to improving health outcomes and advancing UHC. A well-regulated and financially supported private health sector is an essential complement to public systems. The private sector can scale up service delivery, mobilize resources, and foster innovation. Under ADB's new operating model, health was identified as a sector where sovereign and nonsovereign integration was needed. Private sector solutions combined with broader health system strengthening have become essential for more resilient, efficient, and inclusive health systems.

C. Comparison of Multilateral Development Bank Approaches to Health

21. To compare ADB's approach to health and the health sector to the approaches of other MDBs, the evaluation team reviewed strategies for supporting health in four comparator MDBs: African Development Bank (AfDB), Asian Infrastructure Investment Bank (AIIB), Inter-American Development Bank (IDB), and World Bank Group (WBG). A review of publicly available documents found several shared elements in the strategic approach to health sector support adopted by these MDBs, as well as some clear differences, some of which reflected differences in regional needs (Appendix 4).

22. Improving UHC and supporting the global commitment to improving access to health care is a unifying theme across MDBs. All major development institutions have aligned their support for the health sector with the call by the World Health Organization (WHO) and the United Nations

[18] Footnote 14. p. 7.

for UHC. Most MDBs are explicitly addressing barriers to health care services. Another thrust of all five MDBs is to improve the quality of health-care services in parallel to efforts to broaden access to services. Interestingly, although all five MDBs place a high premium on enhancing equity of access to health care and share the same equity objective, the instruments and the degree of specificity about the mechanisms for achieving equity vary.[19] Scope exists for cross-agency learning given the different approaches emphasized by each agency to achieve shared equity objectives.

23. All MDBs acknowledge that health outcomes are partially determined by actions in other sectors, but ADB, AIIB, and IDB place particular emphasis on this. AIIB is committed to achieving health outcomes through synergistic infrastructure projects in clean energy, green transport, water supply and sanitation, urban, and information technology—all of which are expected to produce health co-benefits. The Inter-American Development Bank's commitment to actions in other sectors is more specific and selective, as it was the only MDB to explicitly target changing behavioral factors through multiple strategies. Its approach focuses on addressing the social and environmental determinants of health in the Americas and the Caribbean by targeting key risk factors for the region's leading noncommunicable diseases and by identifying priority sectors, including transport and air pollution. It identifies multiple instruments (e.g., fiscal policies, regulations, and legislation) that can be used to address risk factors directly. Uniquely among the MDBs, IDB focuses on individual and population-based behavioral drivers of noncommunicable disease. However, ADB expresses more commitment than IDB to achieving health outcomes through sectors other than health, although without providing detailed strategic guidance.

24. The MDBs have varying ways of articulating their commitments to health systems (Box 3). AfDB and AIIB maintain a traditional focus on health infrastructure—with AfDB emphasizing primary health-care facilities, secondary and tertiary hospitals, and diagnostic infrastructure—while AIIB also incorporates investment in technology and modernization. Meanwhile, ADB, IDB, and the WBG promote broader health system approaches that address financing, organization, human resources, policies, and institutional capacity. The WBG and IDB place greater emphasis on the expected outputs of health system investments. The WBG aims to expand access, improve the quality of essential services, enhance sustainability and resilience, and strengthen emergency preparedness, while IDB focuses on sustainability, spending efficiency, and reducing fragmentation. ADB's flexible commitment to health systems, supported by broad guidance on financing, governance, policy reform, and public goods, allows it to adapt to its diverse client needs. The evaluation's analysis of ADB's portfolio shows that it has actively engaged across these areas based on country-specific priorities.

[19] ADB prioritizes equity through improved access. IDB focuses on how healthcare is organized and financed to address the needs of marginalized and disadvantaged groups. AfDB targets access to care for underserved populations through investment in primary healthcare infrastructure. The WBG approaches equity through a focus on improving access for the hard-to-reach and reducing financial barriers to services. AIIB's approach focuses on infrastructure targeted at marginalized and underserved communities.

Box 3: Divergent Schools of Thought on Health Systems

Among development agencies, there are currently two main schools of thought on health systems, with corresponding approaches to support them. The World Bank has adapted a Harvard University School of Public Health framework that links actionable health policies (health financing, provider payment, services delivery organization, regulation, and persuasion) to intermediate performance measures (efficiency, quality, and access) and outcomes (health status, consumer satisfaction, and risk protection).

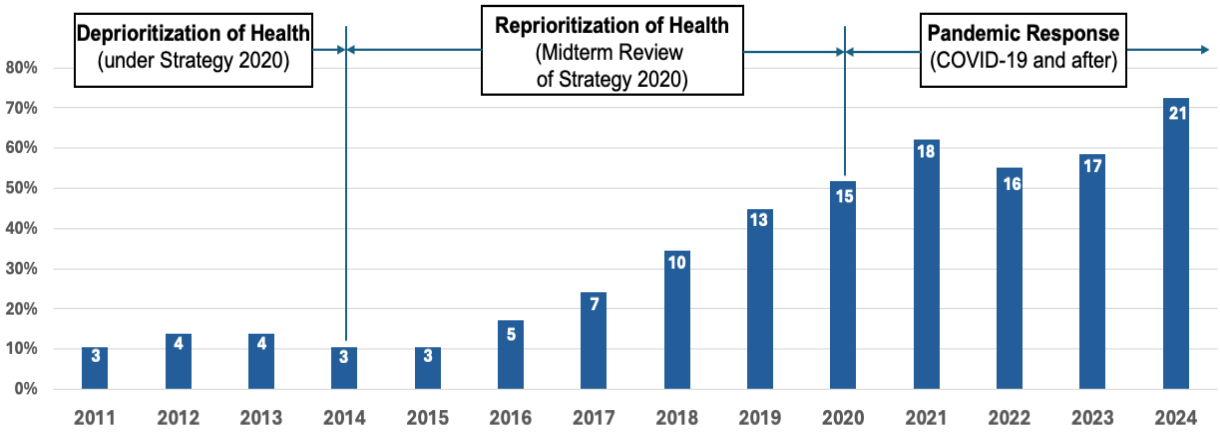
The World Health Organization has developed a competing approach that is usually referred to as "building blocks." Six blocks (service delivery, health workforce, information systems, access to essential medicines, financing, and leadership) lead to access, coverage, quality, and safety, which support the overall goals of improved health, responsiveness, risk protection, and improved efficiency. ADB's most recent health sector guidelines (2022) used the World Health Organization framework for health systems.

Source: Asian Development Bank (Independent Evaluation Department).

D. Country Strategies Increasingly Prioritize Health Needs

25. Despite the absence of a strong institutional mandate for health from ADB, some DMCs have identified health as a priority in their national development plans and have actively sought ADB's continued engagement in the health sector. Evolving corporate priorities within ADB and the health sector needs of its DMCs are reflected in ADB country partnership strategies (CPSs). During 2008–2015, these documents contained very few direct mentions of health-related strategic statements or outcomes, with only four countries (Bangladesh, Mongolia, Pakistan, and Papua New Guinea) containing one or more health indicators in their CPSs. The concerns identified in the Strategy 2020 MTR appear to had an effect on elevating health as a priority sector in many countries, as the number of CPSs with health-related indicators rose steadily from a low of three in 2014 to 15 in 2020—representing just over half of DMCs with CPSs (Figure 2). This trend continued during COVID-19, notwithstanding a few gaps resulting from delays in CPS preparation.[20]

Figure 2: Country Partnership Strategies with Health-Related Indicators, 2011–2024
(number of strategies, % of the total)



COVID-19 = coronavirus disease.
Source: Asian Development Bank.

[20] The CPSs for Kazakhstan, the Lao People's Democratic Republic, the Philippines, Sri Lanka, and Viet Nam were not updated during the COVID-19 pandemic, resulting in CPS coverage gaps during 2021–2023.

26. The number of countries with CPSs that incorporated health indicators began increasing well before the COVID-19 pandemic, suggesting that previously low levels of demand for health sector engagement may have been influenced, at least in part, by ADB's strategic shift away from health in its dialogue with DMC governments. In other words, the resurgence of health-related demands in many DMCs corresponded to ADB's renewed emphasis on the sector, as illustrated by the case of India (Box 4). Fortunately, this renewal of demand preceded COVID-19 and led to DMCs being better prepared for the pandemic.

Box 4: India's Country Partnership Strategies Reflect Growing Demand for Health, 2009–2023

The evolution of ADB country partnership strategies (CPSs) for India demonstrates an effort to improve health service accessibility, quality, and resilience, particularly for underserved populations, while addressing broader challenges faced by the health sector in India.

- **CPS, 2009–2012 (no health components).** Despite significant health challenges, including high levels of malnutrition, anemia among young children and pregnant women, and high neonatal mortality rates, the CPS, 2009–2012 contained no explicit health-related statements, health-specific outcomes, or indicators and targets, although potential scope for ADB support for promoting public–private partnerships (PPP) in health and education was explored during the CPS period.
- **CPS, 2013–2017 (no health components).** As with its predecessor, this CPS did not include explicit health-related statements or health-specific outcomes or indicators and targets.
- **CPS, 2018–2022 (multisector support for health).** This CPS emphasized inclusive urbanization and supporting investments in municipal infrastructure, including urban health services, all under the CPS strategic pillar "Inclusive provision of infrastructure networks and services." ADB's urban sector program's contribution to inclusive growth was to be delivered by assisting low-income states and supporting investment in municipal infrastructure.
- **CPS, 2023–2027 (direct support for health).** The current CPS shifted the focus toward deepening social and economic inclusiveness and included health sector assistance that was to include support for a holistic primary health-care system, increased access to secondary and tertiary care in underserved areas, and strengthened nursing and medical education. The CPS also included strategic statements on enhancing key institutions' capacity for supporting national and regional health security and pushing to attract more private investment through PPPs.

Source: Asian Development Bank, Country Partnership Strategies.

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27. ADB's engagement in health has evolved through a series of strategic shifts, shaped by efforts to align its institutional strengths with the needs of its DMCs. The Policy for the Health Sector (1999), well-conceived at that time, focused on sector reforms but became outdated amid changing regional health challenges and global health paradigms. ADB's decision to prioritize investment in other sectors that impact health over direct investment in the health sector was followed by a partial reversal of that decision to maintain both types of investment. In 2014, ADB began rebalancing its approach by reintroducing direct health sector support alongside existing multisector investment, effectively creating an implicit two-track approach to health. This two-track strategy encompassed core health sector operations, classified as tier 1 projects by this evaluation, and the integration of health-related interventions in other sectors (tiers 2 and 3). Despite these strategic shifts, ADB's approach has strived to stay relevant to the needs of the DMCs by being demand-driven and flexible, with a focus on sectoral inputs over systemic health outcomes. Even with the renewed global focus on health following the COVID-19 pandemic, ADB has yet to establish a strong institutional mandate or a cohesive strategy to sustain and scale up its two-track engagement in the health sector. The next chapter explores how ADB has navigated health and multisector operations under these constraints and how the pandemic catalyzed a shift in priorities.

CHAPTER 3

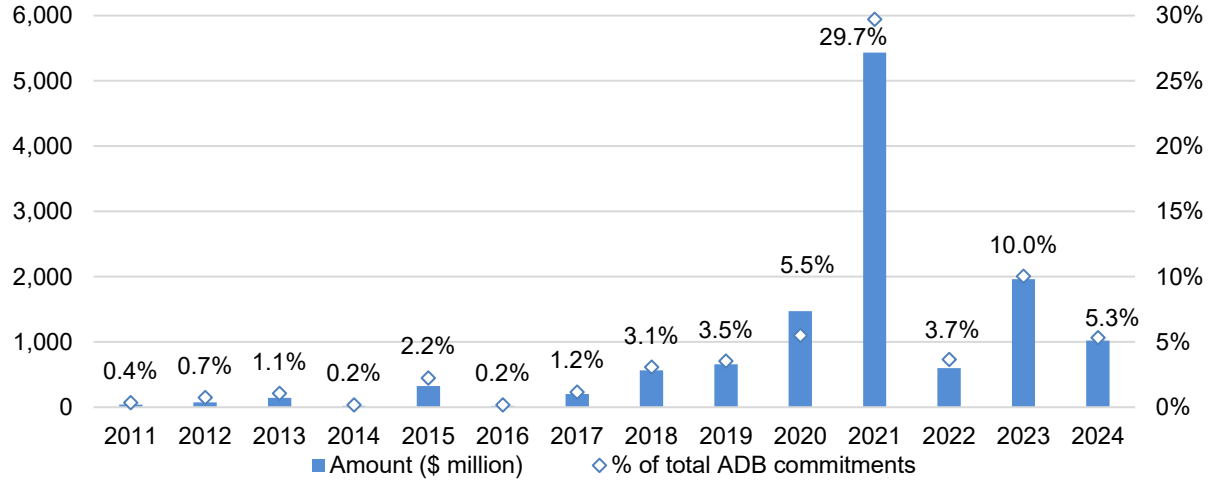
ADB's Portfolio Supporting Health

28. Through the evolution of its health approach under Strategy 2020 and Strategy 2030, ADB has implicitly adopted a two-track approach to health. This chapter reviews ADB's health sector portfolio during the evaluation period to assess the adequacy of its support for health. It reviews how ADB attempted to stay flexible and responsive to the health needs of its DMCs and how it responded to rapidly changing situations such as the COVID-19 pandemic. The chapter delves into the composition of ADB's health portfolio (tier 1), the multisector approach (tiers 2 and 3), ADB's nonsovereign portfolio, and the COVID-19 emergency response financial package.

A. Health Sector Portfolio: Tier 1

29. A review of ADB's sovereign commitments for the health sector from 2011 to 2024 found that the sector was a relatively low priority during 2011–2017, particularly in DMCs with national development strategies that focused more on investing in infrastructure than in health. During this period, annual sovereign commitments to tier 1 projects reached 2.2% of total commitments in 2015, but in other years the percentage was much lower until it began to rise in 2018 (Figure 3). Following a significant spike in commitments during 2020 (5.5%) and 2021 (29.7%) because of the COVID-19 emergency response, the post-pandemic trend shows commitments dropping back below 6%. This means ADB is lagging in progress toward achieving the HSDG's goal of doubling the health sector's share of total ADB commitments to 6%–10% by 2030.

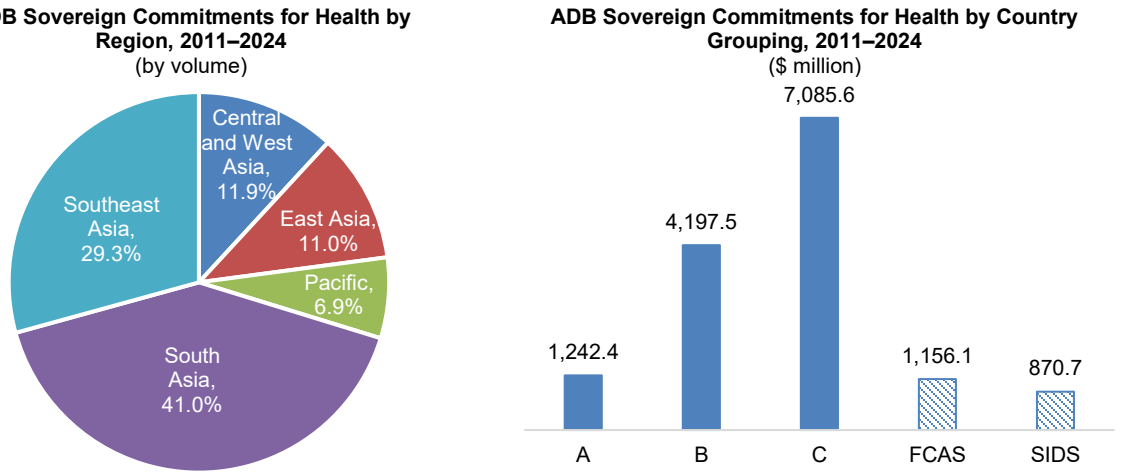
Figure 3: ADB Health Sector Commitments, 2011–2024
($ million, % of total ADB commitments)



ADB = Asian Development Bank, COVID-19 = coronavirus disease.
Note: Includes only commitments for primarily health projects (tier 1).
Source: ADB, eOperations database.

30. The distribution of health sector sovereign commitments was uneven, with 172 of 208 new projects committed after the publication of Strategy 2030 (i.e., since 2018). Two of ADB's five regional groups accounted for 70.2% of all tier 1 commitments for 2011–2024. Regarding ADB country groupings, group B (regular ordinary capital resources and concessional assistance) and group C (regular ordinary capital resources only) received 88.9% of the commitments (Figure 4).

Figure 4: ADB Health Sector Commitments by Region and by Country Group, 2011–2024



ADB = Asian Development Bank, FCAS = fragile and conflict-affected situations, SIDS = small island developing states.
Note: Includes only commitments for primarily health projects (tier 1). To illustrate ADB's support for FCAS and SIDS countries, related commitments were double counted from the tallies for Group A (concessional assistance only), B (regular ordinary capital resources and concessional assistance) and C (regular ordinary capital resources only).
Source: ADB, eOperations database. See Appendix 5.

