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IMPLEMENTATION COMPLETION REPORT
(SCL-43960 TF-22689 PPFB-P3330)

ON A

LOAN/CREDIT/GRANT

IN THE AMOUNT OF US$30 MILLION EQUIVALENT

TO THE

UZBEKISTAN

FOR A

First Health

June 17, 2005

Human Development Sector Unit (ECSHD)
Europe and Central Asia Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective May 24, 2005)

Currency Unit	=	Sum
1 Sum	=	US$ US$0.001
US$	=	1,000 Sum

FISCAL YEAR

January 1 Decemeber 31

ABBREVIATIONS AND ACRONYMS

Vice President:	Shigeo Katsu
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UZBEKISTAN
First Health

CONTENTS

Project ID: P009125	*Project Name:* First Health
Team Leader: Dilnara Isamiddinova	*TL Unit:* ECSHD
ICR Type: Core ICR	*Report Date: June 15, 2005*

1. Project Data

Name: First Health

L/C/TF Number: SCL-43960; TF-22689; PPFB-P3330

Country/Department: UZBEKISTAN

Region: Europe and Central Asia Region

Sector/subsector: Health (89%); Central government administration (9%); Sub-national government administration (2%)

Theme: Rural services and infrastructure (P); Population and reproductive health (P); Health system performance (S)

KEY DATES			*Original*	*Revised/Actual*
PCD:	09/29/1995	*Effective:*	12/18/1998	03/15/1999
Appraisal:	12/18/1997	*MTR:*	02/01/2001	01/02/2002
Approval:	09/22/1998	*Closing:*	06/30/2003	12/31/2004

Borrower/Implementing Agency: GOV'T OF UZBEKISTAN/MIN.HEALTH & SOC.PRO

Other Partners:

STAFF	Current	At Appraisal
Vice President:	Shigeo Katsu	Johannes F. Linn
Country Director:	Dennis de Tray	Ishrat Husain
Sector Manager:	Charles C. Griffin	James Christopher Lovelace
Team Leader at ICR:	Dilnara Isamiddinova	John C. Langenbrunner
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2. Principal Performance Ratings

(HS=Highly Satisfactory, S=Satisfactory, U=Unsatisfactory, HL=Highly Likely, L=Likely, UN=Unlikely, HUN=Highly Unlikely, HU=Highly Unsatisfactory, H=High, SU=Substantial, M=Modest, N=Negligible)

Outcome: S

Sustainability: L

Institutional Development Impact: M

Bank Performance: S

Borrower Performance: S

	QAG (if available)	ICR
Quality at Entry:		S
Project at Risk at Any Time:	No	

3. Assessment of Development Objective and Design, and of Quality at Entry

3.1 Original Objective:

The project was the first operation in the health sector in Uzbekistan. It was part of a broader rural social infrastructure development approach of the Government of Uzbekistan and evolved with the Government's primary health care reform strategy, which was enacted in 1996. This reform focused on rationalization of excessive infrastructure and the re-direction of savings to create a sustainable network of integrated primary care services. The Bank operation thereby sought to support the Government's efforts in three pilot oblasts, taking into account lessons learnt from the early health projects in ECA countries to carefully sequence changes and focus on relatively simple, shorter operations.

The development objective at the national level was to build the MOH capacity to evaluate and then to disseminate the results of the pilots country-wide.

The Project's regional development objectives with a view to pilot oblasts were to: (a) improve the quality and cost-effectiveness of primary health care services; (b) improve management and efficiency of delivery services; (c) develop a new cadre of professional providers (physicians and nurses) focused on general practice and family medicine. The Project Development Objectives (PDOs) for the project are still highly relevant for Uzbekistan at the end of the project, and have been adopted for the country-wide roll-out of activities under the subsequent Health 2 project, which started in January 2005. The PDOs are furthermore in line with the overall government program to improve primary health care which has been maintained by the Government.

