Validation Report
October 2020

Regional: Second Greater Mekong Subregion Regional Communicable Diseases Control Project

Reference Number: PVR-659
Project Numbers: 41505-012, 41507-012, and 41508-013
Loan Number: 2699
Grant Numbers: 0231, 0232, 0448, 0449, and 0450

Raising development impact through evaluation

ABBREVIATIONS

ADB	–	Asian Development Bank
CDC	–	communicable diseases control
COVID-19	–	coronavirus disease
DMF	–	design and monitoring framework
EGP	–	ethnic group plan
GAP	–	gender action plan
GMS	–	Greater Mekong Subregion
Lao PDR	–	Lao People's Democratic Republic
M&E	–	monitoring and evaluation
MOH	–	Ministry of Health
PCR	–	project completion report
RCU	–	regional coordination unit
RMTF	–	Regional Malaria and Other Communicable Disease Threats Trust Fund
WDI	–	World Development Indicators
WHO	–	World Health Organization

NOTE

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

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PROJECT BASIC DATA

Project numbers	41505-012, 41507-012, and 41508-013,		**PCR circulation date**	5 Jul 2019
Loan/Grant numbers	2699, 0231, 0232, 0448, 0449, and 0450		**PCR validation date**	Oct 2020
Project name	**Second Greater Mekong Subregion Regional Communicable Diseases Control Project**			
Sector and subsector	Health	Disease control of communicable disease Health system development Health sector development and reform		
Strategic agenda	Regional integration Inclusive economic growth			
Safeguard categories	Environment		C	
	Involuntary resettlement		C	
	Indigenous peoples		B	
Country	Regional		**Approved** ($ million)	**Actual** ($ million)
ADB financing[a] ($ million)	**ADF:** 49.00	**Total project costs**	64.10	61.17
	OCR: 0.00	**Loan/Grants**	49.00	47.73
		L2699	27.00	25.77
		G0231	10.00	9.97
		G0232	12.00	11.99
		Borrower	5.60	4.76
		L2699	3.00	2.63
		G0450	0.25	0.14
		G0231	1.00	0.79
		G0448	0.20	0.05
		G0232	1.00	1.00
		G0449	0.15	0.15
		Beneficiaries	0.00	0.00
		Others	0.00	0.00
Cofinancier	HFPF[b]	**Total cofinancing**	9.50	8.68
		G0450	2.50	2.02
		G0448	4.00	3.73
		G0449	3.00	2.93
Approval dates		**Effectiveness dates**		
L2699/G0231/G0232	22 Nov 2010			
G0450/0448/0449	26 Oct 2015	L2699	24 May 2011	20 May 2011
		G0450	19 May 2016	19 May 2016
		G0231	27 Apr 2011	22 Mar 2011
		G0448	8 Feb 2016	4 Jan 2016
		G0232	8 Mar 2011	22 Mar 2011
		G0449	15 Feb 2016	4 Jan 2016
Signing date		**Closing dates**[c]		
L2699	23 Feb 2011	L2699	30 Jun 2016	31 Dec 2017
G0450	19 Feb 2016	G0450	31 Dec 2017	31 Dec 2017
G0231	27 Jan 2011	G0231	30 Jun 2016	31 Dec 2017
G0448	10 Nov 2015	G0448	31 Dec 2017	31 Dec 2017
G0232	8 Dec 2010	G0232	30 Jun 2016	31 Dec 2017
G0449	17 Nov 2015	G0449	31 Dec 2017	31 Dec 2017

Project officers		Location	From	To
	V. de Wit	ADB headquarters	Nov 2010	Oct 2013
	G. Servais	ADB headquarters	Oct 2013	Jul 2016
	A. Sato	ADB headquarters	Jul 2016	Dec 2017
IED review				
Director	W. Kolkma, IETC			
Team leader	L. Adams, Principal Evaluation Specialist[d]			

ADB = Asian Development Bank, ADF = Asian Development Fund, HFPF = Health Financing Partnership Facility, IED = Independent Evaluation Department, IETC = Thematic and Country Division, OCR = ordinary capital resources, PCR = project completion report.