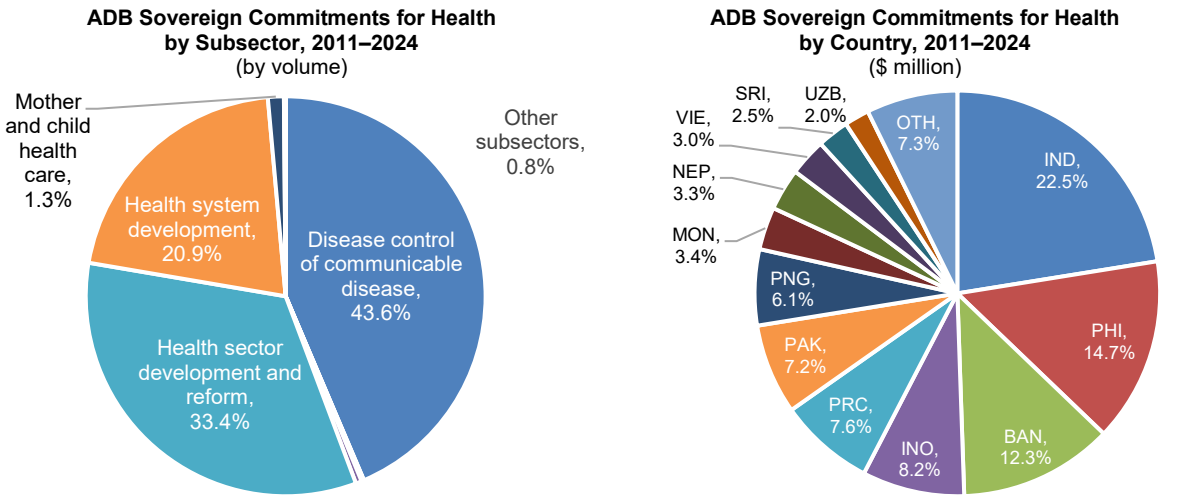
31. The concentration of commitments in a few regional or country groups reflects ADB's support to health in four countries (Bangladesh, India, Indonesia, and the Philippines), which together accounted for 57.6% of all health commitments (Figure 5).[21] By contrast, the 26 countries with the least health support received only 7.3% of ADB's combined health commitments. The imbalance in the health sector portfolio becomes even more pronounced when the portfolio is broken down by subsector: Figure 5 shows that 97.9% of all support was channeled to only three of ADB's eight health subsectors (disease control of communicable disease, health sector development and reform, and health system development). To counter this concentration, the HSDG envisioned ADB engaging with more DMCs across a wider spectrum of health sector topics, including health insurance, service delivery in urban settings, service delivery for noncommunicable diseases, service delivery for reproductive and child health, and early childhood development.

32. In terms of modality, investment projects made up the bulk of ADB's support for health accounting for more than 60% of health sector commitments during 2011–2024. ADB started to diversify its use of modalities in 2015 with a results-based loan (RBL) to India (Supporting National Urban Health Mission, $300 million) and a policy-based loan (PBL) to the Lao People's Democratic Republic (Health Sector Governance Program, $17.1 million). Support for health through PBLs started in earnest in 2018 and overshadowed project loans and grants in 2020, mainly because of COVID-19 Pandemic Response Option (CPRO) financing (which totaled

[21] All four countries were from either South or Southeast Asia and were classified as Group B or C—Bangladesh (South Asia, Group B), India (South Asia, Group C), Indonesia (Southeast Asia, Group C), and the Philippines (Southeast Asia, Group C).

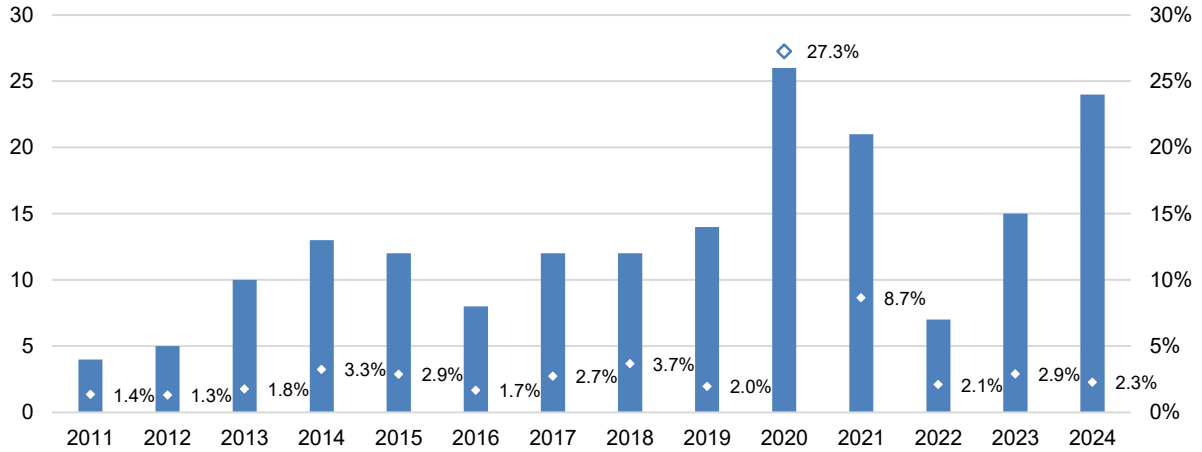
$2,304 million for emergency budget support and extended far beyond the health sector in most DMCs), and contingent disaster financing (which totaled $300 million). Similarly, the number of RBLs ramped up significantly after 2021, but the volume remained low, claiming less than 9% of overall health sector financing during 2011–2024. By contrast, PBLs comprised 30.9% of the portfolio in terms of commitment by volume during the same period. In addition, 135 health TA projects were used to meet DMCs' needs but the number of TA projects and the size of commitments fluctuated depending on ADB's overarching strategy for the health sector at the time. As illustrated by the two spikes in commitments in 2014 and 2020, ADB support through TA projects mirrored (i) the renewed push for health articulated in the Strategy 2020 MTR in 2014, and (ii) increased demand for health support because of COVID-19 in 2020 (Figure 6).

Figure 5: ADB Health Sector Commitments by Subsector and by Country, 2011–2024



ADB = Asian Development Bank, BAN = Bangladesh, IND = India, INO = Indonesia, MON = Mongolia, NEP = Nepal, OTH = other 26 countries, PAK = Pakistan, PHI = Philippines, PNG = Papua New Guinea, PRC = People's Republic of China, SRI = Sri Lanka, UZB = Uzbekistan, VIE = Viet Nam.
Note: Includes only commitments for primarily health projects (tier 1).
Source: ADB, eOperations database. See Appendix 5.

Figure 6: ADB Health Technical Assistance Projects, 2011–2024
(number of TA projects, % of total ADB technical assistance commitments)



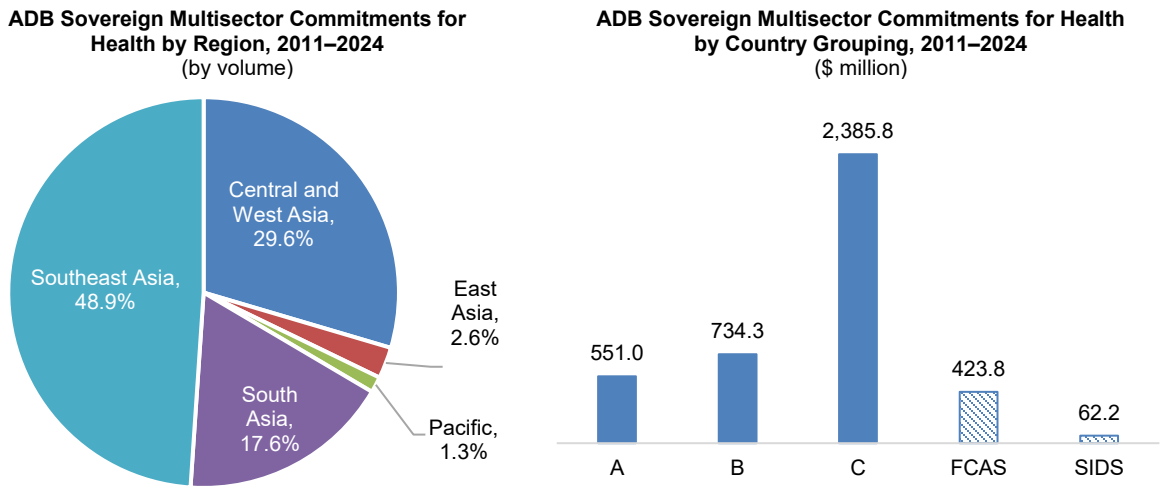
ADB = Asian Development Bank, TA = technical assistance.
Note: Includes commitments for only primarily health technical assistance (tier 1).
Source: ADB, eOperations database.

B. Multisector Approach to Health: Tiers 2 and 3

33. Under Strategy 2030, ADB reintroduced health as a core sector through a rebalancing of priorities, the objective being to achieve "better health for all." Rather than moving away from the multisector approach, the new strategy reaffirmed it by explicitly promoting the integration of health objectives within broader sector engagements.[22] Despite the strategic intent and vision of Strategy 2030, the renewed corporate emphasis on achieving health outcomes through the multisector approach has still not been underpinned by a coherent theory of change or effective mechanisms to monitor and evaluate progress.

34. Multisector projects (tier 2) played a substantial complementary role in ADB health operations, particularly during the pandemic. From 2011 to 2024, ADB committed about $3.7 billion through tier 2 projects, representing about 23% of its total sovereign health sector financing during the period. The distribution of tier 2 sovereign commitments was uneven, with 43 of 53 new projects being committed after the COVID-19 pandemic (i.e., during 2020 or after). Two of ADB's five regions accounted for 78.5% of all commitments for 2011–2024. Regarding ADB country groups, group B (countries eligible for ordinary capital resources and concessional assistance) and group C (countries eligible only for regular ordinary capital resources) received 85.0% of commitments (Figure 7).

Figure 7: ADB Multisector Commitments by Region and by Country Group, 2011–2024



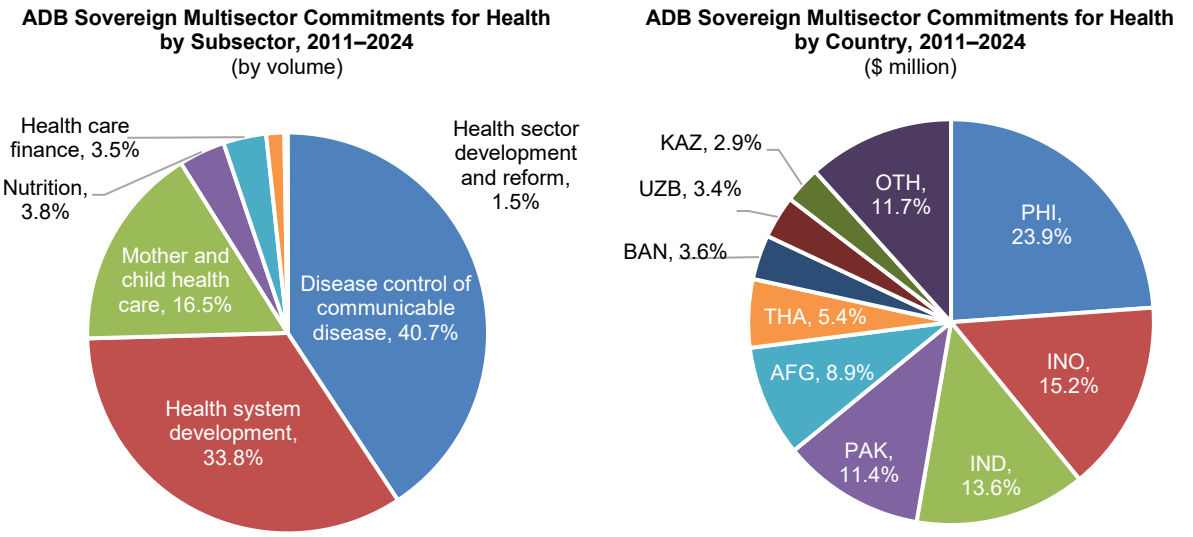
ADB = Asian Development Bank, FCAS = fragile and conflict-affected situations, SIDS = small island developing states.
Note: Includes commitments in health subsectors for only non-health projects (tier 2). To illustrate ADB's support for FCAS and SIDS countries, related commitments were double counted from the tallies for Group A (concessional assistance only), B (regular ordinary capital resources and concessional assistance) and C (regular ordinary capital resources only).
Source: ADB, eOperations database. See Appendix 5.

35. The concentration of tier 2 commitments in a few regional or country groups was driven by ADB's support for health in just three countries (the Philippines, India, and Indonesia), which accounted for 57.6% of all its tier 2 health commitments. The 29 countries with the least health support received only 11.7% overall. The imbalance in the health sector portfolio is even more pronounced when it is broken down by subsector, since 91.0% of all support was channeled to only three subsectors (disease control of communicable disease, health system development,

[22] ADB. 2018. *Strategy 2030: Achieving a Prosperous, Inclusive, Resilient, and Sustainable Asia and the Pacific*.

and maternal and child health care) (Figure 8). About two-thirds of these investments were delivered through the public sector management sector, with significant allocations to communicable disease control, which received $1.5 billion across 29 projects.

Figure 8: ADB Multisector Commitments by Subsector and by Country, 2011–2024

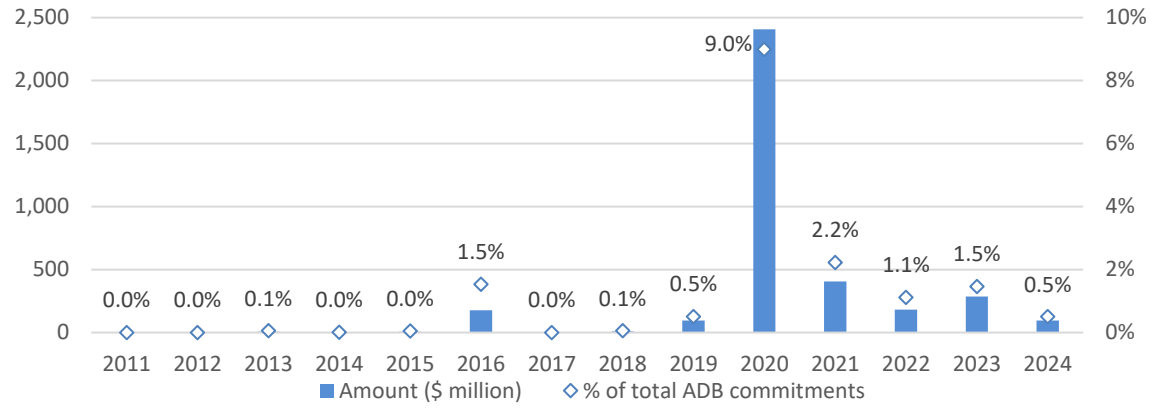


ADB = Asian Development Bank, AFG = Afghanistan, BAN = Bangladesh, IND = India, INO = Indonesia, KAZ = Kazakhstan, OTH = other 29 countries, PAK = Pakistan, PHI = Philippines, THA = Thailand, UZB = Uzbekistan.
Note: Includes commitments in health subsectors for only non-health projects (tier 2). ADB placed its regular assistance to Afghanistan on hold effective 15 August 2021, but it has supported the basic needs of the Afghan people since 2022 through a special arrangement with United Nations agencies.
Source: ADB, eOperations Database. Appendix 5.

36. Notably, 2020 was the highest tier 2 investment year, with $2.4 billion committed across 27 projects—reflecting the agility of multisector mechanisms in scaling up emergency health responses. The evaluation's analysis of ADB's sovereign commitments from 2011 to 2024 revealed that tier 2 health investments, while substantial in certain years, were employed sporadically (Figure 9). Prior to 2020, multisector health support was virtually absent except for small spikes in 2016 and 2019, indicating that the support was crisis-driven rather than embedded within a systematic strategy for integrated health programming. Despite this episodic pattern, tier 2 projects tended to be large, with an average annual commitment of $334 million to health, highlighting the potential of tier 2 projects to deliver health outcomes even when primarily classified under other sectors.

37. ADB also supported projects in other sectors that may indirectly yield health benefits (tier 3), but the extent of the health contributions from these cross-sector interventions was difficult to quantify because of an absence of systematic health subsector tagging or information on the allocation of financing. ADB does not have a database of health-related performance indicators for tier 2 and 3 projects, which makes monitoring health outputs or outcomes in non-health projects problematic. An analysis of design and monitoring frameworks in the reports and recommendations of the President for all health-related projects showed that, although more than 97% of tier 1 projects had both output and outcome health indicators, only about 80% of tier 2 and 3 projects had such indicators, suggesting substantially weaker health-related planning or poor selection of health performance indicators for multisector projects (Appendix 6).

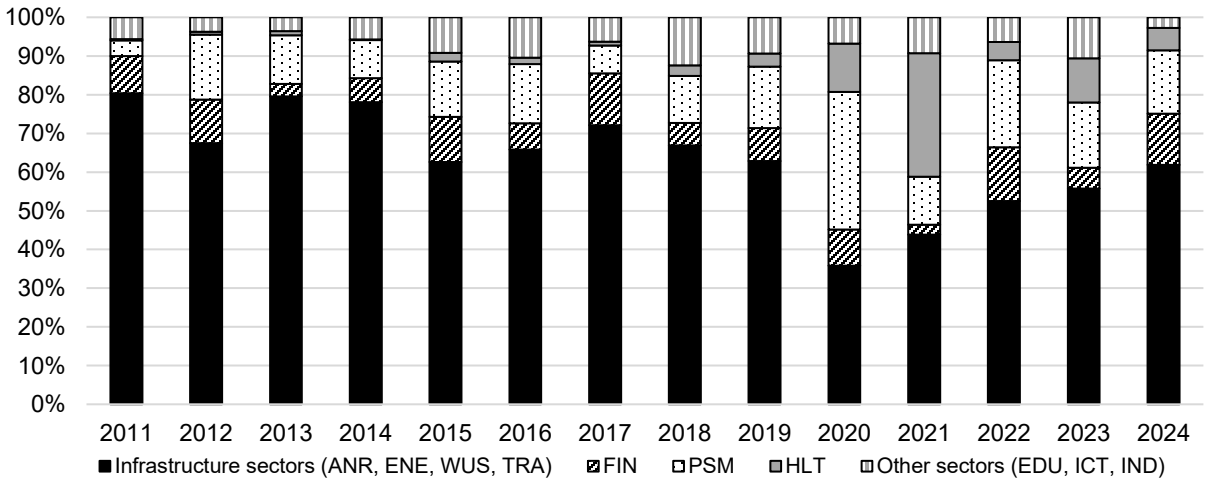
Figure 9: ADB Multisector Commitments for Health, 2011–2024
($ million, % of total ADB commitments)



ADB = Asian Development Bank.
Note: Includes commitments in health subsectors for only non-health projects (tier 2).
Source: ADB, eOperations Database.

