TECHNICAL ASSISTANCE COMPLETION REPORT

Division: PRCM

TA No. and Name TA 4118-PRC: Combating Severe Acute Respiratory Syndrome in the Western Region		**Amount Approved:** $2,000,000 **Revised Amount:**	
Executing Agency: Ministry of Health Foreign Loan Office	**Source of Funding:** TASF	**TA Amount Undisbursed** $22,314.30	**TA Amount Utilized** $1,977,685.70

Date			Completion Date	
Approval	**Signing**	**Fielding of Consultants**	**Original**	**Actual**
22 May 2003	30 May 2003	16 June 2003	31 May 2004	31 January 2007
			Closing Date	
			Original	**Actual**
			31 August 2004	24 April 2007

Description. On 23 April 2003, the Government of the People's Republic of China (PRC) initiated a request to the Asian Development Bank (ADB) for emergency technical assistance (TA) to help contain the threat of severe acute respiratory syndrome (SARS). The request prioritized provinces and autonomous regions (henceforth, simply provinces) in the PRC's Western Region, which—due to socioeconomic conditions and weaknesses in preventive public health systems—were least equipped to respond to SARS, particularly in poor rural areas.

ADB rapidly assembled a project team, headed by the author (a member of ADB's SARS Task Force, ensuring linkages to ADB's regional response) and fast-tracked processing, based on joint design dialogue with the Ministry of Finance (MOF) and the Ministry of Health Foreign Loan Office (MOH-FLO, designated as the TA executing agency). TA design was guided by the principles of timeliness and efficacy in response, incorporating flexibility in the design in view of substantial uncertainties in the way the SARS epidemic would unfold as well as national and international responses. The project team and ADB's Resident Mission in the PRC (PRCM) also maintained liaison with the World Health Organization (WHO) and other international agencies to ensure coordination and complementarity in response. Dialogue with the PRC Government identified four principal target provinces (Ningxia, Qinghai, Xinjiang, and Yunnan), based on population characteristics such as poverty and concentration of ethnic minorities, gaps in local health resources, and other SARS-related risk factors, as well as prospects for coverage by other international support. Inclusion of Xinjiang and Yunnan was deemed doubly critical given their role as economic and transport corridors linking the PRC to Central Asia and the Greater Mekong Subregion.

Approved on 22 May (within one month of the first informal request for support), the TA was designed in parallel with, and in some aspects served as a model for, ADB's regional TA 6108-REG: Emergency Regional Support to Address the Outbreak of SARS. It also marked ADB's first TA on mainstream health (excluding public nutrition) in the PRC.

Expected Impact, Outcome and Outputs. The TA's intended impact (formerly goal) was SARS effectively contained in Western Region and cross-border transmission prevented, feeding into maintained capacity for rapid epidemic detection and response. Its expected outcome (formerly purpose) was SARS outbreaks in target provinces preempted, contained, and reversed, with strengthened local capacities to prevent, diagnose, manage, and mitigate the SARS epidemic. In particular, the TA prioritized (i) timely and targeted support to address threats facing front-line medical workers, the poor, and other at-risk groups; (ii) building of comprehensive capacities, working in close collaboration with domestic and international partners; and (iii) collecting and widely sharing lessons from SARS, in order to advance dialogue on addressing challenges facing the PRC public health system, and to present new models.

While addressing the immediate threat posed by SARS, the TA's design framework prioritized interventions to simultaneously build critical, longer-term capacities in the public health system. The TA design foresaw four components with the following key, broadly defined outputs: (i) assessment and planning, including completion of a rapid assessment and aimed at supporting sound provincial plans to address SARS; (ii) epidemiological surveillance, targeting strengthened systems; (iii) emergency response systems, aimed at augmenting capabilities; and (iv) information, education, and communication (IEC), targeting increased public awareness of SARS and self-protection through multi-mode IEC delivery.

Delivery of Inputs and Conduct of Activities. The TA design proved well founded in its combination of a clear and comprehensive framework with flexibility to periodically reassess and respond to needs, as well as its emphasis on augmenting capacities to respond to SARS but also a broader range of public health threats. After completion of initial interventions and as the immediate risks from SARS waned, TA activities gradually shifted towards building broader, and longer-term capacities in disease prevention and control (DPC), while contributing to vigilance against a possible resurgence of SARS (and later avian influenza). Particular emphasis was given to addressing gaps at the foundations of the DPC system (i.e., the grassroots level), which the initial rapid assessment (RA) confirmed to be a major risk area undercutting system efficacy, and one largely neglected by other interventions. Along with minor changes of scope, the TA was eventually extended through June 2006, with a final extension to January 2007 to allow ADB co-sponsorship of a major international forum on health and development and final liquidation. Likewise, the balance of activities across and within the four components was adjusted in response to the RA and periodic evaluation, as well as priorities expressed by the target provinces and the perceived "value added" of TA support vis-à-vis other initiatives.