[a] Financing support specific per country include grants 0231 and 0448 to Lao PDR, grants 0231 and 0448 to Cambodia, and loan 2699 and grant 0450 to Viet Nam.

[b] Regional Malaria and Other Communicable Disease Threats Trust Fund under the HFPF.

[c] Financial closing dates for G0231 and G0448 (Cambodia) is 28 February 2018; G0232 and G0449 (Lao PDR) is 29 August 2018; and L2699 and G0450 (Viet Nam) is 13 July 2018.

[d] Team members: H. Hettige (quality reviewer), M.J. Dimayuga (Senior Evaluation Officer), B. Prakash and E. Raven (consultants).

I. PROJECT DESCRIPTION

A. Rationale

1. The Greater Mekong Subregion (GMS) countries of Cambodia, the Lao People's Democratic Republic (Lao PDR), and Viet Nam are vulnerable to the communicable diseases due to climatic and environmental conditions, as well as poor socioeconomic infrastructure. The public health system had limited scope and provided inadequate control and protection against communicable diseases. Many diseases with outbreak potential such as dengue, measles, cholera, typhoid, and Japanese encephalitis, remain neglected and unattended; and posed potential threats to social welfare especially for the poor, women, indigenous groups, and other vulnerable population groups in the remote rural regions. Since communicable disease can cause immense and widespread damage to society and the economy, GMS countries have been collaborating with one another to control the hazardous threat of morbidity and mortality. The Asian Development Bank (ADB) has supported such interventions in GMS countries since early 2000.

2. The Second GMS Regional Communicable Disease Control project underscored the need for a broad-based collaborative intervention.[1] The project focused on geographies, which were potential sources of vulnerability such as economic corridors experiencing high frequency traffic and the border areas virtually falling in between public health systems of Cambodia, the Lao PDR, and Viet Nam, targeting remote communities. Building on an earlier ADB project,[2] the second follow-on project was prepared with the help of 2009 technical assistance,[3] which was undertaken in close consultation with the World Health Organization (WHO). The regional project was in compliance with the 2005 International Health Regulations under the Asia Pacific Strategy for

[1] ADB. 2010. *Report and Recommendation of the President to the Board of Directors: Proposed Loan and Grants to the Kingdom of Cambodia, the Lao People's Democratic Republic, and the Socialist Republic of Viet Nam for the Second Greater Mekong Subregion Regional Communicable Diseases Control Project*. Manila.

[2] ADB. 2005. *Report and Recommendation of the President to the Board of Directors: Proposed Loan and Grants to the Kingdom of Cambodia, the Lao People's Democratic Republic, and the Socialist Republic of Viet Nam for the Greater Mekong Subregion Regional Communicable Diseases Control Project*. Manila.

[3] ADB. Regional: Second Greater Mekong Subregion Regional Communicable Diseases Control Project Project Data Sheet. https://www.adb.org/projects/40375-012/main#project-pds.

Emerging Diseases.[4] After the completion of the second project, ADB approved the third project for these countries and expanded coverage to include Myanmar.[5]

B. Expected Impact, Outcome, and Outputs

3. The expected impact of the project was to improve health status of the population in Cambodia, the Lao PDR, and Viet Nam. The project's target outcome was timely and adequate control over communicable diseases that were relevant as per the GMS' field epidemiology. The project had three target outputs: (i) enhanced regional communicable diseases control (CDC) systems, (ii) improved CDC along borders and economic corridors, and (iii) integrated project management.