38. During 2011–2019, ADB focused on leveraging its corporate advantage and committed 60%–80% of its sovereign operations to infrastructure sectors, including agriculture, natural resources, and rural development (ANR); energy; transport; and water and other urban infrastructure and services. Most of these operations were tier 3 projects with possible health benefits or impacts. This contrasts with a dramatic ramp-up of public sector management projects in 2020 and health sector projects in 2020 to support the COVID-19 emergency response. Several stakeholders credited ADB emergency response support during the pandemic with helping them mitigate the negative impacts of physical lockdowns on implementation of ongoing infrastructure projects. However, ADB's internal preference for infrastructure sectors has resurfaced since the pandemic, as the share of these sectors rebounded from an all-time low of 36% in 2020 to more than 60% in 2024 (Figure 10). This suggests that significant potential exists to expand the scope and size of ADB's health portfolio through the multisector approach and tier 3 projects.

Figure 10: ADB Sovereign Commitments by Sector, 2011–2024



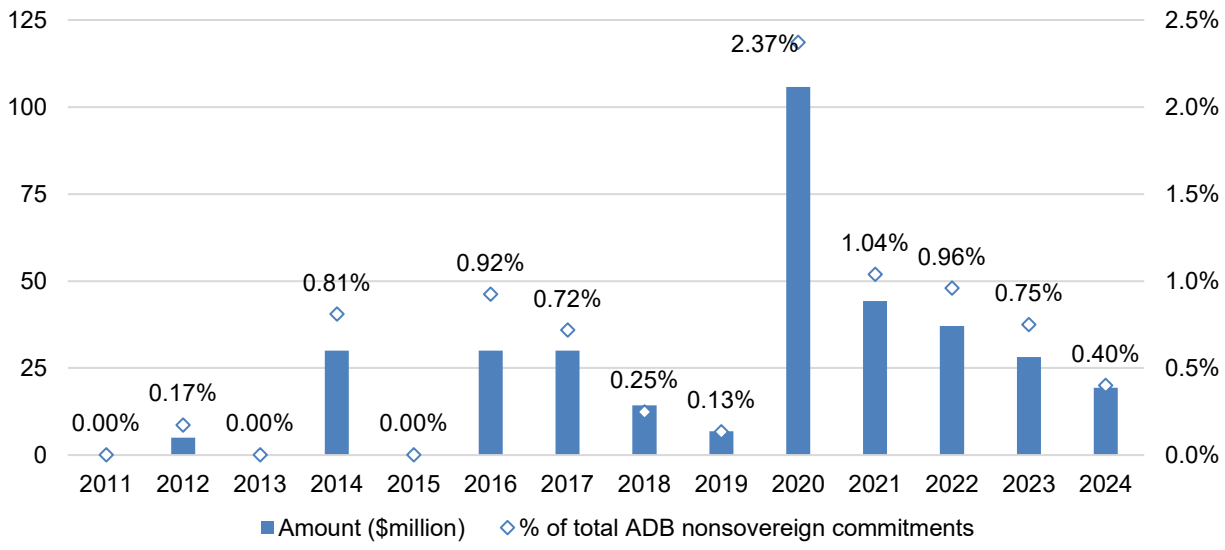
ADB = Asian Development Bank, ANR = agriculture, natural resources, and rural development, COVID-19 = coronavirus disease, EDU = education, ENE = energy, FIN = finance, HLT = health, ICT = information and communication technology, IND = industry, PSM = public sector management, TRA = transport, WUS = water and other urban infrastructure and services.
Source: ADB, eOperations database.

C. Nonsovereign Health Operations

39. ADB's nonsovereign operations (NSO) in health care—focused on private sector provision—represent an important but still nascent pillar of its overall health strategy. Such operations have the potential to fill the gap in health left by the public sector. Although ADB's Operational Plan for Private Sector Operations, 2019–2024 acknowledged that health is fundamental to sustainable development, it lumped education and health under "social sectors" and did not propose any specific or quantifiable goals or specific allocations in terms of increasing NSO commitments for the health sector.[23] Before the publication of the HSDG in November 2022, ADB health documents contained little or no mention of NSO. The HSDG noted that there would be "increased emphasis on nonsovereign health projects, including through pipeline development," but provided no specific guidance on how this could be achieved. Links between ADB's sovereign and nonsovereign support for DMC development goals for health remains weak.

40. Although nonsovereign investments demonstrated ADB's growing recognition of the role of private actors in expanding access to care, especially in underserved regions, the size and scope of ADB's nonsovereign health portfolio remained modest in relation to both its sovereign health lending and the scale of private health-care needs across Asia and the Pacific. The portfolio averaged less than 1% of total NSO commitments—except for in 2020 when NSO spiked during ADB's COVID-19 response (Figure 11). The evaluation notes that there were no direct health NSO commitments (tier 1) prior to 2018, with only four NSO commitments for health as tier 2 projects. However, the status quo was reversed during 2018–2024, wherein ADB approved a total of 15 NSO tier 1 projects but only two NSO tier 2 projects. This shift from multisector to direct NSO support for health is partially explained by ADB's reprioritization of health under Strategy 2030. Under Strategy 2020, ADB staff had little choice but to package health as a subcomponent of other large infrastructure sectors when pitching nonsovereign investment opportunities.

Figure 11: ADB Nonsovereign Health Commitments, 2011–2024

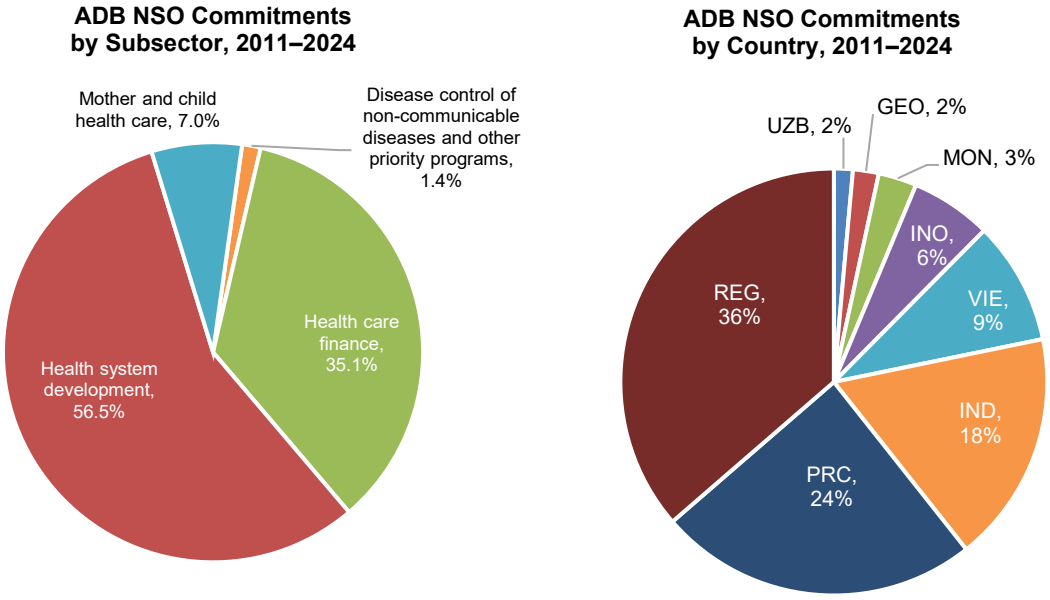


ADB = Asian Development Bank, COVID-19 = coronavirus disease.
Source: ADB, Nonsovereign Operations database.

[23] More specifically, the operational plan proposed that, "… ADB will focus on expanding health-care services to the poor and underserved, hospital services, diagnostic services, affordable pharmaceuticals and medical supplies, elderly care, and use of PPPs to improve efficiency." ADB. 2019. *Operational Plan for Private Sector Operations, 2019–2024*. p.17.

41. The total volume of nonsovereign health commitments during 2011–2024 has been limited, as they have been primarily concentrated in a few middle-income countries and heavily skewed toward support for large urban hospitals, diagnostic networks, and private equity funds (Figure 12). Although these investments have contributed to health infrastructure expansion, they have not directly addressed systemic issues such as workforce distribution, affordability, or rural access. Nevertheless, NSO can play a valuable complementary role when aligned with upstream policy work and public investments that collectively advance inclusive and resilient health systems.

Figure 12: Distribution of ADB Health Sector Nonsovereign Operations, 2011–2024



ADB = Asian Development Bank, GEO = Georgia, IND = India, INO = Indonesia, MON = Mongolia, NSO = nonsovereign operations, PRC = People's Republic of China, REG = regional, UZB = Uzbekistan, VIE = Viet Nam.
Note: Includes commitments in health subsectors for both primarily health (tier 1) and non-health projects (tier 2).
Source: ADB, Nonsovereign Operations database.

42. In addition, the development impact frameworks for ADB's private sector health operations are still evolving. Although ADB tracks indicators such as patient volume, job creation, and climate resilience through its development effectiveness rating system, it does not consistently measure pro-poor outcomes, quality of care, or health equity. There is often limited transparency in evaluating whether projects truly support key health outcomes in the HSDG by aligning with UHC objectives or by catalyzing broader system-level reforms. Although some NSO projects have demonstrated innovation—such as those focused on integrating digital health or energy-efficient infrastructure—ADB's overall pipeline lacks strong thematic diversity in areas such as primary care, long-term care, or local pharmaceutical manufacturing, despite critical needs in these areas in Asia and the Pacific.

D. Emergency Response to COVID-19

43. The global health community mobilized a remarkable response to the COVID-19 pandemic in early 2020. Governments, technical agencies, MDBs, bilateral development partners, and civil society immediately adopted a multisector, "all-hands" approach to the unprecedented global crisis. However, there were considerable differences in their capacity to marshal financial, human, and organizational resources as comprehensively and rapidly as the

situation required. For example, although the World Bank's self-assessment of its own early COVID-19 response rightly describes its actions as extraordinary in both scale and speed,[24] independent evaluations highlighted the World Bank's inability to fully leverage its own most flexible and rapid financing instruments.[25] By mid-2021, although the World Bank was on track to meet its lending commitments, it had disbursed only 60% of its COVID-19 financing target, largely because of underutilization of development policy lending—its most efficient mechanism for rapid fund deployment. This underscores the critical need for agile financial mechanisms to be brought into play during crises, especially in response to heightened demand for both infrastructure and emergency support. By contrast, a consistent theme of this evaluation is DMCs' broad appreciation of ADB's responsiveness to their demands for the COVID-19 response and beyond.

44. The rebuilding of ADB's health sector capacity since 2015 played a significant role in enabling ADB response to the COVID-19 pandemic. So did the establishment of the Regional Health Security Fund under Asian Development Fund (ADF) 12. Although the health security fund was discontinued in 2019, it recognized health security as a regional public good and anticipated the need for stronger health systems and cross-border collaboration, thus laying important groundwork for broader regional health security efforts under ADF 13. Despite a history of shifting strategic emphasis on health, ADB's pandemic response was notably successful in delivering substantial volumes of emergency medical supplies, vaccines, and related resources. This success was made possible by a combination of strengthened internal health sector expertise, deep in-country networks, and the rapid, well-coordinated deployment of multiple financing instruments—spanning both (i) infrastructure and (ii) systems and capacity-building.

45. ADB's speed in mobilizing Asia Pacific Disaster Response Fund (APDRF) resources and procuring supplies (internationally sourced, where needed) was noteworthy. Of the 37 COVID-era APDRF grants, 30 were approved for 30 DMCs by the end of August 2020, earning tremendous goodwill and a reputational boost for ADB's operational agility. These benefits came at relatively low cost, coming in at under $3 million for purchasing test kits and diagnostic reagents, personal protective equipment, recruitment of and overtime salary coverage for emergency health workers, and other urgent needs. APDRF financing helped alleviate financial resource constraints with minimal bureaucratic constraints. Despite never being designed as a health intervention, APDRF's value as a lifesaving tool was well-illustrated during COVID-19, as it served as ADB's arsenal for timely intervention during the life-threatening emergency.

46. Most health-tagged financing (including for both tier 1 and tier 2 projects) during 2020–2023 was through the CPRO budget support facility and, later, the Asia Pacific Vaccine Access Facility (APVAX), which together represented 72.4% of ADB's health sector commitments. Although many CPRO projects were processed and disbursed quickly, the evaluation notes that they were primarily designed and implemented as a crisis response mechanism—not as health interventions or to support long-term strengthening of health systems. This was evidenced by only two CPRO projects being classified as primarily health (tier 1), while the others were classified as public sector management with health subcomponents (tier 2). Of the 25 CPRO operations, only about half had health outcomes, and most of those were specific to the pandemic (e.g., number of COVID-19 incidence or provision of COVID-19 testkits). Broader health system preparedness for future pandemics was an outcome for only three CPRO projects. Instead, outcomes of CPRO projects were primarily oriented toward social protection (e.g., support for individuals, families, or

[24] World Bank. 2022. *The World Bank's Early Support to Addressing COVID-19: Health and Social Response. An Early-Stage Evaluation.* Independent Evaluation Group. Washington, DC: World Bank. DOI: 10.1596/IEG177600.

[25] S. Morris, et al. 2021. *Tracking the Scale and Speed of the World Bank's COVID Response: April 2021 Update*. Center for Global Development.

households), reduction of poverty or food insecurity, or business survival. As a result, CPRO projects offered very few lessons or recommendations for the health sector in their completion reports, which was consistent with the crisis response nature of immediate budget support. Nevertheless, in conjunction with CPRO financing, ADB supported several countries by providing TA and investment loans explicitly designed to support longer-term health system strengthening. These illustrated how ADB's COVID-19 response increased the likelihood of DMCs borrowing for health, and how ADB can offer a new support pathway for strengthening health sector resilience and preparedness.

47. Similarly, some early APVAX operations were strongly oriented toward ADB's direct payments to vaccine manufacturers. This was a vital element of crisis response but had little impact on longer-term health engagement or system strengthening. However, other APVAX projects—and associated repurposed TA—incorporated key longer-term elements of health system strengthening, including procurement arrangements, information and data systems, cold chains, information campaigns countering vaccine hesitancy, and medical waste management. Other longer-term interventions included pooling procurement of multiple vaccines (in addition to COVID-19), integrating immunization programs into broader health systems, and strengthening primary health care. As demand for vaccines eventually receded, In in many instances ADB adapted APVAX loans to longer-term system-strengthening interventions.

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48. ADB's strategic shifts and the COVID-19 pandemic were the two most significant factors influencing ADB's approach to health and its health portfolio during 2011–2024. Although ADB's efforts to channel its infrastructure advantage to health were well intentioned, the portfolio remained limited in size and scope until COVID-19 struck. Thus, the health benefits from what became a two-track approach—core health sector (tier 1) combined with the multisector approach (tiers 2 and 3)—were either absent or difficult to measure or attribute. The COVID-19 pandemic demonstrated ADB's strengths: ADB was one the few development organizations with the mandate, capacity, and financing to collaborate rapidly across sectors and modalities as needed during a pandemic response. NSO in the health sector also expanded during the pandemic in terms of investments, but this growth highlighted the need for a more strategic approach to guide future private sector investments. The following chapter discusses whether these different approaches and efforts to link sectors and modalities were effective in bringing about health benefits in the region.

CHAPTER 4

Performance and Challenges in Health

49. Under Strategy 2020, ADB supported health primarily through indirect investments in infrastructure and social development. Under Strategy 2030, ADB recognized that it needed to return to investing directly in the health sector. This two-track approach to health was implicit in the HSDG, which focused on using ADB's health-specific expertise and resources to strengthen its health portfolio while also supporting the multisector approach to health through cross-sector collaboration in projects in other sectors that may include health benefits or impacts. This chapter assesses the effectiveness of ADB's support, delving into how the implementation of operations under each track differed, along with some of the challenges encountered in monitoring and evaluation of their performance.

A. Health Sector Operations

50. ADB support for health through sovereign operations was carried out effectively. Validations by the Independent Evaluation Department (IED) of self-assessments of ADB health support through its sovereign operations completed during 2011–2024 corroborated a success ratio of 87.9% (29 of 33 operations validated), which was significantly higher than ratios in other sectors (69.0%, or 631 of 914 validated). However, during 2014–2017, when the health sector's average rating fell below that of the rest of ADB, low ratings for relevance, effectiveness, and efficiency were evident (Appendix 7). Investment projects made up the bulk of ADB's support for health before 2015—the year in which PBLs and RBLs began appearing. No assessments of completed PBLs have been carried out, while the only RBL completed and assessed was Supporting National Urban Health Mission in India ($300 million), which was self-assessed to be *highly successful* and validated by IED as *successful*.

51. The drop in the performance of sovereign operations in health can be attributed to four projects. A project in Pakistan (Punjab Millennium Development Goals Program) was rated *unsuccessful*, while one project in Indonesia and two in the Philippines were rated *less than successful*. IED's independent validation of the project completion reports for these projects rated all four projects *less than efficient* or lower, and the performance of the borrower and executing agency as *less than satisfactory*. Since project efficiency is often negatively impacted by poor capacity or lack of experience on the part of the borrower and executing agency, it seems reasonable to assume that more effort from ADB to support these DMCs through project preparatory support and capacity development could have brought about better results. Notably, all four projects were approved during 2003–2009 and evaluated during 2014–2017—a period when ADB had deprioritized direct health sector support in favor of infrastructure-focused operations. Given this, the health objectives of these projects may have been overshadowed by infrastructure priorities. Apart from these four projects, the rest of ADB's health sector portfolio demonstrated significantly higher overall likelihood of success than ADB projects in other sectors.