The project envisioned to create benefits for:
(a) the population in rural areas, where approximately 70 per cent of the total population in Uzbekistan live, in the three pilot oblasts, who would otherwise have limited access to quality health care;
(b) women and children, who tend to be the main users of rural primary health facilities;
(c) at a later stage, the population at large by rolling-out demonstration or pilot programs to the entire country;
(d) decision makers in the oblast and central government health administration by improving information flow and opportunities for efficiency gains and fiscal savings;
(e) health workers, particularly doctors and nurses, through improved clinical and management skills.

3.2 Revised Objective:

The objectives were not revised during project implementation.

3.3 Original Components:

Component A: Strengthening of Primary Health Care Services in Participating Regions (total estimated costs US$m 53.8, of which Bank financing US$m 18.6): The component comprised three subcomponents, namely: (i) construction, consolidation and rehabilitation of Selsky Vrachebny Punkti (SVPs – rural medical centers), (ii) upgrading of services; and (iii) health promotion. The component envisaged the construction and provision of equipment for new SVPs, provision of equipment for central rayon polyclinics, and consolidation, rehabilitation and upgrading of existing rural health facilities by (1) upgrading of services of SVPs for individual clinical, primary and preventive care, child health services, reproductive health care and emergency care, including provision of drugs, medical supplies and health promotion activities at the SVP level; and (2) provision of transportation and communications equipment to SVPs in remote rural areas. While the government was to finance the construction and rehabilitation of SVPs and other infrastructure, the Bank loan was to finance medical and other equipment for SVPs, lab equipment for central rayon hospitals, communications and transport equipment and technical assistance

and training.

Component B: Training of Medical Personnel (total estimated costs US$m 6.8, of which US$m 5.5 Bank financing): This component envisaged to finance the training of medical personnel of SVPs in the participating regions, including: (i) retraining of existing physicians; (ii) continuing medical education of SVP physicians in three oblasts; (iii) training of trainers of existing physicians; (iv) long-term reforms for strengthening medical education; (v) development of training sites; (vi) training of universal nurses and (vii) accreditation, certification and licensing. The Bank loan was to finance goods, consulting services and training. Additionally, technical assistance for the development of a curriculum for 'training of trainers' was to be received from the U.K. Know How Fund.

Component C: Strengthening of Finance and Management of Primary Health Care (PHC) Services (total estimated costs US$m 3.9, of which US$m 2.8 Bank financing): This component consisted of two subcomponents: (i) rationalization of the delivery system, and (ii) new financing and management models. It was to finance the introduction of new finance, management and information models for SVPs with pilot demonstrations in selected districts in the initial three participating regions. This component foresaw the provision of necessary computer equipment, advisory services and training from the Bank loan. USAID was to finance technical assistance and training.

Component D: Project Management (total costs US$m 3.3, of which US$m 1.1 Bank financing): Component D financed the provision of training, consultants' services (including audit) and office equipment including vehicles for strengthening the project preparation and implementation capacity of CPIB and Oblast PIBs, including monitoring and evaluation.

3.4 Revised Components:

Following the drought in Western Uzbekistan in 2000, the Government requested the Bank in November 2000 to re-allocate funds for emergency aid and extension of component activities to the autonomous Republic of Karakalpakstan and to Khorezm oblast. The Bank agreed to this request, and the loan agreement was amended correspondingly in January 2001, allowing for "*the extension of project activities in all components to be geographically extended to other regions in Uzbekistan as agreed between the Bank and the borrower*". For this purpose, funds were transferred from the unallocated to the goods expenditure category. The amendment was in line with the development objectives of the project as the requested intervention aimed to mitigate potential public health risks triggered by the effects of the drought through the provision of emergency drugs and vaccines to the target population in rural areas. It was furthermore the starting point to rolling out implementation of other main project activities tested in the initial pilot oblasts to Karakalpakstan and Khorezm, documented in a further amendment to the Loan Agreement in March 2003. Subsequently, an additional number of SVPs, CRH and Rayon computer centers were supplied with equipment and established the financial management system developed by the project in these oblasts.