C. Provision of Inputs

4. Approved in November 2010, the project became effective in early 2011 and was completed in June 2017. The estimated total cost of the project at appraisal was equivalent to $54.0 million. The approved project cost was $11.0 million (Cambodia), $13.0 million (Lao PDR), and $30 million (Viet Nam). ADB approved its financing of the project up to $49.0 million through Asian Development Fund grants for Cambodia ($10.0 million) and the Lao PDR ($12.0 million), and an Asian Development Fund loan to Viet Nam for $27.0 million. The remaining cost was contributed counterpart funding from the governments.

5. In 2015, an additional component related to eliminating malaria in the subregion supported by the Regional Malaria and Other Communicable Disease Threats Trust Fund (RMTF) was added to the project.[6] It was estimated to have an additional project cost of $10.1 million across the three countries: Cambodia ($4.2 million), the Lao PDR ($3.15 million), and Viet Nam ($2.75 million). RMTF financed the project through grants in the total amount of $9.5 million.

6. With the original approved project cost and the additional RMTF component together, the total project cost estimate was at $64.1 million. The actual project cost at closing was $61.2 million, with ADB and the RMTF actual financing at $56.4 million: $13.7 million for Cambodia, $14.9 million for the Lao PDR, and $27.8 for Viet Nam.

D. Implementation Arrangements

7. The Ministry of Health (MOH) in each country was designated as the executing agency for the project and worked under the guidance of two oversight bodies— a steering committee for MOHs and a regional steering committee. Project management units were set up under each of the executing agency. A number of institutions, including the national and provincial health departments and related institutions, were the implementing agencies.[7]

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[4] The International Health Regulations 2005 is a global framework endorsed by the 58th World Health Assembly. It serves as a legal instrument intended to identify core minimum capacities that need to be implemented nationally.

[5] ADB. 2016. *Report and Recommendation of the President to the Board of Directors: Proposed Loans and Grant to the Kingdom of Cambodia, the Lao People's Democratic Republic, Republic of the Union of Myanmar, and the Socialist Republic of Viet Nam: Greater Mekong Subregion Health Security Project.* Manila.

[6] ADB. 2015. *Additional Financing: Proposed Administration of Grants to the Kingdom of Cambodia, the Lao People's Democratic Republic, and the Socialist Republic of Viet Nam for the Second Greater Mekong Subregion Regional Communicable Diseases Control Project*. Manila. Financed under the Health Financing Partnership Facility with governments of Australia, Canada, and the United Kingdom as the financing partners.

[7] The project's report and recommendation of the President noted the key implementing agencies. For Cambodia, these were the Communicable Diseases Control Department; National Center for Parasitology, Entomology and Malaria Control and 10 provincial health departments. For the Lao PDR, the agencies were the National Center for

8. Nearly 5% of the grant funds (to Cambodia and the Lao PDR) were allocated as pooled funds to facilitate regional activities through a regional coordination unit (RCU) administered by ADB. It covered expenditures for the regional steering committee, technical forums, some international consulting services, regional studies, cross-border activities, and RCU operations.

9. The project supported engaging 10 consulting firms and a set of individual international and national consultants for 16 and 30 person-months each, respectively. Details in the Linked document highlights the complexity of management coordination support arrangements. The RCU also engaged four international individual consultants to support the regional activities on knowledge management, laboratory quality, regional coordination, and safeguards. All loan covenants, except one, were fully complied with in all countries. The exception was on ethnic groups in Viet Nam. Midterm review of the project in all three countries was held in May 2013.

10. The project completion report (PCR) data indicated that the project was generally implemented as appraised.[8] Implementation costs for the Lao PDR were broadly in line with appraisal estimates. Viet Nam was similar except that it underspent on the consulting services ($0.007 million as against the allocation of $0.145 million). Cambodia had some deviations from the appraisal estimates under both ADB and RMTF grants. It spent much more under training, workshops, and fellowships. Other deviations related to categories of system development, community mobilization in cash, and consulting services. The partial cancellations resulted from unused grant in Viet Nam. The implementation of additional financing was shorter in Viet Nam (13 months only) due to start-up delay.