52. The evaluation notes that 51% of health TA projects by number and 73% by volume were classified as capacity development TA (i.e., they aimed to improve the technical capacity of a

public health counterpart). Although such TA is essential to effective collaboration and to the implementation of ADB projects, the ADB TA program would have been better balanced if it had supported more policy and advisory and research and development TA projects, which together accounted for only 21% of TA projects by number and 9% of TA by volume.[26] Such TA can offer greater mid- to long-term impact by providing in-depth country-specific knowledge and policy reform direction (Box 5).

Box 5: ADB Technical Assistance Lays the Foundation for New Projects in India

The Supporting National Health Authority in India technical assistance (TA) project aimed to enhance health-care access by addressing infrastructure gaps and exploring financing mechanisms for secondary and tertiary care. Initially, the focus was on establishing a health financing intermediary. However, in response to shifting government priorities during the coronavirus disease pandemic, the project pivoted to a public–private partnership (PPP) model. This led to the development of a comprehensive PPP road map and a model concession framework. The outputs of this small-scale knowledge and support TA—diagnostic assessments, financial structuring options, and institutional capacity insights—were instrumental in shaping policy and investment strategies, offering potential for replication and sustainability across India's health-care system. The TA was assessed as having added transformational value by improving access to universal health care and social protection for poor and vulnerable populations across India. It created a refinancing window for health service providers in partnership with the National Health Authority to implement Jan Arogya Yojana, a health insurance scheme.

Source: IED. 2024. *Validation of Technical Assistance Completion Report: Supporting National Health Authority in India*. Asian Development Bank.

53. Private spending on health in Asia has remained a significant component of overall health-care financing, particularly in low- and middle-income countries. Many Asian nations continue to rely heavily on out-of-pocket expenditures, which account for more than 40% of total health spending in lower-middle income countries like India, Bangladesh, and the Philippines.[27] After surging in the early pandemic years, average per capita government spending in all country income groups decreased in 2022 compared with the previous year.[28] This reliance on the private sector is well illustrated in a WHO's Global Health Observatory report, according to which the private sector provides 57% of all health-care services and 69% of outpatient care in Southeast Asia.[29] However, heavy reliance on out-of-pocket expenditures can worsen the gaps between the poor and better-off populations in terms of their access to high-quality health services. A system that relies on private spending is one of the least equitable and least efficient forms of health sector financing. A move toward more public financing for health should be regarded as an indicator of success for the sector.

54. To mitigate the current heavy reliance on out-of-pocket expenditures in DMCs and in line with the prioritization of UHC as a long-term goal in its HSDG, ADB has attempted to play a more prominent role in supporting its DMCs' progress toward UHC, while making better use of its corporate advantage in areas such as health financing, policy reform, service provision, and capacity development. Although ADB has supported UHC in some cases (Box 6), most of these

[26] ADB has simplified its TA classification to two types—transaction TA and knowledge and support TA. However, the prior TA classification system, which included capacity development, policy and advisory, and research and development TA, is referred to here, as it was in use during much of the evaluation period.

[27] World Health Organization. *Global spending on health: emerging from the pandemic*. 2024

[28] World Health Organization. *New WHO Report Reveals Government Deprioritizing Health Spending*. 12 December 2024.

[29] World Health Organization. *The Global Health Observatory: Sources of care in mixed health systems*. Accessed on May 1, 2025.

preceded the HSDG in their design and are still in various stages of implementation, resulting in limited results or outcomes thus far.

Box 6: Country Cases of ADB Support for Universal Health Coverage

Of the five case countries in this evaluation, ADB has supported three in implementing or improving on their local universal health coverage (UHC) programs.

- **India**. Strengthening Universal Health Coverage in India: Supporting the Implementation of Pradhan Mantri Jan Arogya Yojana aims to improve the effectiveness of the national UHC program through (i) digital solutions, (ii) innovative models of financing and service delivery, and (iii) strategies for capacity strengthening and private sector response to the coronavirus disease pandemic.

- **Mongolia**. An ADB technical assistance project, Improving Access to Affordable Medicines in Public Hospitals, supported progress toward UHC, as did an investment program, Improving Access to Health Services for Disadvantaged Groups. ADB played a critical role in health-care financing reform by providing the technical research and knowledge needed through another technical assistance project, Improving Health Care Financing for Universal Health Coverage.

- **Philippines**. Two subprograms have been implemented under the Build Universal Health Care Program, aimed at supporting the Universal Health Care Act (signed into law in February 2019); and ensuring successful implementation of health financing, service delivery, and performance monitoring reforms.

ADB's support for UHC varies in size and complexity depending on the level of need and the maturity of the UHC policy and system in each developing member country. Although all three cases described above are works-in-progress, they illustrate ADB's flexibility in the design of its interventions to meet its developing member countries' needs in an optimal way.

Source: Asian Development Bank (Independent Evaluation Department).

55. At the project level, the evaluation finds that most ADB operations targeted improved access to health services. Lacking a unified set of outcome or output indicators to cascade up into a portfolio-wide assessment, the evaluation team conducted a proxy assessment by analyzing the health-related performance indicators in project DMFs to understand what type of health outcomes were being pursued by ADB (Appendix 6). Among health sector projects, 30.1% contributed to "coverage of essential health-care services" (Sustainable Development Goal [SDG] 3.8), making this the single largest subsector in health. Support for vaccine coverage, research, and affordable medicine (SDG 3.b) came in next with 22.3%, followed by health worker distribution (SDG 3.c) and health emergency preparedness and health worker capacity (SDG 3.d) which combined for 19.3%. This reflects ADB's long-term focus on primary health service provision before the COVID-19 pandemic when vaccine and emergency health service provision predominated.

56. With respect to gender equality in access to health care, ADB-supported perinatal and maternal health projects in Uzbekistan have made notable progress, particularly in improving outcomes for vulnerable women in underserved regions. Nonetheless, persistent gender-specific challenges remain, such as cultural and societal barriers that continue to limit women's access to health care and their participation in decision-making within the health sector. Practices vary on the incorporation of gender-based violence and other gender issues in health projects.

B. Multisector Approach

57. Although the multisector approach is widely recognized for its potential to improve health outcomes, evidence of the effectiveness of this approach remains fragmented and mixed (Box 7). Positive impacts have been observed when interventions are intentionally aligned, rigorously evaluated, and tailored to local contexts. Their success depends on strong institutional coordination, adaptive designs, robust monitoring, and meaningful community engagement.[30] Conversely, fragmented planning, inadequate financing, and weak governance often undermine their effectiveness.[31]

Box 7: Multisector Approach to Health: Insights from South Asia

South Asia offers illustrative cases of how well-designed multisector interventions can lead to tangible health gains—particularly when they are context sensitive, coordinated, and explicitly aimed at improving health outcomes. In Bangladesh, a comprehensive strategy combining maternal and child health services, family planning, girls' education, transport subsidies, and rural electrification have contributed to a reduction of more than 4% in maternal and neonatal mortality since 2000.[a] In Nepal, community-led programs involving women's self-help groups—offering nutrition education, livestock support, and social capital development—yielded stronger child growth outcomes than those of less integrated interventions.[b] In India, convergence of multisector interventions across six sectors—health; women and child development; education; water, sanitation, and hygiene; clean energy; and growth—were associated with improvements in child nutrition, especially in underdeveloped districts.[c] However, these cases also highlight the challenges of operationalizing multisector approaches. In Bangladesh, limited baseline data constrained the robustness of the evaluation, while in Nepal, the inclusion of social capital components significantly raised costs. Meanwhile, in India, the specific contribution of convergence to observed outcomes proved difficult to isolate.

More broadly, these case studies underscore the importance of designing multisector interventions with explicit health objectives, community-driven priorities, and robust monitoring frameworks. Despite their conceptual appeal, the success of multisector approaches is often hard to measure because of fragmented implementation and limited evaluative rigor. Large-scale sanitation programs, for example, have had mixed health impacts, with their effects often constrained by weak study designs, low uptake, behavior change, variable sanitation use, and lack of information on baseline conditions.[d] Although some studies have underscored the importance of infrastructure in influencing health outcomes, the overall evidence base remains thin. Similarly, although transport infrastructure is often associated with improved health access, empirical research establishing clear causal pathways is limited.

[a] A. T. Hossain, et al. 2024. Effective multi-sectoral approach for rapid reduction in maternal and neonatal mortality: The exceptional case of Bangladesh. BMJ Global Health, 9: e011407.
[b] L. C. Miller, et al. 2020. Multisectoral community development in Nepal has greater effects on child growth and diet than nutrition education alone. Public Health Nutrition, 23(1): 146–161.
[c] S. Rajpal, et al. 2020. Child undernutrition and convergence of multisectoral interventions in India: An econometric analysis of National Family Health Survey 2015–16. Frontiers in Public Health, 8:129.
[d] M. C. Freeman, et al. 2017. The impact of sanitation on infectious disease and nutritional status: A systematic review and meta-analysis. International Journal of Hygiene and Environmental Health, 220(6): 928–949.
Source: Asian Development Bank (Independent Evaluation Department, Study on the Literature and Systematic Reviews of the Multisector Approach to Health).

58. It remains difficult to track health impacts from tier 3 projects because of inadequate tagging, weak data systems, and limited accountability frameworks. This makes it difficult to

[30] I. N. Sutarsa, et al. 2024. Multisectoral interventions and health system performance: A systematic review. Bulletin of the World Health Organization, 102(7): 521–532F..
[31] M. Amri, A. Chatur, and P. O'Campo. 2022. An umbrella review of intersectoral and multisectoral approaches to health policy. Social Science & Medicine, 315: 115469.; and V. T. Sanga, E.D. Karimuribo, and A.S. Hoza. 2024. One Health in practice: Benefits and challenges of multisectoral coordination and collaboration in managing public health risks: A meta-analysis. International Journal of One Health, 10(1): 26–36.

assess the contribution of multisector investments to health outcomes and has raised concerns about the coherence and strategic alignment of health-related work across ADB sectors. The absence of strategic integration and robust planning mechanisms also contributes to poor implementation of multisector projects, limiting their effectiveness in improving health outcomes. Sanitation projects often focus on infrastructure provision without ensuring behavior change, community ownership, or sustained use—key factors that influence actual health gains.[32]

59. At the project level, the multisector approach to health was often perceived by project officers as procedural rather than strategic, and as imposing an additional layer of complexity and risk on top of what might already be a complex project design. Many project managers felt the multisector approach added little to the main project and noted the weak institutional incentives, limited integration of health sector experts during the design phase, and focus on infrastructure outputs by non-health sectors. The evaluation's perception survey results also point to significant internal fragmentation and misalignment across ADB on the strategic value and operationalization of the multisector approach to health. ADB's health strategy and vision are largely unfamiliar to staff outside the health sector, with familiarity ratings dropping from 4.76 (out of 6) among health staff to just 3.84 (slightly positive) among non-health staff. This limited awareness suggests that ADB's health vision has not been effectively communicated or institutionalized, hindering cross-sector collaboration.

60. The evaluation's country case studies suggest that ADB investment in the multisector approach to health has been uneven, and that this has affected the quality and consistency of monitoring frameworks, including the choice and tracking of health indicators. Although some sectors—including education, public sector management, and industry and trade—demonstrated involvement in health through tier 2 projects, engagement from other key sectors remained limited. Tier 3 contributions to health from infrastructure-related sectors—including operations in transport; water and other urban infrastructure and services; and agriculture, natural resources, and rural development—were present, but were not institutionally coordinated or strongly incentivized. In Papua New Guinea, the Philippines, and Uzbekistan, inclusion of health indicators that were relevant, specific, and measurable would have enhanced monitoring of tier 3 projects (Box 8). The evaluation's perception survey further highlights the need for stronger design logic and more data monitoring, as international staff gave a slightly negative response (3.43 out of 6.00) when asked whether they had been provided with sufficient guidance on how to incorporate health outcomes in non-health projects. This suggests a broader lack of internal operational support, which has limited the capacity of project teams to integrate health indicators into multisector projects in a systematic way. ADB has limited evidence of success from the multisector approach, due in large part to the absence of dedicated monitoring frameworks to capture health outcomes within ADB multisector projects and investments led by other sectors.

[32] M.C. Pajaron. 2025, Literature review conducted for this evaluation report (Supplementary Appendix 3).

Box 8: ADB's Role and Multisector Approaches to Health in Uzbekistan

Over the years, ADB-funded projects have contributed to Uzbekistan's health infrastructure and policy environment. These initiatives have spanned health facility upgrades; national guideline development; and support for water, sanitation, and hygiene interventions (WASH) in schools and communities. ADB's comparative strength in infrastructure has been complemented by targeted efforts to integrate capacity building, training, and community engagement into infrastructure projects. This dual focus has yielded tangible results in the form of improved hygiene awareness, waste management, and school-based WASH practices. Although technical working groups involving the ministries of health, education, and construction are in place at the country level, collaboration has often been fragmented. Embedding health objectives across infrastructure, social development, education, and climate resilience initiatives will be critical to achieving more cohesive and impactful support in Uzbekistan.

Source: Asian Development Bank (Independent Evaluation Department).

C. Collaboration with the Private Sector

61. ADB has been responsive to emerging investment opportunities for nonsovereign health projects, but these operations have sat uneasily alongside ADB's broader health sector strategy, which aims to advance UHC, strengthen health system resilience, and promote equitable access to quality care. While sovereign operations have been anchored in national health plans, regional cooperation frameworks, and technical assessments, the nonsovereign portfolio has been shaped more by the availability of investable private sector partners. Although this may reflect the actual nature of ADB's NSO, a more clearly articulated strategic framework could have improved alignment of such operations with DMC priorities and promoted coherence across ADB's health portfolio.

62. Private sector engagement in health spans a continuum, from upstream policy and regulatory reforms to midstream market-enabling interventions such as public–private partnerships (PPPs) to downstream NSO in service delivery and infrastructure. Although ADB has made progress in mobilizing private sector investment in health, its approach along this continuum remains fragmented and characterized by persistent operational challenges. These include difficulties in sourcing bankable projects with measurable health outcomes, the limited technical capacity of private sponsors in frontier markets, and shortages of staff and sector expertise within ADB (e.g., only one international staff covers NSO in all of Southeast Asia). These constraints have limited both the visibility and the sourcing of nonsovereign opportunities. This may be appropriate for the current small portfolio size, or to test the appetite for nonsovereign lending across the region, but may not be sustainable in the medium to long term. ADB has attempted to address some of these issues through blended finance tools and TA, but the link between its knowledge work and its nonsovereign project pipeline remains weak.

63. Aside from broad references to the need for "innovative financing," ADB has provided little institutional clarity on the roles, expectations, and challenges associated with increasing private sector participation in the health sector. This has led to inconsistency in implementation and missed opportunities for strategic alignment. As ADB continues to refine its approach to nonsovereign health investments, there is growing recognition of the need to assess the comparative benefits and risks of different financing instruments, including direct and indirect equity investments, in a strategic way. Several NSO investments have supported public service delivery—e.g., investments in private hospitals that allocate beds for publicly funded patients. ADB should build on such positive outcomes by developing clearer guidance on how private investment can complement public health objectives to strengthen social outcomes while avoiding perceptions of inequity.

64. Despite the issues, there is evidence that ADB has had early success with several PPP projects, including the Urban Primary Health Care Project in Bangladesh.[33] Bringing together sovereign and nonsovereign lending in PPPs for health care could allow ADB to play a catalytic role in addressing complex health system needs. The rationale for this blended approach lies in its ability to leverage public financing to create enabling environments, such as robust regulatory frameworks or co-investment in shared infrastructure, while using nonsovereign instruments to mobilize private capital, inject technical expertise, and promote operational efficiency. Such a two-track model could enable more comprehensive and scalable health-care interventions. When they are well designed, such arrangements can align incentives, attract long-term private investment, and accelerate progress toward UHC, particularly in underserved areas or settings with little infrastructure.

65. This approach is not without risks, however, and these need to be better understood across both sovereign operations and NSO. As well as the danger of institutional fragmentation if the roles and responsibilities of public and private actors are not well governed, PPPs may also shift public health priorities toward commercially viable services, potentially sidelining essential but less profitable areas such as primary care or rural service delivery. To be effective and equitable, ADB's approach to PPP has to be strategic. It needs to rigorously assess PPP structuring, ensure transparency, and embed safeguards that prioritize access, equity, and long-term sustainability.

66. NSO are an important pillar of ADB's broader strategy to support health outcomes, particularly through investments in sectors that influence the social and environmental determinants of health—such as water, sanitation, and urban infrastructure. Multisector NSO projects offer valuable opportunities to harness commercial capital and private sector innovation while contributing to public health objectives. However, such projects could be driven by commercial returns rather than public health outcomes, resulting in health-related objectives being secondary or poorly integrated into project design and implementation. Without strong cross-sector governance, robust monitoring systems, and mechanisms to ensure accountability for health outcomes, the link between nonsovereign infrastructure investments and tangible health benefits could be weakened. For ADB to continue pushing for health outcomes via its nonsovereign operations in other sectors, more explicit commitments on the integration and monitoring of health outcomes through non-health sectors will be needed.

67. In Mongolia, ADB piloted family health centers that have revolutionized the delivery of primary care and have been replicated nationwide (Box 9), as the country transitioned away from family group practices. In addition, ADB introduced a multifunctional design for district-level hospitals in Mongolia, marking a departure from the country's traditional specialized hospitals and allowing for the provision of a one-stop, holistic health-care service for patients. This design has since been used as the benchmark for other government- and EBRD-financed district hospitals. Regarding private sector operations, Intermed, a private hospital in Ulaanbaatar, took out a nonsovereign loan from ADB to expand and modernize its facilities, effectively establishing itself as a forerunner in cutting-edge medical service provision. It also became a teaching hospital that public health officials and specialists have regularly visited to learn and observe best practices in health service provision. Intermed offers patients a practical alternative to traveling overseas for risky, complex medical procedures—contributing to more equitable access to advanced care.