Domestic experts provided principal consultant inputs: the combination of excellent experts drawn from various units within the PRC's centers for disease prevention and control (CDC) system and leading hospitals was particularly key in

ensuring that TA interventions could address a range of needs and strengthen coordination between local CDC and clinical staff in the target provinces (a key constraint identified in the RA). The full-time TA Coordinator (domestic) effectively supported liaisons across flexibly deployed individual consultants and coordinated between MOH-FLO, ADB, and local partners. Consultants (generally rated satisfactory to excellent) were augmented by drawing on additional expert inputs from ADB and other organizations (e.g., contributions by WHO, United States CDC, and the United Nations Children's Fund to the design of the capacity building curriculum and IEC materials) as well as joint activities (e.g., an ADB-World Bank Beijing Seminar to support needs assessment and national planning in November 2003).

ADB played a very direct role in implementation, facilitated by three missions prior to the author's transfer to the PRC Resident Mission (PRCM), four subsequent field missions, and substantial time working directly with the consultants in intervention design. Sound management of the flexible TA was also supported by strong inputs from MOH-FLO as well as provincial/local partners, who recognized the practicality of the TA and had strong ownership (e.g., reflected in counterpart contributions to numerous training sessions). Overall, ADB and MOH-FLO inputs were highly satisfactory.

Evaluation of Outputs and Achievement of Outcome. TA support was very well received by local partners and the TA has been widely recognized for the quantity, quality, and practical relevance of deliverables, including:

- A Strengthening Disease Response Foundations (SDRF) initiative, including (i) participatory applied skills training for staff of all county-level CDCs and roughly two thirds of township hospitals in the target provinces; (ii) distribution of 62,000 copies of an applied DPC handbook (with 5,000 copies in Uyghur language) and 42,000 copies of a disease diagnosis "photo bank" in all Western Region provinces; and (iii) dissemination of 300,000 flowchart posters to township hospitals nationwide. The SDRF also promoted CDCs' and hospitals' support to village clinics;
- As part of the SDRF, provision of an innovative, integrated training-of-trainers (TOT) program, including face-to-face training and provision of print- and computer-based resources to a corps of roughly 180 trainers;
- Packaged provision of vehicles, equipment, and an applied and multi-stage, multi-mode practical training on epidemiological investigation for provincial and selected prefecture CDCs;
- A training for provincial health education institutes in the four target provinces and Guangxi on IEC strategies to respond to public health emergencies; and
- As part of "school-to-community" IEC, distribution of 150,000 copies of a health booklet for grade 4-6 students in all nationally-designated poverty counties in the target provinces and 140,000 copies of a teacher handbook to support health education in grades 7-9; Mongolian-language versions were distributed in Inner Mongolia (working with local youth federations), and e-versions with expanded avian influenza content were put on China CDC's website.

A final publication disseminated project experience and identified key policy implications. Among evidence of the TA's efficacy and sustainable impact, core elements of participatory capacity building approaches and materials developed under the SDRF are being replicated in other target province capacity building programs. Also, World Vision China is funding reproduction of the noted children's health booklet in Chinese and Uyghur, while content of the teacher-targeted IEC booklet was incorporated in a recent Ministry of Education publication distributed nationwide.

In sum, while SARS' decline nationwide proved fortuitous, the TA went beyond the full achievement of its outcome in strengthening broader and longer-term DPC capacities and demonstrating new models for reaching grassroots staff.

Overall Assessment and Rating. The TA is rated as highly successful, having achieved its intended outcome and delivered high-quality outputs, including a range of needs-targeted deliverables that have been strongly praised by local partners and identified by MOF counterparts as good models of practical knowledge dissemination. As ADB's first mainstream health TA in the PRC, it also has helped set a strong foundation for ADB participation in policy dialogue and potential future support.

Major Lessons. A first lesson is that the TA's flexible and iterative approach (with interventions refined via continual needs assessment) was effective and appropriate given the need to address a complex and evolving challenge, especially in a new area for ADB in the PRC. Fluid coordination across flexibly deployed consultants and project partners and a continuous, hands-on role by the ADB TA officer were critical in capturing the benefits of such flexibility.

Secondly, although often informal, effective collaboration with international agencies like WHO supported increased TA efficacy, allowing all parties to tap their strengths in win-win collaboration.

Finally, at a more micro-level, the efficacy of the TA's capacity building interventions required sustained emphasis on (i) needs identification and audience-targeting; (ii) embedding multiple approaches, ranging from participatory face-to-face training with limited group size, to in-field "practicum" or learning-by-doing supported by informal on-demand support, to dissemination of needs-targeted print-based materials; (iii) involvement of local experts and iterative design via pilot testing, key to ensuring relevance and impact for final beneficiaries; and (iv) greater focus on applied content and especially on methodology, particularly in TOT for the SDRF. By contrast, capacity building in the PRC and other contexts is sometimes narrowly envisaged as one-shot, lecture-based, and theory-centered training, which prioritizes provision to large numbers of participants but may compromise quality and impact on applied competencies.

Recommendations and Follow-Up Actions. Given the Government's increasing demand, scale of health-related challenges in the PRC, and linkages to poverty reduction and other development objectives, ADB should continue to explore health sector involvement, particularly in rural DPC and health reform.

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