II. EVALUATION OF PERFORMANCE AND RATINGS

A. Relevance of Design and Formulation

11. The PCR rated the project relevant.[9] It assessed the project aligned with countries' public health development strategies including Cambodia's Second Health Strategic Plan 2008–2015,[10] the Lao PDR's National Strategy on Emerging Infectious Diseases 2006–2010, and 2007 Viet Nam's Law on Prevention and Control of Infectious Diseases.[11] The thrust was also in line with ADB's country program and operation strategies for these countries.[12] It was also in accordance with ADB's long-term strategic framework, and its goal of regional cooperation and integration has been under implementation in the GMS region since the 1990s. It was consistent with ADB's Operational Plan for Health that emphasizes on health security as a regional public good.[13] In the context of ongoing coronavirus disease (COVID-19) pandemic, the emphasis of the project on communicable diseases is well placed and was ahead of its time.

Laboratory and Epidemiology; National Center of Malariology, Parasitology, and Entomology; and 12 provincial health offices. Lastly, for Viet Nam, the implementing agencies were the National Institute of Hygiene and Epidemiology; Institute of Hygiene and Epidemiology in Highland, Pasteur Institute in Nha Trang, Pasteur Institute in Ho Chi Minh City, and 20 preventive medicine centers of provincial health departments.

[8] ADB. 2019. *Completion Report: Second Greater Mekong Subregion Regional Communicable Diseases Control Project.* Manila.

[9] The PCR assessment on relevance is inconsistent. A rating of both highly relevant and relevant are provided. As per IED 2016 Guidelines, there is no transformative impact that substantiates a highly relevant rating.

[10] Government of Cambodia, Ministry of Health. 2008. *Health Strategic Plan 2008–2015*. Phnom Penh.

[11] Government of Viet Nam. 2007. *Law on Prevention and Control of Infectious Diseases.* Ha Noi. https://www.ifrc.org/docs/idrl/1011EN.pdf.

[12] ADB. 2009. Country Operations Business Plan: Cambodia, 2009–2012. Manila; ADB. 2008. Country Operations Business Plan: Lao People's Democratic Republic, 2009–2011. Manila; and ADB. 2008. Country Operations Business Plan: Viet Nam, 2009–2011. Manila.

[13] ADB. 2008. *An Operational Plan for Improving Health Access and Outcomes Under Strategy 2020*. Manila.

12. The PCR acknowledged that the project design took off from ADB's previous regional public health project in GMS. The deliberations and understandings reached on the public health policy in various GMS fora with ADB's leadership as a foundation. It helped build a consensus among project countries and secure mutual agreement. The project design supported some common elements of CDC across Cambodia, the Lao PDR, and Viet Nam while allowing for country-specific variations to be pursued in the context of cross-border cooperation. It prioritized communicable and neglected diseases. It supported vulnerable populations, majority ethnic groups, in border districts and remote communities by strengthening provincial training systems and incentivizing community-based CDC. The project was also coordinated with and well supported by other development partners, especially through RMTF and with the United Nations Children's Fund in the field.

13. The project design had some limitations, which were acknowledged by ADB and project teams. The project design and monitoring framework (DMF) was complex, overly detailed, and difficult to tackle since some indicators were neither easily identifiable nor conducive to routine data collection. Given the project's effective gender mainstreaming classification, supporting value addition to women and children under 5 years old, it is likely to directly benefit from the project. Inconsistencies between the DMF and gender action plan (GAP) and lack of baseline data for gender-related targets in the DMF reflect additional weaknesses in design oversight.