[33] ADB. Bangladesh: Urban Primary Health Care Project. This is one of the largest PPPs delivering primary healthcare in South Asia. It was implemented from 1998 to 2024 and financed by ADB, the United Kingdom, and Sweden through various cofinancing arrangements. By strengthening and mainstreaming the PPP model of service delivery, the project encouraged alternative ways of public services delivery and enabled a greater role for the private sector.

Box 9: Replicating Family Health Support to Improve Primary Healthcare in Mongolia

ADB support for primary health care in Mongolia started with the introduction of family group practices (FGPs) under the First Health Sector Development Project (1997–2003), which consisted of a policy-based loan ($4.0 million), an investment loan ($11.9 million), and technical assistance ($600,000). Family group practices were intended to provide family medicine services and to reduce reliance on expensive hospital care. After their initial implementation in Ulaanbaatar, FGPs were rolled out across the country over a 5-year period and eventually covered 60% of the population. However, a 2008 ADB evaluation pointed to multiple unresolved challenges related to the FGPs' legal and budgetary status. It noted the lack of a well-defined service package, undertrained clinical and administrative staff, and inadequate public communication. Based on these findings, the Third Health Sector Development Program (2007–2014) supported the government's restructuring of FGPs into the current family health centers (FHCs), with new standards, service packages, and referral arrangements, and the development of core indicators to monitor and evaluate FHC performance. FHCs are now the first contact point for health care in urban areas, especially for the poor and vulnerable, including the elderly, children, and people with disabilities.

Source: ADB. 2021. *Supporting Primary Health Care in Mongolia: Experiences, Lessons Learned, and Future Directions*, East Asia Working Paper Series, No. 35, January; Operations Evaluation Department, 2008. *Performance Evaluation Report: Health Sector Development Program in Mongolia*. ADB.

D. Post-COVID-19 Momentum in Health

68. ADB's support during the COVID-19 pandemic was successful in achieving its objective of rolling out emergency financing and supplies quickly. However, although CPRO was launched in response to a global health crisis, many of its operations concerned public finance and were not exclusively or even primarily focused on health. All CPRO projects were rated either *successful* or *highly successful* in both their project completion reports (PCRs) and their validation reports, and all CPRO operations were rated *effective*. Given the straightforward nature of the overall CPRO objective to provide rapid liquidity to governments under pandemic crisis conditions, these ratings are not surprising—despite these projects' lack of attributable health outcomes or results to monitor or assess.

69. ADB responded well to the COVID-19 crisis, mobilizing significant resources to address urgent health needs across the region. The pandemic served as a catalyst for ADB to temporarily expand its health sector engagement, with health lending reaching a peak share of 29.7% of total operations in 2021. However, by 2024, this share had returned to pre-pandemic levels (5.3%), and the momentum generated during the crisis has not yet been translated into sustained, long-term health agendas. Although infrastructure-focused sectors remain a significant pillar of ADB operations, opportunities to embed health considerations more strategically within these sectors remain underutilized. As a result, earlier commitments to broaden the health portfolio have yet to be fully reflected in country strategies and resource allocations.

70. ADB continues to benefit from the enhanced institutional standing it gained through its swift and effective response to the COVID-19 pandemic. While it did not immediately or comprehensively address systemic gaps exposed by the crisis—such as weaknesses in primary care, health information systems, and public health infrastructure—it is well positioned to build on the momentum it gained during the pandemic. By shifting from a largely reactive approach to a more proactive, strategic, and evidence-driven approach, ADB could better align its health investments with its long-term development goals. It has several comparative advantages to leverage: strong relationships with government counterparts; access to a broad range of financing and cofinancing mechanisms across many sectors; an infrastructure focus that can be harnessed to deliver health outcomes; the ability to integrate sovereign operations and NSO in health; and

extensive regional knowledge and networks. These strengths present a valuable opportunity for ADB to reposition itself as a more deliberate and long-term partner in health sector development.

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71. During the evaluation period, ADB's health sector operations were not guided by a current policy, corporate-level strategy, or goal that could have united its efforts or interventions. As a result, although individual operations were successfully implemented, they did not contribute to high-level or corporate-level outcomes or impacts. ADB's multisector approach to health was well intentioned and recognized the potential of engaging numerous sectors to improve health outcomes. However, it has not produced measurable results, largely because of an absence of a strategic approach, a lack of robust monitoring and evaluation frameworks, and insufficient planning and resource allocations to support effective oversight. Although ADB has participated in innovative and successful private sector collaborations, NSO remain a small niche in the overall health portfolio. The COVID-19 pandemic temporarily elevated the profile of health, but ADB has struggled to sustain that momentum and translate increased demand into a pipeline of concrete investments. The next chapter explores additional institutional factors that may have contributed to this loss of traction in ADB's health sector engagement.

CHAPTER 5

Knowledge, Data, and Staffing Synergies

72. Given that health remains a small portfolio within ADB, it is important to consider the synergies between resources and staff ADB has to support its health agenda. In particular, recent changes under ADB's new operating model (NOM) offer an opportunity to improve the integration of ADB resources to better deliver on health outcomes.

A. Knowledge and Data Utilization

73. ADB has undertaken extensive knowledge work in the health sector aimed at informing policy, guiding investments, and supporting countries to achieve UHC. During 2011–2024, ADB published more than 500 health-related knowledge products, including technical reports, policy briefs, toolkits, working papers, and regional health sector assessments. These covered a wide range of thematic areas, with an emphasis on health finance, public financial management, private sector engagement in health, digital health, pandemic preparedness, and integrating climate resilience in health systems. ADB published country-specific health system reviews for India, Indonesia, Mongolia (Box 10), and the Pacific islands, as well as thematic reports on the health–finance nexus and innovative financing for health. ADB's knowledge work—typically developed in partnership with governments, academic institutions, and global health agencies—is designed to be practical, evidence-based, and regionally contextualized to support implementation of sovereign and nonsovereign health investments.

Box 10: Documenting and Sharing Lessons from ADB's Approach to Health in Mongolia

Mongolia's Soviet-era system did not incentivize providers to deliver quality health services while making efficient use of scarce resources. This required extensive health sector reform support from ADB, which worked with the government to employ a mix of instruments, balance urban and rural interventions, and facilitate a smooth transition from a socialist to a market-based system. This resulted in: (i) a Health Sector Master Plan, (ii) the introduction of family health centers as focal points of primary health care; (iii) updated medical guidelines to ensure quality public health services and provide new incentives for hospitals to take on difficult and challenging cases; (iv) piloting of multifunctional rather than specialized hospitals; (v) health insurance reform to lower barriers to health-care access and incentivize service quality; and (vi) upgrading of sterilization services, blood banks, transfusion centers, and microbiology laboratory services to improve infection control.

These health sector interventions were well sequenced and the result of a strategic approach to the health sector that required effective linking of knowledge, policy dialogue, technical assistance, and lending from ADB. In addition to ADB support, the following factors were identified by the evaluation as contributing to the success of Mongolia's health portfolio: (i) consistent government demand for health support; (ii) a stream of strong analytical work by ADB that resulted in reforms and loans; and (iii) the long-term presence of a politically aware, technically competent, local member of staff at the ADB Mongolia Resident Mission who championed the much-needed health sector reforms. Many of the experiences, lessons, and future directions for the health sector in Mongolia were well documented through ADB East Asia Working Paper Series (Nos. 35, 37, 49, and 55) published during 2021–2022.

Source: Asian Development Bank (Independent Evaluation Department).

74. Despite the breadth and depth of ADB's knowledge work in the health sector, much of it may not be reaching its intended audiences, particularly policymakers, implementers, and private sector actors in low- and middle-income countries. ADB has produced text-heavy technical publications that assume a high degree of familiarity with development finance and health systems, and may not resonate with time-constrained or non-specialist readers. ADB needs to produce shorter and more direct knowledge products, in addition to the policy briefs and toolkits it has published so far. Moreover, dissemination strategies have tended to rely on ADB's own channels, such as its website or formal ADB events, rather than broader platforms or partnerships that could have increased visibility among ministries of health, subnational decision-makers, and frontline implementers. As a result, although the content of ADB's health publications has often been technically robust and policy relevant, uptake in country programming or operational decision-making has been limited.

75. ADB's lack of structured, publicly accessible data on its health portfolio significantly undermines efforts to evaluate the effectiveness of its investments in the sector. Without a consistent framework for reporting project outcomes, disbursement progress, and measurable health indicators, it is difficult to assess whether projects—collectively or individually—have achieved their intended impact or offered value for money. This lack of a framework is most evident at the corporate level. ADB's corporate results framework (2019–2024) included only a single outcome-level indicator related to health: "number of people benefiting from improved health services, education services, or social protection." This indicator, meant to serve as the highest-level performance indicator for health, is not particularly useful as it does not disaggregate beneficiaries by sector. The lack of data also impedes comparative analysis across countries, asset classes, and financing modalities, limiting learning and accountability. Moreover, the absence of a consolidated database of health performance indicators hampers transparency and makes it difficult for researchers, partner governments, and civil society to scrutinize performance, identify trends, or inform future programming. In the context of development finance, where robust evidence is essential for policy alignment and long-term strengthening of health systems, this lack of structured information on ADB's health portfolio performance represents a major strategic shortcoming.

B. Strategic Staffing and Collaborative Engagement

76. A distinctive feature of health sector support from development partners is the complex combination of technical and policy expertise required to navigate this multifaceted sector. MDBs often categorize their health staff as either health specialists or health economists, but in practice health specialists encompass a diverse range of technical competencies rarely found within a single individual. These include physicians (generalists or specialists), public health professionals with advanced degrees, epidemiologists, demographers, and health policy experts with specialized skills in policy development, political analysis, and legal frameworks. Even the classification of health economists covers broad areas of expertise, including insurance systems, provider payment mechanisms, strategic purchasing, and outcomes research. Furthermore, as the health sector does not lean heavily on infrastructure, expertise to support health systems development can be difficult to source, despite it being critical for the sector.

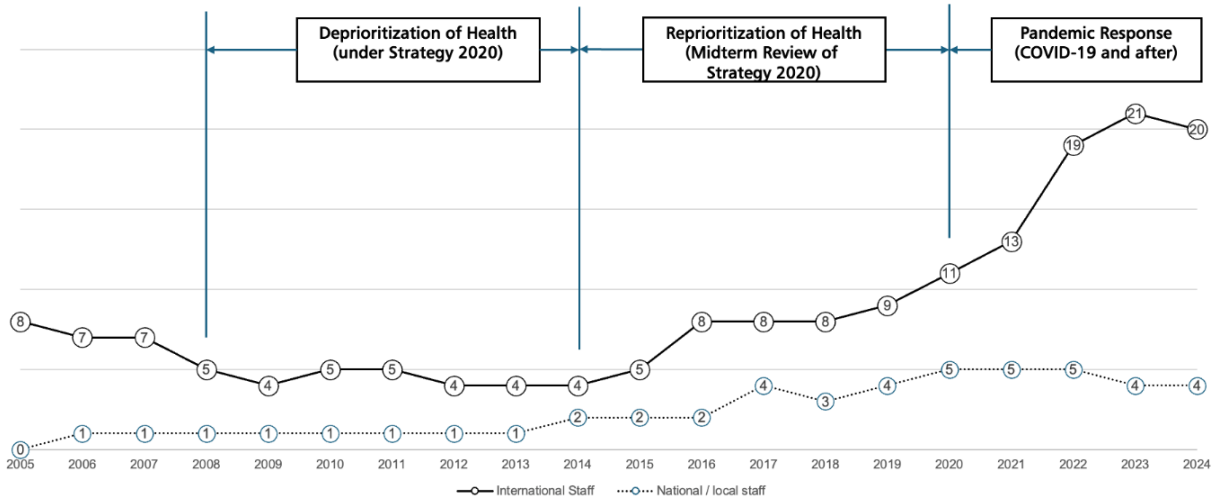
77. TA has played a vital role in strengthening ADB's health expertise and in supporting its capacity, given the organization's limited dedicated internal staff resources. TA projects proved invaluable in supporting ADB's ability to source local health experts, technical development agencies, nongovernment organizations, civil society organizations, and faith-based organizations during the ramp-up for ADB's COVID emergency response. Recruiting such local expertise was the only way for ADB to implement health interventions in DMCs that were under

lockdown with strict international and domestic travel restrictions. ADB's dependence on external consultants and experts to implement its capacity development and project preparatory TA projects is evidenced by the fact the two TA types accounted for 107 of 135 health sector TA projects and 91% of the total commitment by volume during 2011–2024.

78. MDBs have consistently found it difficult to recruit highly specialized health personnel capable of addressing diverse country contexts alongside institutional operational needs, often resorting to working in coordination with other global health institutions or amplifying long-standing health research.[34] The evaluation team found that the in-country presence of ADB health staff with deep knowledge of national systems and sector dynamics had played a significant role in the success, sustainability, and growth of several country health portfolios, as exemplified by the Mongolia Resident Mission, where a highly experienced national health officer contributed to a robust health portfolio and provided critical support for policy dialogue (Box 10).

79. ADB's intermittent approach to lending for the health sector has had a destabilizing impact on staffing and on the corporate guidance that influences country partnership strategies and portfolio development. ADB's Policy for the Health Sector (1999) noted that ADB had the equivalent of eight full-time staff working on the health sector in August 1998; this number had not changed a decade later when ADB decided to step away from working directly in health in favor of a multisector approach (Figure 13). The pivot to a multisector approach resulted in a lull in hiring health specialists, with some of the ongoing work managed by national staff at headquarters or resident missions. After the midterm review of Strategy 2020 in 2014 and the rollout of the Operational Plan for Health in 2015, the number of health sector staff increased to 16 in 2020. To meet the sudden surge in demand from DMCs amid the COVID-19 pandemic, more international staff were brought onboard, with the total peaking at 21 international and 4 national or local staff in 2023. However, this increase has proved insufficient to meet the long-term demands of DMCs for health sector support. ADB will need to recruit more health specialists (including health economists and administrators) if it is to translate the boost in DMCs' health sector demands post-COVID into long-term project pipelines.

Figure 13: ADB In-House Health Sector Capacity, 2005–2024
(number of ADB health staff)



Source: Asian Development Bank (Budget, Personnel, and Management Systems Department).

[34] M. Tichenor, et al. Interrogating the World Bank's Role in Global Health Knowledge Production, Governance, and Finance. *Global Health* 17, 110 (2021). https://doi.org/10.1186/s12992-021-00761-w.

80. The evaluation team's discussions with government officials from five of the largest borrowing countries found that the officials were concerned about the adequacy of ADB's staffing for the health sector.[35] Senior government leaders expressed strong appreciation for ADB's support during the COVID-19 response and noted the flexibility demonstrated by ADB staff, but they also questioned whether ADB staff were sufficient in number or had the required technical skills. Consultations with the WHO and the United Nations Children's Fund (UNICEF) highlighted cases where partnerships had allowed ADB to leverage their specialized technical expertise, thereby expanding ADB's capacity in health operations. Future health sector strategies could systematically strengthen such partnerships by combining ADB's comparative advantage in infrastructure development with the technical health expertise of agencies such as WHO and UNICEF (Box 11). Additionally, expanding collaboration with other MDBs could augment ADB's technical and financial resources for the sector.

Box 11: ADB's Partnerships and Collaboration during COVID-19 in India

The World Health Organization (WHO) India office told the evaluation team that ADB had played a significant role in strengthening India's health systems, particularly during the coronavirus disease (COVID-19) response in Uttar Pradesh and Uttarakhand. ADB had supported household-level monitoring and training through video-based methods, enabling the tracking of 1.6 million beneficiaries. In collaboration with the WHO, ADB had trained over 160,000 frontline workers and promoted best practices in biomedical waste management.[a] The WHO acknowledged ADB's responsiveness and flexibility in fund utilization. Weekly monitoring meetings with India's Ministry of Health and Family Welfare helped reporting mechanisms improve over time. In addition to emergency response, ADB's evolving commitment to health was evident in its shift from infrastructure-focused investments to broader health sector engagement. WHO recognized ADB's growing health workforce, although officials noted that ADB staffing remained limited. While ADB and WHO have collaborated closely in Afghanistan and Bangladesh,[b] their engagement in India has been more limited, partly because government capacity varies across the three countries. WHO emphasized the potential for deeper collaboration, especially in leveraging complementary expertise and engaging the private sector, which played a key but informal role during the pandemic. Enhanced coordination between ADB and WHO could further strengthen health outcomes in India.

Finance and Health Ministry officials in India recognized ADB's health sector support for its timeliness and relevance, particularly during the COVID-19 pandemic. A $300 million results-based loan for the Strengthening Primary Health Care in Urban Areas Program and a $1.5 billion Asia Pacific Vaccine Access Facility loan were highlighted as having made a positive impact, although use of the vaccine facility was limited by ADB's retroactive financing rules.[c] Ministry officials also emphasized the need for greater private sector participation through public–private partnership models and revenue-generating projects. Although ADB's Private Sector Operations Department has supported major hospital chains and other health-related investments, these have not been sufficiently strategic and have delivered mixed results. Concerns were also raised about ADB's staffing capacity to scale up health sector engagement, although the new operating model has resulted in additional health sector staff in the India Resident Mission. Strengthening partnerships, harmonizing cofinancing protocols, and translating technical knowledge into market-specific strategies were identified as key next steps to enhance ADB's contribution to India's health sector.

[a] ADB. *Technical Assistance to India: Supporting COVID-19 Response and Vaccination Program*.
[b] ADB placed its regular assistance to Afghanistan on hold effective 15 August 2021, but it has supported the basic needs of the Afghan people since 2022 through a special arrangement with United Nations agencies.
[c] ADB Procurement Guidelines (https://www.adb.org/documents/procurement-guidelines)
Source: Asian Development Bank (Independent Evaluation Department).