3.5 Quality at Entry:

This was the first Bank operation in the health sector in Uzbekistan. While initial contacts and discussions with the government began early after independence, the Bank mainly was engaged in policy dialogue with the Government during the first half of the 1990s in the absence of a targeted lending operation. The ICR deems this continued policy dialogue as crucial for influencing Government thinking in favor of a primary health care focused approach instead of the initial government proposals for interventions aiming at pharmaceutical and vaccine production, which were seen as non-sustainable. It is also useful to focus on improvement of primary care, especially in rural areas as this improves access for the poorest segments of the population and creates the opportunity to gradually shift health care services from hospital to outpatient care as well as from narrow specialists to family medicine or GP care. As rationalization of hospital

services without functioning PHC is not easily possible, this created the opportunity to rationalize the all too abundant hospital sector. More detailed project planning started around the mid nineties. Project preparation gained momentum with the general decision to introduce universal primary health care reform in Uzbekistan in 1996. The Presidential Decree # 182 "On the Program for rural infrastructure development" which determined priority for primary health care was approved by the Cabinet of Ministers on May 21, 1996.

Subsequently, the project components were planned keeping in view the aims and objectives of overall primary care reform, and lessons learnt from earlier interventions in FSU countries and transition economies. The project design adequately took into account major risk factors and a potential social impact from closure of facilities, and promoted a careful and sequenced approach. Project activities were designed as pilot interventions in three geographically and socially diverse project oblasts. The project design also provided for sufficient means for supporting implementing agencies and to build institutional capacity, another area deemed crucial for project success. Bank-financed preparation work leveraged operations from other financing agencies, and the project benefited from close cooperation among donors, particularly with DFID and USAID, during preparation. A Japanese PHRD grant and a PPF were used to establish the CPIB and for design of the project components.

The project did not undergo a formal QER during preparation. It was in line with the provisions of the 1998 CAS. Furthermore, taking into account that health care reform is a lengthy process, it was already clear from the beginning that a follow-on project would be required for a later country-wide roll-out, and the loan agreement contained had earmarked funds to be used for institution building for the preparation of a Health 2 project. However, the Bank in its policy dialogue and during the time proceeding the design phase itself, has missed the opportunity to come to a more comprehensive diagnosis of the ailments of the health care sector. There has been no attention to the sub-sectors of the health care system that were not somehow covered by the project, i.e. the system for secondary (except for the CRH labs) and tertiary care, the Sanitary Epidemiological Services (whose building standards affect the design/rehabilitation of the rural primary health care centers, SVPs) and the human resources management capacity of MOH. Some areas where an intervention would have been useful for a more effective integrated development, such as pharmaceuticals and drug testing laboratories, were dropped by the government at Negotiations. Thus during the design phase, the Bank did not fully succeed to influence further rationalization of hospital care and of the many vertical and parallel systems for specific medical conditions and segments of the population. As a compromise, a rationalization sub-component was included in the project to support development of restructuring plans in the pilot oblasts. Project evaluation suffered somewhat from a lack of detailed monitoring indicators for project outcome and output, and no specific baseline was prepared by the start of the project.

As this was the first operation in the health sector, it might have been beneficial to allow for a longer implementation period from the beginning as the complexity of Bank-financed project implementation is often under-estimated by the borrower. This is particularly the case if implementation involves significant construction and institution building from the start as was the case in this project. Alternatively, it could have been beneficial to limit pilots to a smaller number of rayons, or limit the number of activities in Component B with a view to a faster, and more focused, piloting under Health 1 and subsequent country-wide roll-out of financing reforms under Health 2. Having said that, at the time of preparation the Bank's leverage in the sector was limited by an institutional strategy focusing on macroeconomic reform, and by other donors who were providing grant funding for health projects, and the Bank has made satisfactory use of its window of opportunities during project preparation.

4. Achievement of Objective and Outputs

4.1 Outcome/achievement of objective:

Overall achievement of the development objectives is rated *satisfactory*.