14. More substantively, the project design was narrowly focused on training at the provincial-level. The PCR indicated its awareness of this. It would have been better if the project provisions had included support for some substantive activities like civil works, water, and sanitation facilities within its scope. The absence of these basic and essential services limited the potential leveraging of the project to address known vulnerabilities of remote communities. Besides, the project's training focus was on the provincial-level while its community-based CDC approach was focused at the district-level. The PCR acknowledged that the emphasis on provinces might have restrained undertaking, having more activities at the district-level. It also noted that the project design did not support village health volunteers through better compensation, nonmonetary recognition, additional training, and leadership opportunities. Provision of incentives could have reduced the high turnover of the village health volunteers, which constrained both project implementation and sustainability of impacts.

15. This validation notes that the project had a laudable objective and was designed in a region, which ADB was fully familiar with as it had been operating in GMS for a number of years. Project preparation should have revealed that more investment was needed especially in the remote districts and provinces. Notwithstanding a narrow focus on provincial-level training, the project design was top-heavy, intricate, and complex. While a regional cooperation project across three countries would entail a multilayered and multifaceted synchronization across decision makers, the project was completed without substantive support, weakening its rationale. Despite these limitations, this validation assesses the project relevant.

B. Effectiveness in Achieving Project Outcomes and Outputs

16. The PCR rated the project effective and noted that the project outcomes were either achieved or substantially achieved. In particular, the project had improved regional cooperation in public health policy and expanded surveillance and response systems in the region. Its focus on the emerging and neglected diseases assisted in promoting the regional CDC systems. The project paid special attention to capacity building in border districts and along economic corridors, with a focus on community-based CDC. It helped reduce the incidence of malaria in targeted provinces. Although the project succeeded in strengthening surveillance and response

system in the GMS, the PCR indicated a number of shortcomings in the achievement of outcomes and outputs, including the fact that the Lao PDR had not until then started reporting cross-border outbreaks of communicable diseases to other countries.

17. At appraisal, the project targeted 550 model health villages for the community-based CDC. During implementation, the number of model health villages was reduced. The PCR did not state by how much and when the decision to reduce the target was actually undertaken. Likewise, the targeted distribution of medicines and supplementary vitamins to women of reproductive age and children was less than 100%, especially in the Lao PDR. Additionally, the numbers of envisaged joint cross-border activities per district per year to increase to two or more, were not fully realized. Similarly, all the training opportunities envisaged during appraisal could not be provided. In some places, the monitoring of project implementation was partial, resulting in incomplete monitoring of progress. The PCR noted some target indicators in the DMF as inappropriate. These low achievements contributed to some countries being only in partial compliance with International Health Regulations and Asia Pacific Strategy for Emerging Diseases at provincial-levels.

18. The project was classified as effective gender mainstreaming and a GAP was prepared. The PCR noted that the GAP was successfully implemented in all the three countries and the project pursued a gender-sensitive approach in CDC. It was stated that Cambodia completed 100% of all six actions and achieved 87% of targets (13 out of 15); the Lao PDR completed 100% of 19 activities and achieved 87.5% of targets (14 out of 16); and Viet Nam implemented 88.9% of activities (8 out of 9) and achieved 91.7% of targets (11 out of 12). This validation notes the deviations between the DMF and GAP including two actions and two targets in the DMF, which were not in the GAP, and one gender numerical target in the DMF which was inconsistent with the GAP. Such deviations were not corrected during implementation, including midterm review stage. In addition, the lack of baseline data in the GAP and DMF-related gender targets, contributed to unrealistic target setting. For instance, the target of 60% female CDC staff trained was not achieved, largely since an adequate number of female staff was not available, especially in Viet Nam and Cambodia. Viet Nam trained only 52% of village health workers citing difficulty in reaching out to those in remote areas. Under the project, all women of reproductive age and children aged 1–5 years were expected to receive micronutrients and deworming medicines, but it was only partly achieved. Also, no data was available on micronutrients for women in Viet Nam. The PCR acknowledged that executing and implementing agencies should have paid greater attention to the gender-related provisions of the project.