[35] The five countries were India, Mongolia, Papua New Guinea, the Philippines, and Uzbekistan—representing the largest borrowers in health from each of ADB's subregions in Asia and the Pacific.

C. New Operating Model and Health

81. In the poorest countries in Asia and the Pacific, investments in simple health sector interventions have had an enormous impact on health outcomes. These have included infrastructure for the provision of clean drinking water, leading to lower infant mortality;[36] immunization programs to prevent the spread of communicable diseases;[37] programs for improved nutrition; and neonatal care to decrease childhood mortality.[38] However, the health challenges faced by these countries have become significantly more complex in recent years. Rapid economic growth has driven changes in behavior and lifestyle, and DMCs now need to address more complex challenges, such as prevention of noncommunicable disease, provision of affordable tertiary care, and progress toward UHC.

82. To address countries' need for complex and cross-sector interventions, ADB has been implementing a "One ADB" approach under Strategy 2030 and the NOM, aimed at facilitating greater collaboration among staff, departments, and resident missions, and across sectors and themes. IED's evaluation of the One ADB approach noted that it lacked coherence and that ADB needed to develop an explicit plan of selective, purposely sequenced, and achievable institutional reforms over the medium term.[39] This recommendation, among others, fed into the planning and implementation of the NOM in 2023.

83. Operationally, the NOM has reshaped internal collaboration dynamics, presenting opportunities as well as challenges to the multisector approach to health. The NOM rollout has broken down regional silos while establishing links across sectors and modalities within ADB. This has resulted in health specialists, who had previously been spread across regional departments, being consolidated under the Human and Social Development Sector Office. Staff supporting the health sector are primarily headquarters-based although a few staff are either assigned to or hired at resident missions. However, said staff have complained that they now need to report both to headquarters and to the resident mission. Interviews and a survey by an ongoing evaluation of the NOM found that ADB staff regarded the NOM rollout as rushed and poorly managed and that this had resulted in a lack of buy-in and support from ADB staff.[40] Procedural inconsistencies, an unclear delineation of joint roles and responsibilities, and increased transaction costs associated with working across teams were also criticized. As a result, the extent of collaboration among sector offices still falls short of what is needed, constraining multisector approaches to health. However, there have been early indications that such collaboration may be increasing.

84. ADB's transition from a single Sectors Group to three distinct sector departments under the NOM was an important institutional shift aimed at enhancing sector focus. Although the new structure is still in its early stages, it has the potential to streamline technical engagement among sectors. Within this revised structure, the health sector team is positioned in the Social Sectors Group under the Human and Social Development Sector Office, together with the Finance Sector

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[36] H. S. Waddington, et al. 2023. Impact on Childhood Mortality of Interventions to Improve Drinking Water, Sanitation, and Hygiene (WASH) to Households: Systematic Review and Meta-analysis. PLoS Medicine. Vol. 20. No. 4. doi:10.1371/journal.pmed.1004215.

[37] M. Jit, et al. 2015. *Thirty Years of Vaccination in Viet Nam:* Impact and Cost-effectiveness of the National Expanded Programme on Immunization. *Vaccine*. Vol. 33. Supplement 1. doi:10.1016/j.vaccine.2014.12.017.

[38] A. Baqui, et al. 2008. Impact of an Integrated Nutrition and Health Programme on Neonatal Mortality in Rural Northern India. *Bulletin of the World Health Organization*. Vol. 86. No. 10. pp. 796–804, A. doi:10.2471/blt.07.042226.

[39] ADB. 2022. *One ADB: An Evaluation of ADB's Approach to Delivering Strategy 2030*.

[40] Independent Evaluation Department. 2025. *Renewing, Revitalizing and Reforming: An Evaluation of the Asian Development Bank's New Operating Model*. ADB.

Office and the Public Sector Management and Governance Sector Office. This configuration offers the potential for greater synergy and complementarity, especially with public sector management and finance. Given that strengthening health systems often depends on integrated policy dialogue and coordinated financing reforms, enhanced alignment between health and these sectors could generate mutually reinforcing outcomes.

85. In addition, as part of its push to integrate ADB operations, since 2023 the NOM has piloted integrated sector teams. The health sector was one of the sectors chosen to test how a unit head from the Private Sector Operations Department (PSOD) would carry out dual reporting to the sector group and PSOD management. As these integration efforts are ongoing, results from the pilot have been limited to knowledge-sharing, but there is potential for joint sovereign and nonsovereign operations in Bhutan, India, and Uzbekistan.

86. Exploring potential links between sovereign and nonsovereign operations as part of the NOM is an encouraging start, but ADB needs a more strategic approach than simply piloting potential solutions. To expand its role in health across the public and private sectors and deliver on the HSDG's goal of "achieving universal health coverage in Asia and the Pacific," ADB needs a strategy that ties together sovereign and nonsovereign operations, and combines direct health interventions and the multisector approach.

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87. Although ADB demonstrated agility in mobilizing resources and coordinating support as part of its COVID-19 emergency response, its overall organizational resources, structure, and capacity remain only partially aligned with the scale and complexity of its evolving health goals. The lack of a clear institutional mandate or updated strategic framework in the health sector, along with its on-and-off approach to health, have eroded ADB's knowledge base and in-house capacity, as well as its reputation among its peers in the sector. ADB's knowledge products are not easily accessible to clients and the lack of structured, publicly available data on its health portfolio limits transparency and hampers performance monitoring and strategic planning. ADB has been unable to build on its knowledge and TA work in a consistent way, or to leverage staff skills and available lending instruments to support transformative change in DMCs. ADB's comparative advantage in infrastructure has not been translated into a significant increase in health support, as staff outside the health sector receive limited incentives to pursue multisector collaboration. The NOM and the One ADB approach offer the potential for ADB to enhance internal collaboration and cross-sector integration, but it is still too early to assess their impact.

CHAPTER 6
Findings and Recommendations

88. In the 26 years since ADB published its Policy for the Health Sector (1999), much has changed in global and regional health, development assistance, and ADB itself. In Asia and the Pacific, life expectancy has increased, child and maternal mortality has declined, and access to essential health services has expanded. ADB's engagement in the health sector has shifted strategically, reflecting efforts to align its institutional strengths with the evolving needs of clients. Direct investment in the health sector was deprioritized under Strategy 2020, but health was reintroduced as a core sector under Strategy 2030. However, these shifts were not matched by corresponding updates to its existing policy, operational guidance, monitoring frameworks, or institutional incentives, which made it difficult to conduct a systematic assessment of the health impacts of these interventions. Collectively, these inconsistencies and fluctuating priorities have limited the clarity of ADB's vision, approach, and support for health in Asia and the Pacific.

89. ADB's intermittent prioritization of health and the absence of a strategic approach—embodied through an updated health sector policy or a binding health sector framework—have created a mismatch between strategy and implementation, and led to lost opportunities in the sector. This mismatch has limited the integration of health across sectors and constrained the design and implementation of impactful health operations. ADB also lacks a clearly defined framework that could align its health sector engagement with contemporary regional health priorities and the institution's evolving role in supporting health in the region. The current approach does not provide consistent mechanisms for tracking and measuring health outcomes, making it difficult to assess the effectiveness of both direct health sector (tier 1) and multisector (tiers 2 and 3) investments. The absence of clear operational guidance, monitoring frameworks, and institutional incentives undermine the effectiveness of ADB's health support. An updated strategic approach to health is needed to address this operational risk, starting with a thoughtful consultative process to assess DMCs' demand for health support, along with an internal rethinking of ADB's institutional priorities and capacities. The current combination of overarching corporate strategy and the HSDG is insufficient to drive ADB's health strategy forward, as the former proposes a general approach for multisector and sector support while the latter offers non-binding, technical guidance for the sector only.

90. Health is complex because of its multisector nature, the wide range of stakeholders, and the need to balance preventive and curative services. ADB has made efforts to optimize its public and private contributions, including financing. Addressing medical, epidemiological, public health, demographic, economic, and insurance issues requires a variety of technical skills. ADB has had to face these multifaceted issues despite limited staff skills in these areas, especially after deprioritizing direct health investments under Strategy 2020. The reprioritization of health that started with the midterm review of Strategy 2020 in 2014 led to ADB tripling its in-house health expertise from 2014 to 2020—enabling ADB to mount a strong emergency response to COVID-19. However, ADB needs a clear health policy or strategy to sustainably address this "people risk" and continue to supplement its health expertise post-COVID. ADB should also use the NOM and the One ADB approach to deploy its existing health staff more effectively, while simultaneously

strengthening consultant networks and partnerships with other agencies, think tanks, and academia to fill remaining gaps in its in-house expertise.

91. ADB can build on the lessons and success of its previous health interventions to strengthen DMC health systems. The inclusion of health indicators in more CPSs shows that countries are increasingly prioritizing the health sector, although the reasons for this vary. In India, Mongolia, and the Philippines, a deep knowledge of the countries' needs and the use of grant TA projects informed ADB project pipelines and policy reforms even before COVID-19, enabling ADB to engage deeply in the health sectors of these countries. Elsewhere, ADB needs to use country-specific analytical work more consistently to deepen engagement, ensure support is based on needs analysis, and contribute to national development. This analytical work can be sector specific (e.g., related to the epidemiological and demographic transitions and to health system needs) or designed to address broader cross-sector development goals such as equity, innovation, and private sector involvement.

92. The evaluation makes the following recommendations to ADB.

93. **Recommendation 1: ADB should update its health strategic framework to provide a clear vision and mandate in meeting the rising health needs in Asia and the Pacific.** In line with its evolving institutional priorities and the changing health landscape across Asia and the Pacific, ADB needs to update its Policy for the Health Sector (1999), or retire it and replace it with a new health strategic framework comprised of a set of strategic documents, that fills gaps and provides consistent and aligned strategic and operational guidance. To help implement the multisector approach in achieving health outcomes, ADB should consider replacing the existing policy with an appropriate strategic document under the Policy Architecture, such as a board direction. In terms of delivering health outcomes through other sectors, ADB's Strategy 2030 provides only high-level goals. The health strategic framework should be a bridge between ADB's Strategy 2030 vision and operational-level guidance providing a translation layer that turns strategic aspirations into practical, consistent decision-making across the institution for delivering both health and for multisector health outcomes. It should outline principles and provide direction that reflects the region's current public health challenges, the role of the private sector, and health's central importance to resilience-building, economic stability, and sustainable development. In doing so, it should ensure health priorities are embedded across sectors to support cross-cutting priorities such as climate, nutrition, and pandemic preparedness. The framework should also ensure coherence with international frameworks and commitments, such as the Sustainable Development Goal 3 on health and well-being.

94. **Recommendation 2: In implementing its updated health strategic framework, ADB should provide clear guidance and incentivization on how to operationalize the health and multisector approach for better health outcomes.** At the operational level, the framework should provide guidance as an operational plan or approach for both sovereign and nonsovereign health operations by updating the HSDG. It should provide direction on ADB's two-track approach—tier 1 projects that support health directly along with tier 2 and 3 projects that follow the multisector approach. Specific emphasis should be given to strengthen and harmonize the multisector approach in alignment with both the One ADB approach and ADB's NOM. An effective multisector approach to health will also require health objectives to be explicitly integrated into both project designs and design and monitoring frameworks to ensure operations make meaningful contributions to health outcomes, which can be monitored and evaluated. The approach should be grounded in a clear theory of change that reflects ADB's comparative advantages and demonstrates how ADB's strengths can be leveraged to support health outcomes in the region. ADB should pilot new multisector projects and evaluate on-going ones to measure

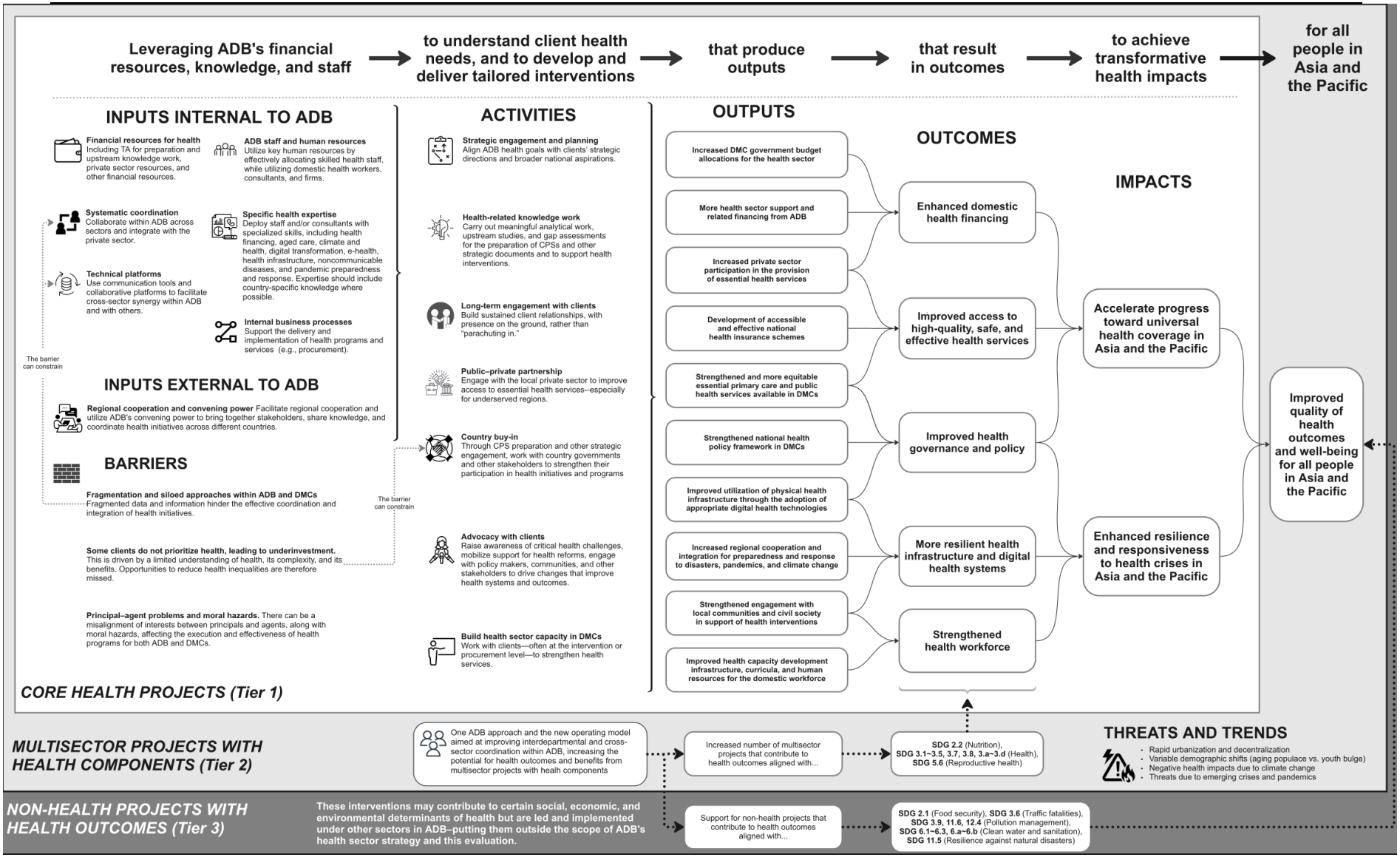
health impacts, draw lessons, and develop formal implementing mechanisms such as technical guidance, shared performance metrics, and joint planning instruments—to enable coherent engagement, shared ownership, proactive knowledge communication, and clear incentivization to collaborate for results across sectors. ADB should also expand on this push for integration and build on lessons from the ongoing sovereign–nonsovereign integration pilots to develop guidance on how sovereign support for improving the enabling environment can contribute to public–private partnerships and private sector development in health.

95. **Recommendation 3: ADB should develop and implement a strategic staffing and resource plan aligned with the updated health strategic framework.** ADB needs a strategic approach to staffing and resourcing if it is to meet the long-term needs of its DMCs. Although external experts hired temporarily through TA projects have provided valuable short-term support, particularly during the COVID-19 pandemic, ADB must create a strategic staffing plan grounded in the health strategic framework proposed in recommendation 1, while also supporting the multisector approach of recommendation 2. This will require an understanding of the technical capacities of ADB staff while also promoting collaboration with external expertise. ADB needs to push for better balance of its workload distribution by taking into consideration staff expertise along with sector needs, while diversifying and strengthening its network to include health-related consultants, specialized technical agencies, local private partners, civil society, and nongovernment organizations.

96. **Recommendation 4: ADB should strengthen country-focused diagnostic work and knowledge management to complement its demand-driven approach to health.** If ADB is to sustain and expand its health sector operations under Strategy 2030, it should invest more deeply in country-focused analytical work while strategically empowering and incentivizing its health staff as needed, particularly in countries where demand for health sector support is increasing and where there may be an opportunity to build a more sustained health program. This will enable ADB to understand protection gaps, unmet needs, regulatory challenges, and other key health system features, so it can predict systemic challenges and cultivate projects that address them. This is critical to generating a pipeline of long-term, sustainable investments. This process will also provide a foundation for ADB's efforts to link and promote synergies between health and multisector projects. Given ADB's aims of UHC and greater resilience to future health crises (Appendix 1), robust analytical work and knowledge management will be essential to complement ADB's traditional demand-driven approach. ADB should also tap into its networks in the region to identify country and regional diagnostics already being carried out by other development partners in the health sector to avoid duplication of efforts. Connecting analysis and knowledge to key health system issues will ensure strategic program designs and measurable impacts, ultimately leading to demonstrable health benefits for people in Asia and the Pacific.