The outcome of the Project can be seen as satisfactory since the development objectives at the national and at the regional levels were achieved as originally planned. In addition, the Project managed to cover two more oblasts and provided vaccines and emergency medicines support for drought-stricken areas. The Project also provided for the basic legislative and institutional framework for rolling out of the pilots to the remaining oblasts as part of the Health 2 Project.

Monitoring & Evaluation efforts were mainly driven by donor requests. In addition to Bank-supported project monitoring and background studies, such as the Living Standards Assessment and Facility Survey, USAID financed pre- and post project household surveys in Ferghana oblast and supported capacity building in the CPIB in year 2 of the project. However, project M&E suffered from the lack of a baseline with quantified and qualified indicators at the start of the project, and some deficits in the system were never fully addressed during project implementation. The selection and documentation of monitoring indicators to demonstrate achievement of objectives continues to be weak, and reflects the generally difficult and unsatisfactory situation with regard to data collection, interpretation, evaluation and publication in Uzbekistan. The monitoring indicators used are a mix of output and outcome indicators, and are not directly tied to the stated DOs. Their validity suffers from a generally weak framework for meaningful data collection, which still focuses to a great extent on soviet-style data collection, lacking consistency checks and critical assessment. The current government health information system provides data but no further information or interpretation of results which could be used by policy makers. The issue is being addressed under Health 2, which envisages the establishment of a comprehensive project and, later, health management information system. In the light of these weaknesses, it is also difficult to directly link some outcomes mentioned in the Borrower's contribution to this report (see *9. Partner Comments (a) Borrower/implementing agency*) to the inputs provided by the Project.

PDO at the national level*:*

To build the MOH capacity to evaluate and then to disseminate the results of the pilots country-wide.

DO rating: *marginally satisfactory*

The government has built appropriate capacity in the Central Project Implementation Bureau (CPIB), the main implementing agency for this project, to regularly monitor and evaluate the results of pilot activities, and CPIB has taken an active roll in planning for the country-wide extension of activities in the forthcoming Health 2 project. However, the project failed to generate a more pro-active behavior in evaluation and policy-making in the Ministry of Health itself, and other ministries and agencies involved in project implementation, such as the Ministry of Finance, Uztibmakhsolut (distribution agent) and Uzmedexport (procurement agent). Firstly, the Ministry of Health was very slow in establishing a baseline to monitor the impact of pilot project activities. The project baseline was only established in 2000, almost two years into implementation. By then too much time had passed to appropriately validate baseline data. The Government also did not actively collaborate on sharing and using data and information obtained from other sources, such as the Demographic and Health Survey (DHS), with the implementing agencies. The 2002 DHS, supported by USAID, was embargoed for 2 years before data became publicly available, hence missing out on the opportunity to evaluate and re-adjust decision making based on realities on the ground. Lastly, a facility survey, planned to be implemented around the time of mid-term review, was only

conducted towards the end of Health 1 implementation. Here again, while the results were valuable for some adjustment in the planning for Health 2, earlier assessment could have helped to address common problems impacting on the quality and quantity of service provision, particularly in the area of availability of drugs and consumables, maintenance and training needs.

Regional Development Objectives for pilot oblasts:

In general, the amount and quality of data to measure attainment of the regional development objectives is sufficient for the initial 3 pilot oblasts. Data availability and quality for outcome evaluation in the two additional pilots, Karakalpakstan and Khorezm, is insufficient to establish if the development objectives have been met in those two regions, as project activities have only been implemented from the beginning of 2004, and attainment of those objectives is medium- to long-term in nature.

By combining a number of different structural changes and inputs, the project has contributed to establishing a comprehensive system of primary care services in pilot oblasts. This new approach integrates clinical, management and financial aspects of service provision to improve effectiveness, efficiency and access to health care in rural areas, hence leveraging synergies from a variety of inputs to create a balanced and sustainable primary care network.