19. The project was classified category B for indigenous peoples safeguards, due to significant ethnic group populations residing in the targeted border district communities and suffering disproportionate health impacts. An ethnic group plan (EGP) was developed for Cambodia, the Lao PDR, and Viet Nam. The implementation of EGP was generally satisfactory. The project recruited CDC staff and village-level workers from among the ethnic population. Both, Cambodia and the Lao PDR engaged a national gender and safeguard consultant to design and monitor the implementation of the GAP and EGP. Data was disaggregated by ethnic groups and analyzed relevant ethnic group issues, activities, and budgets in an integrated manner under the provincial plans in support of model health villages. The PCR observed that in the Lao PDR, achievements were particularly high in terms of training ethnic staff (85% trained) and recruiting new staff from the ethnic groups (63% newly recruited staff from ethnic groups), but also in terms of reporting disaggregated data by ethnic groups; integrating ethnic group issues, activities, and budget in provincial operational plans; and prioritizing ethnic group villages for model health village support. However, with eight indicators achieved, four indicators partly achieved, and five with unknown results due to unavailable data, the implementation of EGP in Viet Nam was less

than satisfactory and training for health staff and village health workers was the main benefit provided under the project.

20. The project was classified category C for environmental safeguards. It did not envisage constructing major buildings, renovation, or solid waste management support, and provided only laboratory equipment in some provincial hospitals. It provided some material for latrines in model villages, besides the usual compliance with government regulations related to medical waste management. As such, understandably, the project did not have much impact on the environment and the PCR did not say much on environmental safeguards under effectiveness.

21. The PCR observed that executing and implementing agencies should have put more emphasis on the GAP and activities related to implementation of the EGP. On the margin, this validation assesses the project effective.

C. Efficiency of Resource Use

22. The PCR rated the project efficient, indicating that it had achieved its outcome and outputs within budget and on time. It estimated the economic internal rate of return at 21%, as compared to the appraisal estimate of 28%. Economic efficiency analysis is conservative and takes into account only the direct benefits from the lower disease burden and enhanced productivity. Other benefits included in the analysis relate to reduction in the cost of accessing health services and benefits resulting from better maternal outcomes as a result of dispensing some micronutrients and deworming medicine. Post-completion economic rate of return was probably estimated lower than that at appraisal since the investment costs had increased on account of RMTF by about $9.5 million. However, the net present economic value is positive only when the results of the three countries are lumped together. For each country individually, it is unevenly distributed, as Cambodia and the Lao PDR had yielded negative net present economic value, and only Viet Nam had high positive economic value.

23. The PCR, however, did not explain this crucial intercountry difference or what factors led to the negative and positive rates either in the main text or in its Appendix 10. Such an exploration would have explained the features of project design as well as the underlying results chain more clearly. The PCR noted that, to some extent, these estimates were constrained by lack of "substantive data collection and modeling." Deeper analysis would have clarified the issues related to regional public goods and how to finance them in the future. The PCR also did not supplement its economic analysis with the help of process efficiency aspects of the project. On the margin, this validation assesses the project efficient.

D. Preliminary Assessment of Sustainability

24. The PCR rated the project likely sustainable on the expectation that various legislative and administrative provisions will keep the health functionaries on track, and they will continue developing measures to strengthen public health regimes in their respective countries, including surveillance and outbreak response capability. These measures would thus serve the goals of CDC well at different levels.

25. The project had helped develop capacities internally at the national-, provincial-, and district-levels, notwithstanding inter-country differences. It also contributed to mobilizing more domestic resources in favor of public health. More importantly, the external fora like GMS had rallied support in favor of such initiatives and thus engendered mutual cooperation at the regional-level. These commitments reflect in the deliberations of GMS Summit of Leaders, as well as the

Association of Southeast Asian Nations' Health Ministers conferences. This validation assesses the project likely sustainable as it is supported with a broad-based consensus on fighting communicable and emerging infectious diseases. ADB has also continued to support these initiatives.