Appendixes

APPENDIX 1: THEORY OF CHANGE FOR ADB'S SUPPORT FOR HEALTH IN ASIA AND THE PACIFIC



ADB = Asian Development Bank, CPS = country partnership strategy, DMC = developing member country, SDG = Sustainable Development Goal, TA = technical assistance.
Source: Asian Development Bank (Independent Evaluation Department), based on ADB health policy papers, reports, and workshops with Sector Department 3 – Human Social Development.

APPENDIX 2: EVALUATION METHODOLOGY

1. **Mix of qualitative and quantitative approaches.** The evaluation methods are summarized below. Data sources included Asian Development Bank (ADB) corporate documents, project documents and portfolio reports, databases, and country and regional reviews on specific issues; Independent Evaluation Department (IED) evaluation reports; and development literature on health.

2. **Document and literature review.** The review covered ADB documents (policy papers, staff instructions, guidance notes, annual corporate reports on portfolio and project performance); IED corporate, thematic, and country evaluations; and theoretical literature covering health sector issues and challenges in Asia and the Pacific region:

(i) **Analysis of the evolution of the health sector approach and policy together with the corporate results framework indicators.** The evaluation team reviewed ADB corporate documents to understand the evolution of ADB's health sector approach and policy before and during the evaluation period (2011–2024) and to identify key inflection points and policy decisions that affected ADB's overall health approach. The team analyzed the evolution of policy—from operational plans to Strategy 2020, Strategy 2030, and the Health Sector Directional Guide (HSDG)—released in response to rising demand for ADB health support from developing member countries (DMCs). To assess the causal chain from policy actions to intended development outcomes, the team examined to what extent the indicators in ADB's corporate results framework were aligned with the strategies and the HSDG.

(ii) **Review of selected country-based reports.** The review analyzed the health sector strategies and/or priorities contained in the country partnership strategies for every country in ADB's portfolio.

(iii) **Review of project planning documents for all health-related sovereign operations**. To assess the quality of ADB's health sector planning, a review was undertaken of selected procurement transactions (only transactions meeting a certain threshold are included in ADB's Procurement Review System).

3. **Portfolio analysis.** The evaluation team undertook portfolio review and data analysis for the evaluation period (2011–2024) to examine trends in health sector projects and to analyze portfolio and performance data sourced from ADB data systems. However, it was unable to carry out a similarly detailed analysis of multisector projects or non-health projects with health outcomes or impacts, as ADB does not have a standard classification system for such programs or projects.

4. **ADB stakeholder interviews.** Structured group interviews and/or focus group discussions were held during November 2024–February 2025 with country directors, directors, and project officers who had been in charge of ADB's health sector projects and with staff in charge of multisector projects in ADB's five regional departments. The objective was to solicit staff views on their expectations of ADB's multisector approach to health and on the results of the approach. Structured group interviews and/or focus group discussions were held with staff in the sector group covering the health sector.

5. **Perception surveys.** The evaluation team administered an online perception survey to ADB staff involved in health projects or multisector projects with health outcomes during the evaluation period. The survey aimed to gauge staff perceptions of ADB's health policy and sector approach and the extent to which staff had incorporated the multisector approach to health into

their work. The survey was administered from 1 March to 26 March 2025 to 2,643 ADB staff at headquarters and resident missions, with 500 staff responding (a response rate of 19%). Staff from the following departments took part: Central and West Asia Department; Climate Change and Sustainable Development Department; East Asia Department; Economic Research and Development Impact Department; Office of Markets Development and Public–Private Partnership; Office of Safeguards; Pacific Department; Procurement, Portfolio, and Financial Management Department; Private Sector Operations Department; Sectors Group; South Asia Department; Southeast Asia Department; and Strategy, Policy and Partnerships Department. Appendix 4 presents key findings from the survey.

6. **Country assessments.** Using a country assessment framework developed for the evaluation, the team collected data on health systems and ADB's performance in the five countries selected for the case assessment: India, Mongolia, Papua New Guinea, the Philippines, and Uzbekistan. These five countries were selected based on the following considerations: (i) their potential to offer lessons from health sector operations and financing modalities (e.g., the blend of investment projects, policy-based lending, and results-based lending); (ii) regional distribution; (iii) innovation, complexity, and comprehensiveness of interventions in the country, (iv) overall health portfolio volume, (v) share of NSO, and (vi) inclusion of multisector projects.

7. In addition to reviewing country-specific reports,[1] the team held virtual evaluation missions to gather feedback and insights from in-country stakeholders on ADB's health support. Discussions centered on stakeholders' views and insights on (i) ADB's approach to health in the DMC, (ii) the relevance of ADB support for health in the DMC, (iii) the effectiveness of the support, (iv) the appropriateness of the support, and (v) partnerships and collaborative efforts made by ADB in support of the sector. The team met with ADB counterparts in central authorities, line ministries, and executing and implementing agencies of selected projects, as well as with ADB country directors and resident mission staff involved in the health or multisector projects. It also interviewed contractors and nongovernment organizations to solicit feedback based on their own experience supporting ADB health projects.

8. **Study on the multisector approach to health.** This study reviewed evidence on multisector approaches to health outcomes, including ADB knowledge products, to assess their health impacts. The study included an analysis of the role of multisector interventions in achieving health outcomes, focusing on the work of multilateral development banks and international development organizations. It identified which sectors contributed most effectively to health outcomes and which strategies delivered the most significant results. The key results and findings from the study are included as Supplementary Appendix 3 to this report.

9. **Study on health sector approaches of other multilateral development banks.** This study was undertaken to understand other agencies' policies, strategies, and/or approaches to the health sector, how they measured results, and how they planned to achieve their health goals (Supplementary Appendix 1). The study reviewed other development organizations' health policies, strategic documents, and corporate reports, and interviewed their health sector officers.

[1] These included country partnership strategies, country operations business plans (now called indicative country pipeline monitoring reports), and project documents for sample projects.

APPENDIX 3: FINDINGS FROM A PERCEPTION SURVEY ON ADB'S SUPPORT FOR HEALTH IN ASIA AND THE PACIFIC

A. Survey Characteristics

1. **Survey methodology**. An online survey conducted using SurveyMonkey was administered to 2,643 staff in ADB from 1 March to 26 March 2025 and received 500 valid responses, a response rate of 19% (4.03% error based on Slovin's formula). The survey was sent to all ADB regional department project officers and to the staff at the Climate Change and Sustainable Development Department; Economic Research and Development Impact Department; Office of Markets Development and Public–Private Partnership; Office of Safeguards; Procurement, Portfolio, and Financial Management Department; Private Sector Operations Department; Sectors Group; and Strategy, Policy and Partnerships Department.

2. **Methodology**. A T-test was used to determine whether statistically significant differences existed between the means of the responses of different groups of ADB project officers. Staff were asked to respond to a statement, and responses were translated into a numerical scale, where 1 = strongly disagree, 2 = disagree, 3 = slightly disagree, 4 = slightly agree, 5 = agree, 6 = strongly agree. The findings in Sections C – F focused on the response that showed statistically significant difference between two comparison groups at a 99% confidence level.

B. Participation in the Health Sector

3. **Relatively low participation in the health sector.** Among the respondents, 46.0% either had no significant involvement in the health sector (tier 1) or other related sectors (tier 2 or 3) or were unsure about their involvement.[1] Only 29.2% said they had directly supported the design or implementation of health projects, while 9.0% supported health outcomes through other sectors (tiers 2 or 3). The remaining 15.8% said they had supported knowledge-sharing, safeguards, procurement, administrative and/or logistic support for health outcomes.

4. National and administrative staff had fewer opportunities to work in the health sector or on multisector projects. Of the international staff who responded, 39.8% had directly supported health project design or implementation; 11.7% had supported health outcomes through other sectors; 11.2% had supported knowledge-sharing, safeguards, procurement, administrative and/or logistic support for health outcomes; and 32.1% had had no significant involvement in health or could not respond. By contrast, only 22.4% of technical local staff (national staff and administrative staff) had directly supported health project design or implementation; 7.2% had supported health outcomes through other sectors; 18.8% had supported knowledge-sharing, safeguards, procurement, administrative and/or logistic support for health outcomes; and 51.6% had had no significant involvement in health or could not respond.

C. Relevance of Support

5. **Health needs were not universally understood by respondents outside the health sector.** Familiarity with challenges in the health sector was significantly higher among those in the health sector (5.42 or "strongly agree"), compared to those in other sectors (4.39 or "slightly agree").[2]

[1] Tier 1 projects are health sector projects, tier 2 projects are non-health projects with health subcomponents or financing, while tier 3 projects are non-health projects with health-related benefits or impacts.
[2] Figures given in this appendix are averages.

6. **There was significant variation among the regional departments in terms of their familiarity with the challenges in health.** Compared to the overall response of 4.56 for the whole of ADB, East Asia Department (3.25) and Southeast Asia Department (3.88) demonstrated a significantly low familiarity with the health needs of the region, while the Pacific Department (5.38) and South Asia Department (5.16) showed very strong familiarity. This suggests that ADB has had a fragmented approach to health.

7. **ADB's health sector strategy or vision was largely unknown outside staff directly working on health.** Familiarity with ADB's latest vision for the health sector was significantly higher among staff in the health sector (4.76 or "strongly agree") when compared with staff in other sectors (3.84 or almost "neutral").

8. **Responses to the value of the multisector approach to health were significantly lower among staff outside the health sector.** While health sector staff responded positively to the statement "overall value proposition for my project improved significantly by including the component with health outcomes or impacts" (5.20, "strongly agree"), responses were significantly lower for non-health sector staff (4.34, "slightly agree").

9. **Sector, procurement, safeguards, gender, and climate specialists saw less value in the multisector approach to health.** While the rest of ADB agreed with the statement "overall value proposition for my project improved significantly by including the component with health outcomes or impacts" (4.66), sector, procurement, safeguards, gender, and climate specialists' average response was significantly lower (4.09, "slightly agree"). This is in line with the perception that there is risk-averse culture within ADB, since it suggests that adding health components provided an additional source of risk and/or potential failure or complication for a project.

D. Effectiveness of Support

10. **There was a consistent positive bias among health staff with regard to the replication of successful health projects or the adoption of health policies by developing member countries (DMCs).** Health sector staff strongly agreed that they had "observed the scale-up or replication of successful health projects in their DMC" (4.97), significantly higher than the response by among non-health staff (4.04). Health staff also strongly agreed that "policy or reform related outputs from ADB health projects have been successfully adopted" (5.07), compared with non-health staff (4.22).

11. **Project team leaders and specialists had much more positive attitudes than other staff did about the adoption of health policies or reform-related outputs in DMCs.** Project team leaders strongly agreed that "policy or reform related outputs from ADB's health projects have been successfully adopted" (4.85), while other staff only slightly agreed (3.95). This could be a result of negative bias among specialists, who have often encountered cases of pushback or resistance from the DMCs against policy reforms and such.

E. Adequacy of Support

12. **Multisector approaches or support for health outcomes through other sectors happened only in a few sectors.** While 29.2% of all respondents indicated that they were involved in direct health support through projects in other sectors, respondents from the education (51.5%), industry and trade (37.5%), and public sector management sectors (34.6%) demonstrated above average involvement through non-health projects with health subcomponents (tier 2 projects). Meanwhile, although only 9.0% of all respondents indicated that they supported health outcomes through other sectors (tier 3 projects), certain sectors—namely

water and other urban infrastructure and services (20.4%); agriculture, natural resources, and rural development (17.1%); transport (16.7%); and climate (10.3%)—had above-average involvement.

13. **ADB could have provided more guidance on the multisector approach.** The overall response to the "provision of guidance for the inclusion of health components or outcomes into non-health projects" had the lowest average response among all questions in the perception survey (3.73). This was driven mostly by a perception of inadequate support among international staff, whose responses suggested disagreement with the statement (3.43—or less than a 3.5 "neutral" rating), while administrative staff responded more positively (4.30).

14. **ADB could have done more to engage the private sector in health.** The overall response regarding the "provision of support to promote private sector engagement for health in the DMC" was low (3.98, "slight agreement'). Only staff working in the agriculture, natural resources, and rural development sector strongly agreed (4.70) that the support was sufficient. Staff from education (3.57), energy (3.78), and transport (3.37) were neutral or slightly disagreed with the statement, while other sectors slightly agreed (4.00).

F. Partnership, Impact, or Sustainability of Support

15. **ADB's effort to support collaboration with think tanks, centers of excellence, or academia to support its DMCs' health sectors was most appreciated by staff at lower levels.** Most administrative staff at levels TL1–4 strongly agreed (4.71) when inquired whether ADB collaborated with academia and others to support health. The level of agreement remained positive but was lower among national staff at levels TL5-8 (4.25); international staff at levels 1-6, TI1-4 (4.20); and international staff 7 and above, MI1-3 (4.10).[3]

16. **There was a consistent positive bias among health staff with regard to ADB's role in "mobilizing critical resources to support the health sector in DMCs."** Health sector staff strongly agreed that ADB had played a key role in mobilizing critical resources for health (5.14), while non-health staff were less positive (4.46).

17. **There was a consistent positive bias among health staff with regard to ADB's support to "strengthen the resilience of the health system in DMCs."** Health sector staff strongly agreed that ADB had strengthened the resilience of DMCs' health systems (5.08)—a higher level of agreement than among non-health staff (4.50).

18. **There was a consistent positive bias among health staff with regard to ADB's "significant value addition through its support in the health sector."** Health sector staff strongly agreed that ADB's support for health has offered strong value addition for its DMCs (5.10)—a higher level of agreement than for non-health staff (4.54).

19. **There was a consistent positive bias among health staff with regard to the sustainability of ADB support for health in the region.** Health sector staff strongly agreed that ADB support for health would be sustainable (5.14), while agreement was lower among non-health staff (4.47).

[3] TL = technical local or local staff, TI = technical international or international staff, MI = management international or international staff at managerial positions.

APPENDIX 4: APPROACHES TO HEALTH AT MULTILATERAL DEVELOPMENT BANKS

Agency	Objective (Publication Year)	Priorities and Guiding Principles
African Development Bank	Secure increased access to quality health services for the people of Africa by 2030 (2022)	**Primary health-care infrastructure for underserved populations.** Infrastructure investment to ensure facilities are connected to water and sanitation, energy, transport, and communications services
		Secondary and tertiary health-care facilities. New secondary and tertiary health-care facilities, alongside specialist facilities for cancer, dialysis, and pain management
		Diagnostic infrastructure. A range of delivery models, including public–private collaborations to address serious bottlenecks
Asian Development Bank	Support DMCs' pursuit of UHC (2022)	**Improve quality and coverage of health services**
		Strengthen health systems, including financing and insurance. Improve governance, policy, and public goods
		Tackle equity through improved access to high-quality care
		Tap synergies across sectors to improve health outcomes
Asian Infrastructure Investment Bank	Maximize co-benefits in all of AIIB'S non-health sector investments while increasing the value of its investments in the health sector (2024)	**Synergistic.** Infrastructure projects—including investments in clean energy, green transport, water supply and sanitation, urban, digital, and other infrastructure projects—can lead to a wide range of health co-benefits.
		Equitable and people-centered. Health services must be accessible to all segments of the population, especially marginalized and underserved communities.
		Innovative. Embracing technology and innovation is essential for the modernization, accessibility, affordability, efficiency and greening of health.
		Sustainable. AIIB's approach will incorporate its strong commitment to sustainability. Health infrastructure financed by AIIB must be financially viable, generate positive economic impact, and should not threaten an economy's debt sustainability.
Inter-American Development Bank	Make progress toward UHC possible (2021)	**Multisector action to promote population health**. Fiscal policies, laws and regulations, and behavioral strategies
		Address fiscal and financial sustainability. Increased resource commitments, more efficient spending, reduced fragmentation, and health financing reforms
		Improve the organization and quality of health-care service delivery. Include diverse, marginal, and disadvantaged groups
World Bank Group	Reach 1.5 billion people through (i) expanding access (ii) reaching the hard-to-reach; and (iii) reducing financial barriers (2024)	**Equity**. Improved access, utilization, and financial protection, particularly for the most vulnerable
		Quality coverage at scale. Improved coverage of quality essential health and nutrition services
		Sustainability. More resilient, adaptive, and low-carbon health systems. More and better financing for health. Enhanced institutional capacity
		Population health protection and promotion. Countries are prepared to prevent, detect, and respond to health emergencies. Reduced risk factors for health.

AIIB = Asian Infrastructure Investment Bank, DMC = developing member country, UHC = universal health coverage.
Source: Asian Development Bank (Independent Evaluation Department).

APPENDIX 5: ADB'S COMMITMENTS FOR HEALTH, 2011–2024

Table A5.1: Annual Sovereign Health Operations

Signing Year	Sovereign Commitment for Tier 1 (Health Sector)		Sovereign Commitment for Tier 2 (Multisector)		Total Sovereign Commitment for Health		Total Sovereign Commitment for All Sectors		Share of Health Commitment (%)
	No.	Amount ($ million)	No.	Amount ($ million)	No.	Amount ($ million)	No.	Amount ($ million)	
2011	2	36.9	0	0	2	36.9	103	11,335.2	0.3
2012	3	74.8	0	0	3	74.8	98	10,125.9	0.7
2013	4	141.8	1	7.5	5	149.3	119	13,278.5	1.1
2014	2	20.0	2	0.5	4	20.6	103	12,018.7	0.2
2015	4	325.4	1	6.5	5	331.9	106	14,557.3	2.3
2016	1	20.3	2	176.0	3	196.3	106	11,499.9	1.7
2017	3	201.2	0	0	3	201.2	101	17,402.7	1.2
2018	11	563.9	1	10.0	12	573.9	135	18,445.2	3.1
2019	9	659.0	3	95.0	12	754.0	132	18,685.4	4.0
2020	32	1,470.4	27	2,406.4	59	3,876.8	138	26,771.1	14.5
2021	21	5,431.4	5	406.0	26	5,837.4	100	18,273.1	31.9
2022	8	598.4	5	181.8	13	780.2	96	16,345.7	4.8
2023	9	1,959.2	4	285.3	13	2,244.6	99	19,532.3	11.5
2024	10	1,020.0	2	96.0	12	1,116.0	134	19,161.9	5.8
Total	**119**	**12,522.5**	**53**	**3,671.1**	**172**	**16,193.6**	**1,570**	**227,432.8**	**7.1**

No. = number.
Source: Asian Development Bank.