(a) improve the quality and cost-effectiveness of primary health care services

Attainment of this DO is rated *satisfactory.*

Under the project, the provision of health care services in SVPs in the pilot oblasts has increased, and the focus has shifted from more expensive, hospital-based in-patient care to ambulatory out-patient care provided by SVPs. The facility survey conducted at the end of 2003 showed that population in the catchment area of pilot oblast SVPs generally appreciated the services offered, and acceptance and use of preventive services, in particular MCH services and vaccinations, was high. As compared to the time of the baseline in 1998, the number of visits to SVPs in the pilot oblasts had increased considerably by the end of the project in 2004. The number of visits to SVPs from 1998 to 2004 increased by more than two-fold in Syrdaya, about 7.6-fold in Ferghana, and more than nine-fold in Navoi. This provides a sound basis for the provision of effective primary care services provided that trained personnel, equipment and supplies are readily available.

As a first indicator of quality improvement, the percentage of pregnant women visiting SVPs for antenatal care during the first three months of pregnancy increased in all three pilot oblasts. In total, the percentage of pregnant women attending practice for antenatal checks increased between 5.7 to 6% to about 90% of pregnant women. However, monitoring of quality improvement of care at the SVP level will require continued attention during the implementation of Health 2, as more detailed indicators and evaluation of these indicators is needed to obtain universally valid results.

(b) improve management and efficiency of delivery services

This DO is rated *satisfactory.*

The project has established an extensive infrastructure network for primary health care, which substantially exceeded the originally envisaged outputs (for further information, see *4.2 Outputs by components*). As a result, coverage with primary health services increased, and admissions from SVPs to hospitals in the initial pilot oblasts have decreased between 4.1% in Navoi, 8.6% in Ferghana and 22.4% in Syrdarya

oblast from 2001, the first year during which SVPs were supplied with both, equipment and trained GPs, until 2004. This is thought to also reflect different geographical features of pilot regions. Hospital admission in Navoiy, a sparsely populated oblast with less accessible health facilities and in some areas long travel distances to the nearest hospital, decreased less than in Syrdarya oblast, a more densely populated area relatively close to Tashkent.

Data for Khorezm and Karakalpakstan show in parts a considerable increase in hospitalization, which is not surprising given that project measures were only implemented at the very end of Health 1 in 2004. Hence no impact is showing for these two regions yet.

(c) develop a new cadre of professional providers (physicians and nurses) focused on general practice and family medicine.

Overall, this DO is rated *satisfactory*.

The project has helped to train almost 900 family doctors / general practitioners, of which most are now working as GPs. In the pilot oblasts, between 70% (Navoiy) and 100% (Ferghana) of SVPs are now staffed with trained GPs. However, some problems with regard to institutionalizing general GP training and re-training prevail and will be addressed under Health 2. Among those are the legal recognition of the GP as specialization by the Ministry of Labour, which is expected before July 1, 2005 as all the legal documents have been prepared, and the further improvement of undergraduate training and pre-diploma curriculum review for medical students. Furthermore the Bank and the Government, with technical assistance from USAID, are working on the establishment of the EBM centre and the introduction of revised treatment protocols, which was initiated under Health 1 and will be further developed during Health 2.

Outcome of the training of nurses, however, is considered to be less than satisfactory. While the project succeeded in establishing the physical infrastructure for appropriate training of nurses and the equipping of nursing schools, the present three-year nurse training curriculum does not achieve its objective of providing a supply of adequately trained universal nurses. The curriculum concentrates on the continuation of general secondary school during the first two years of training, and thus fails to deliver appropriately trained workforce for family medicine and general practice. Nurses graduate at too young an age and are not mature enough to fulfill their roles properly. The government has so far been reluctant to extend nurse training to a total of four years, and specialization courses offered after the initial 3 year training are not yet attracting the number of nurses required to provide an adequate workforce.

4.2 Outputs by components:

On balance, all Project components are rated *satisfactory*. Furthermore, the project complied with all covenants established during project implementation.

Component A: Strengthening of Primary Health Care Services in Participating Regions (total actual costs US$m 71.38, of which US$m 22.27 Bank financing).