III. OTHER PERFORMANCE ASSESSMENTS

A. Preliminary Assessment of Development Impact

26. The PCR rated the development impact of the project satisfactory. It indicated that project outcomes and outputs were achieved as envisaged and that they contributed to the development impact in Cambodia, the Lao PDR, and Viet Nam. For example, it presented that no major breakout of communicable disease had taken place since 2011, implying greater resilience in the region on account of the public health policy. It also indicated that country specific data showed lower incidence of the diseases that were targeted under the project. Among others, there were reductions in the incidence of malaria, filariasis, and trachoma in Cambodia; under-5 mortality in the Lao PDR; and incidence of dengue related mortality rate in Viet Nam. The PCR also noted reduction of incidence in other diseases including avian influenza, cholera, Japanese encephalitis, and schistosomiasis. The underlying data for some of these were sourced from the project documents while some other evidence was from the World Bank Group's World Development Indicators (WDI). It is hard to conclude, however, if these and other claimed improvements in health indicators were solely due to the project or due to the provincial-level training under the project, in view of the limited availability of project data and its monitoring and evaluation (M&E) systems. This validation assesses the development impact of the project satisfactory.

B. Performance of the Borrower and Executing Agency

27. In general, the PCR rated the performance of the borrower and the executing agencies satisfactory. Counterpart staff were provided. Project management and implementation units at different levels (national, provincial, and district) were set up and performed well as some of them had experience under the previous ADB project. The executing agencies helped implement cross-border activities smoothly and were able to integrate CDC within the broad framework of preventive health programs of respective MOHs. The PCR did not cite whether the progress reports were prepared and submitted regularly, or if they were of the requisite quality. Available data does not clarify if the MOHs prepared PCRs, what the role of advisory committees were, and what guidance was provided at GMS level or other regional meetings on the functioning of the executing agencies. The PCR's assessment of executing agencies' performance is narrow and largely confined to routine project implementation and operation. It does not elaborate on their performance given this special regional cooperation project providing public goods. This validation assesses the role of the borrower and executing agencies satisfactory.

C. Performance of the Asian Development Bank and Cofinancier

28. The PCR rated ADB's performance satisfactory. ADB helped design the project through a technical assistance and supervised the project's implementation closely. The PCR recounted the number of missions and person-days spent (on average 32 per country per annum) during supervision. ADB played an important role in implementing the project through RCU and a number of consultants administered by ADB were directly engaged in lending support to the project. ADB's involvement went beyond just supervising the project implementation. Similarly, ADB facilitated the provision of RMTF support. These roles, however, were not featured in the PCR's assessment of ADB's performance, even though the RCU is discussed under the lessons.

It also did not state the broader high-level support that ADB provided to the GMS in building the consensus for this cross-border initiative for regional public goods. These features would have shed light on the significance of the project in a regional context. This validation assesses ADB's performance satisfactory.

D. Others

29. There are no fiduciary or governance issues related to the project. The PCR did not indicate if any of the governments had prepared PCRs.

IV. OVERALL ASSESSMENT, LESSONS, AND RECOMMENDATIONS

A. Overall Assessment and Ratings

30. The PCR rated the project overall successful with criterion ratings of relevant, effective, efficient, and likely sustainable. The project has valuable features (i.e., regional public good and support for regional cooperation). This validation assesses the project overall successful, with assessments of relevant, effective, efficient, and likely sustainable, as shown in the table below.

Overall Ratings

Validation Criteria	PCR	IED Review	Reason for Disagreement and/or Comments
Relevance	Relevant	Relevant	
Effectiveness	Effective	Effective	
Efficiency	Efficient	Efficient	
Sustainability	Likely sustainable	Likely Sustainable	
Overall Assessment	**Successful**	**Successful**	
Preliminary assessment of impact	Satisfactory	Satisfactory	
Borrower and executing agency	Satisfactory	Satisfactory	
Performance of ADB	Satisfactory	Satisfactory	
Quality of PCR		**Satisfactory**	Para.35

ADB = Asian Development Bank, IED = Independent Evaluation Department, PCR = project completion report.
Source: ADB (IED).