Table A5.2: Annual Nonsovereign Health Operations

Signing Year	Nonsovereign Commitment for Tier 1 (Health Sector)		Nonsovereign Commitment for Tier 2 (Multisector)		Total Nonsovereign Commitment for Health		Total Nonsovereign Commitment for All Sectors		Share of Health Commitment (%)
	No.	Amount ($ million)	No.	Amount ($ million)	No.	Amount ($ million)	No.	Amount ($ million)	
2011	0	0	0	0	0	0	13	1,983.20	0
2012	0	0	1	5.0	1	5.0	19	2,899.90	0.2
2013	0	0	0	0	0	0	15	2,444.30	0
2014	0	0	1	30.0	1	30.0	21	3,706.00	0.8
2015	0	0	0	0	0	0	22	2,870.50	0
2016	0	0	1	30.0	1	30.0	16	3,246.60	0.9
2017	0	0	1	30.0	1	30.0	27	4,184.10	0.7
2018	2	14.3	0	0	2	14.3	32	5,771.40	0.2
2019	1	6.8	0	0	1	6.8	38	5,136.50	0.1
2020	3	63.2	2	42.5	5	105.7	38	4,461.40	2.4
2021	3	44.2	0	0	3	44.2	35	4,257.60	1.0
2022	3	37.1	0	0	3	37.1	37	3,867.10	1.0
2023	2	28.2	0	0	2	28.2	40	3,764.40	0.7
2024	1	19.4	0	0	1	19.4	58	4,838.40	0.4
Total	**15**	**213.2**	**6**	**137.5**	**21**	**350.7**	**411**	**53,431.40**	**0.7**

No. = number.
Source: Asian Development Bank.

Table A5.3: Sovereign Health Operations by Financing Modality, 2011–2024

Sovereign Operations Financing Modality	Commitment for Tier 1 ($ million)	Commitment for Tier 2 ($ million)	Total Commitment for Health ($ million)	Share of Health Commitment (%)
Asia Pacific Vaccine Access Facility	4,509.0	0	4,509.0	27.8
Contingent disaster financing	0	300.0	300.0	1.9
COVID-19 Pandemic Response Option	500.0	1,884.2	2,384.2	14.7
Multitranche financing facility	158.3	0	158.3	1.0
Policy-based lending	1,689.6	279.1	1,968.7	12.2
Project loans and grants	3,070.1	911.9	3,982.0	24.6
Results-based lending	1,111.6	285.0	1,396.6	8.6
Sector development programs	845.6	0	845.6	5.2
Special assistance loans and grants	632.3	10.6	642.9	4.0
Others	6.0	0.3	6.3	0.0
Total	12,522.5	3,671.1	16,193.6	100.0

Note: Includes commitments in health subsectors for both primarily health (tier 1) and non-health projects (tier 2).
Source: Asian Development Bank.

Table A5.4: Sovereign Health Operations by Year and Financing Modality ($ million)

Sovereign Operations Financing Modality	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Investment Projects	**36.9**	**74.8**	**149.3**	**20.6**	**14.7**	**196.3**	**201.2**	**369.9**	**535.4**	**1,120.4**	**4,462.4**	**610.2**	**1,343.0**	**656.7**
APVAX	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4,057.6	115.0	336.5	0.0
MFF	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	76.1	0.0	0.0	0.0	0.0	82.2
Project loan and grant	36.9	74.8	149.3	20.6	6.5	196.3	201.0	268.4	459.3	495.0	401.8	483.3	964.5	224.5
Special loan and grant	0.0	0.0	0.0	0.0	2.2	0.0	0.2	0.5	0.0	625.4	3.0	11.6	0.0	0.0
SDP – project loan and grant	0.0	0.0	0.0	0.0	0.0	0.0	0.0	101.0	0.0	0.0	0.0	0.0	42.0	350.0
Other loans (TA, PRF)	0.0	0.0	0.0	0.0	6.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3	0.0	0.0
Policy-based operations	**0.0**	**0.0**	**0.0**	**0.0**	**17.1**	**0.0**	**0.0**	**154.0**	**218.6**	**2,756.4**	**905.0**	**45.0**	**540.0**	**369.3**
CPRO	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2,304.2	80.0	0.0	0.0	0.0
CDF	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	300.0	0.0	0.0	0.0	0.0
PBL and grant	0.0	0.0	0.0	0.0	17.1	0.0	0.0	40.0	130.0	152.2	825.0	45.0	540.0	219.3
SDP - program loan and grant	0.0	0.0	0.0	0.0	0.0	0.0	0.0	114.0	88.6	0.0	0.0	0.0	0.0	150.0
Results-based lending	**0.0**	**0.0**	**0.0**	**0.0**	**300.0**	**0.0**	**0.0**	**50.0**	**0.0**	**0.0**	**470.0**	**125.0**	**361.6**	**90.0**
Total	**36.9**	**74.8**	**149.3**	**20.6**	**331.9**	**196.3**	**201.2**	**573.9**	**754.0**	**3,876.8**	**5,837.4**	**780.2**	**2,244.6**	**1,116.0**

APVAX = Asia Pacific Vaccine Access Facility, CDF = contingent disaster financing, CPRO = COVID-19 Pandemic Response Option, MFF = multitranche financing facility, PBL = policy-based loan, PRF = project readiness facility, SDP = sector development program, TA = technical assistance.
Note: Includes commitments in health subsectors for both primarily health (tier 1) and non-health projects (tier 2).
Source: Asian Development Bank.

APPENDIX 6: FINDINGS FROM AN ANALYSIS OF DESIGN AND MONITORING FRAMEWORKS OF HEALTH PROJECTS

1. **Methodology.** A keyword search of the design and monitoring frameworks (DMFs) of all projects approved since 2011 identified 862 possible health-related projects, of which 73 were classified as tier 1 (health sector projects), 97 as tier 2 (non-health projects with health subcomponents or financing), and 545 as tier 3 (non-health projects with health-related benefits or impacts), following an in-depth analysis of the DMFs to verify relevance of the indicators with regards to health (Table A6.1). The evaluation uses the Sustainable Development Goal (SDG) tagging adopted by ADB in 2018 and the classification methodology used in the theory of change (Appendix 1) for the tier 1, 2, and 3 projects.

Table A6.1: Results of Design and Monitoring Framework Analysis for Health-Related Indicators

Indicators	Tier 1		Tier 2		Tier 3	
	No. of Projects	Share of qualifying projects (%)	No. of Projects	Share of qualifying projects (%)	No. of Projects	Share of qualifying projects (%)
Has a health-related output indicator	72	98.6%	93	95.9%	508	93.2%
• The output indicator has a dated baseline	67	91.8%	87	89.7%	443	81.3%
• The output indicator has a specific target	70	95.9%	90	92.8%	488	89.5%
Has a health-related outcome indicator	73	100.0%	97	100.0%	545	100.0%
• The outcome indicator has a dated baseline	69	94.5%	68	70.1%	404	74.1%
• The outcome indicator has a specific target	72	98.6%	73	75.3%	423	77.6%
The output and outcome indicators are logically linked	72	98.6%	76	78.4%	434	79.6%
Projects with health-related design and monitoring framework indicators	**73**		**97**		**545**	

Source: Asian Development Bank (Independent Evaluation Department).

Table A6.2: Classification of Projects based on Health-Related Indicators in Design and Monitoring Frameworks

Health-Related Classifications under the Sustainable Development Goals	Number of Projects with Health-Related Outputs and/or Outcome Indicators		
	Tier 1	Tier 2	Tier 3
SDG 2.2. Stunting, malnutrition, and anemia	2	5	0
SDG 3.1. Maternal mortality	10	7	0
SDG 3.2. Neonatal mortality	6	5	0
SDG 3.3. HIV and other infectious disease	4	9	0
SDG 3.4. Noncommunicable disease	2	2	0
SDG 3.5. Alcohol and substance abuse	0	1	0
SDG 3.7. Reproductive health and family planning	1	2	0
SDG 3.8. Coverage of essential health services	50	58	0
SDG 3.a. Tobacco use	1	0	0

Health-Related Classifications under the Sustainable Development Goals	Number of Projects with Health-Related Outputs and/or Outcome Indicators		
	Tier 1	Tier 2	Tier 3
SDG 3.b. Vaccine coverage, research support, affordable medicine	37	27	0
SDG 3.c. Health worker density and distribution	23	17	0
SDG 3.d. Health emergency preparedness, health worker capacity	9	18	0
SDG 5.6. Guarantee full and equal access to reproductive health care	5	3	0
SDG 2.1. Undernourishment and food security	4	23	124
SDG 3.6. Road traffic injuries and death	0	4	110
SDG 3.9. Mortality due to pollution of air, water, and poisoning	0	3	8
SDG 6.1. Access to safely managed drinking water	1	12	166
SDG 6.2. Access to sanitation services and handwashing facility	4	18	172
SDG 6.3. Treatment of wastewater and good ambient water quality	1	5	117
SDG 6.a. Expansion of support for WASH activities and programs	0	0	41
SDG 6.b. Local participation in water and sanitation management	0	0	33
SDG 11.5. Death, loss, and damage due to disasters	1	7	159
SDG 11.6. Municipal solid waste collection / fine particulate matter	1	12	127
SDG 12.4. Management of hazardous waste and other chemicals	4	3	8

SDG = Sustainable Development Goal, WASH = water, sanitation, and hygiene.
Note: Some projects may have been tagged several times for different SDGs, as they could have more than one health-related outcome or output indicators.
Source: Asian Development Bank (Independent Evaluation Department).

APPENDIX 7: PERFORMANCE RATINGS OF ADB HEALTH SOVEREIGN OPERATIONS, 2011–2024

Table A7.1: ADB Health Sovereign Operations with Project Completion Reports, Project Performance Evaluation Reports, or Program or Project Completion Report Validation Reports, 2011–2024

Year of Assessment	Number of Health Projects (Tier 1) with PCRs	Number of Non-Health Projects with PCRs	Number of Health Projects (Tier 1) with PVRs or PPERs	Number of Non-Health Projects with PVRs or PPERs
2011	5	76	2	70
2012	3	79	2	59
2013	1	65	1	50
2014	6	53	5	42
2015	7	50	6	43
2016	1	56	1	50
2017	3	54	3	54
2018	0	48	0	48
2019	1	58	1	58
2020	1	70	1	70
2021	1	97	1	97
2022	3	100	3	100
2023	6	101	6	101
2024	1	77	1	72
Total	39	984	33	914

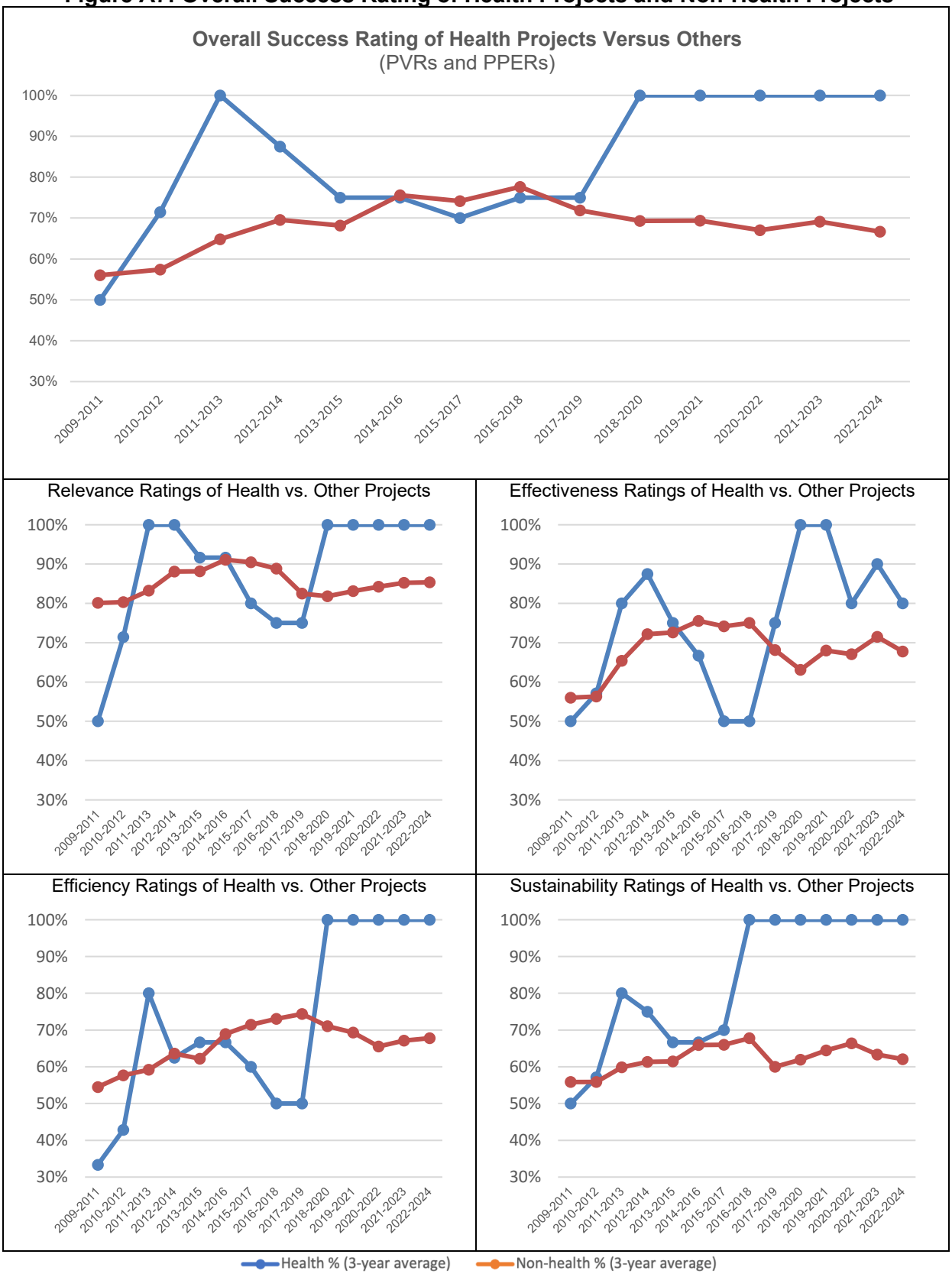
ADB = Asian Development Bank, PCR = project completion report, PPER = project performance evaluation report, PVR = program or project completion report validation report.
Source: Asian Development Bank (Independent Evaluation Department).

Table A7.2: Ratings of Health Projects (Tier 1) Validated by the Independent Evaluation Department, 2011–2024

Countries	Highly Successful	Successful	Less than Successful	Unsuccessful	Total
Armenia		1			1
Bangladesh		1			1
India		1			1
Indonesia		1	1		2
Kyrgyz Republic		1			1
Lao People's Democratic Republic	1	2			3
Mongolia		4			4
Nepal		1			1
Pakistan				1	1
Philippines			2		2
Papua New Guinea		3			3
Tajikistan		1			1
Uzbekistan		1			1
Viet Nam		6			6
Regional		5			5
Total	**1**	**28**	**3**	**1**	**33**

IED = Independent Evaluation Department.
Source: Asian Development Bank (Independent Evaluation Department).

Figure A7: Overall Success Rating of Health Projects and Non-Health Projects



PPER = project performance evaluation reports, PVR = program or project completion report validation report.
Source: Asian Development Bank (Independent Evaluation Department, Annual Evaluation Report database).

APPENDIX 8: FINDINGS FROM A STUDY ON THE MULTISECTOR APPROACH TO HEALTH AMONG MULTILATERAL DEVELOPMENT BANKS AND INTERNATIONAL ORGANIZATIONS

Potential Benefits of the Multisector Approach	Challenges to the Multisector Approach	Enablers and Facilitators for the Multisector Approach
• Targets broader determinants of health—such as poverty, inequality, and environmental risks—beyond the health sector	• Absence of a shared vision or alignment across sectors	• Development of a common vision or shared strategic goals
• Improves operational effectiveness in the health sector when dealing with complex health challenges	• Inadequate funding or commitment for cross-sector	• Mobilization of consistent and long-term financing
• Promotes inclusive and holistic health outcomes by accounting for political, socioeconomic, and environmental influences	• Lack of political leadership	• Political leadership and commitment that provides enabling legal and governance structures
• Enhances coordination and coherence across health and non-health sectors to support improved health outcomes, provided that key stakeholders are engaged and financial barriers to funding cross-sector initiatives are addressed	• Ambiguity in sectoral roles and lack of accountability	• Strengthening of technical capacities, institutional accountability, and access to timely information
• Fosters cross-sector knowledge exchange and collaboration across sectors, which in turn provides opportunities for sharing knowledge and expertise that enhances efficiency, reduces transaction costs, and improves accuracy, which then could lead to informed decision-making.	• Limited data availability and inadequate indicators to track impact	• Use of evidence-based methodologies (e.g., modeling, impact evaluations)
• Encourages integrated planning and action, moving beyond fragmented, sector-specific interventions	• Low community participation and ownership	• Active community engagement to ensure uptake and relevance of interventions
• Addresses the multifaceted nature of health problems and considers the complexity of modern health challenges	• Silos and sectoral fragmentation	• Application of systems thinking to navigate complexity and dynamic relationships across sectors; supported by governance structures that enable coordinated planning and response

Source: Asian Development Bank (Independent Evaluation Department).