B. Lessons

31. This validation supports the four lessons the PCR identified. The first two are: investment in regional initiative is essential for health security, and effective CDC starts in communities. The other two are: strong laboratory capacity and field epidemiology is vital for rapid response, and experience and dedicated teams contribute to implementation success. A few lessons were identified by "ADB and country project teams." These were: the need for a better designed DMF in consonance with indicators of the GAP and EGP, and inclusion of prophylaxis in case of certain diseases like helminth under the project. It is unusual to have two sets of lessons in a PCR.

32. This validation suggests additional lessons.

(i) **Country-level lesson.** Regular or periodic harmonization of policies is essential in a regional project in which a number of countries, with different levels of development, are engaged together to deliver regional public goods.

(ii) **Sector-level lesson.** Assessing and clarifying the indirect economic welfare generated by the provision of public goods is essential since these are not readily evident, especially in a regional context.

(iii) **Project-level lesson**. In public health projects, it is important that the underlying results chain have adequate components to ensure the welfare of ultimate beneficiaries, and not just confined to serving the involved agencies and their stakeholders. Following wider lessons learned from ADB projects, recruitment of a single specialist to support implementation and monitoring of both gender and safeguards technical areas is insufficient. These are different scopes of work requiring specific skill sets for each technical area. Typically, safeguards take priority over gender where resources are stretched. In part, this may have resulted in the lack of attention to course correction arising from inconsistent DMF and GAP targets.

(iv) **Results framework and methodology-level lesson.** The initial indicators for assessing the benefits can be refined during implementation to yield reliable results.

C. Recommendations for Follow-Up

33. A follow-up project has already been approved and is presently under implementation. Hence, no additional recommendation is required.

V. OTHER CONSIDERATIONS AND FOLLOW-UP

A. Monitoring and Reporting

34. The project had laid much emphasis on preparation and implementation of a comprehensive M&E system in accordance with WHO practice, especially in relation to the gender disaggregated data. However, the PCR did not elaborate on these achievements and instead used some WDI. To what extent project M&E systems have contributed to WHO or WDI databases is unclear.

B. Comments on Project Completion Report Quality

35. The PCR is comprehensive and well written and provided adequate details especially in relation to gender and ethnic group populations. It rightly emphasized that the project needed to have more substantive support in provision of medicines, medical supplies, and incentives to retain frontline-trained village health workers focal persons, etc. It could have performed a better job in describing the results of midterm evaluation and should have explained when the number of villages was reduced during implementation. Similarly, it does not elaborate on the inter-country differences in economic rates of returns. It takes a limited view of executing agencies and ADB's performance, i.e., the report did not refer to initiatives for broader level support of public health. Notwithstanding, it covered most of the topics well and provided a candid description of the project. This validation assesses the PCR quality satisfactory.

C. Data Sources for Validation

36. Data sources used for this validation are the report and recommendation of the President, PCR, and country and regional and ADB strategies plus other internal documents of ADB.

D. Recommendation for Independent Evaluation Department Follow-Up

37. Given the current context of COVID-19, the three GMS projects' focus on health security and provision of regional public goods should be evaluated. While endorsed by GMS countries after project closure, the GMS Health Cooperation Strategy, 2019–2023 and its related commitments should be considered in a future evaluation. Apart from yielding real-time insights for the currently ongoing project, the exercise will also have useful lessons for other countries in the region.[14]

[14] ADB. 2019. *Health Cooperation Strategy: Greater Mekong Subregion, 2019–2023*. Manila.

LINKED DOCUMENT

Provision of Consultants Under the Project for the Project Completion Report Validation of Loan 2699-Regional: Second Greater Mekong Subregion Regional Communicable Diseases Control Project

https://www.adb.org/sites/default/files/evaluation-document/649326/files/l2699-provision-consultants.pdf