Component A generated the following outputs, which substantially exceeded the initially planned number of facilities to be covered by the project:

(i) 682 primary care centers (SVPs) were constructed or rehabilitated, while originally a number of between 266 to 320 were planned. A substantial number of Feldsher/midwife stations and rural hospitals (SVAs and SUBs) were closed or transformed into SVPs. The numbers of referrals to district hospitals (Central Rayon Hospitals, CRSs) and hospitalizations were substantially reduced as was the average length of stay, creating savings in the amount of 3,638,744,000 Soums.

(ii) Upgrading of services: 673 SVPs were provided with medical equipment; 70 vehicles were procured (50 more then planned); SVPs in remote areas received radio communication equipment. Only 210 SVPs were supplied with drugs according to the agreed list of essential emergency drugs. The remainder of the SVPs managed to procure their own drugs, enabled by changes in their legal status and the introduction of a new (per capita) financing mechanism of the SVPs
(iii) Health Promotion: the "Institute of Health" was established, together with branch offices in three Oblasts and provided with vehicles, office and presentation equipment. Staff was trained in promoting healthy life styles. Promotion materials were published and the WHO Health Schools program introduced, but overall, the sub-component did not fully achieve its planned outputs and lacked introduction of a comprehensive health promotion strategy.

Component B: Training of Medical Personnel (family physicians and universal (primary care) nurses, total actual costs US$m 7.35, of which US$m 4.85 Bank financing)
This component produced the following outputs:
(i) 14 training centers for family physicians (FPs) have been set up and equipped in Tashkent and the Oblasts.
(ii) 105 trainers of FPs were trained with support of DFID (64 originally planned)
(iii) 898 SVP doctors and 61 city policlinic doctors received a 10 month training course in family medicine, including skills training (200 were originally planned). A number of 94 of those retrained doctors, who were among the best in their classes, received an additional training of 14 days in Estonia, together with some staff of MOH and some trainers.
(iv) Continuing Medical Education of SVP doctors: 355 SVP doctors got additional short course training in topics like integrated management of childhood diseases, pre- and postnatal care (including breast feeding), rational use of drugs and the fundamentals of public health.
(v) Long-term reforms for strengthening medical educations: A start has been made with the review and cosmetic reform of the undergraduate curriculum as well as a postgraduate FP curriculum has been established. However the reform of the undergraduate curriculum is not yet finished and will continue under Health II. The postgraduate FP training is too little focused on learning typical FP practical skills and treating medical conditions in PHC. Besides this, the faculty for Pediatrics is not integrated with the training for FP's, producing pediatricians for primary care while the model should aim for FP's capable to deal with patients of both genders and of all ages.
(vi) Training of universal nurses (for PHC): 15 medical colleges (for nurses training) in Tashkent and in the Oblasts have been equipped and nurses trainers were trained. 599 SVP nurses received additional training (320 originally planned).
(vii) Accreditation, Certification and Licensing: A Center for methodical Elaboration and Educational Technologies was established and equipped under the Council Rectors of the Medical Institutes (Faculties) to prepare the training programs to be accredited by the Ministry of Higher and Specialized Education. Another achievement is the establishment of the Republican Center for Licensing and Certification of doctors and pharmacists, which was equipped by the Project.

This component benefited from excellent cooperation with the DFID-funded training program for GPs, and the USAID-financed work on quality and treatment protocols delivered by ZdravPlus.

Component C: Strengthening of Finance and Management of Primary Health Care Services (total estimated costs US$m 4.09, of which US$m 2.02 Bank financing; total actual costs US$m 2.04, of which US$m 1.0 Bank financing):

Main objectives of this component were to change incentives and improve managerial skills for the

provision of efficient primary health care by SVPs, through the introduction of a financing, management and information system with per-capita budget allocations and the pooling of funds at the oblast and rayon levels. The project achieved the following outputs:

(i) Pilots were started in three rayons in Ferghana oblast in 1999. Following evaluation of the Ferghana work, the pilots were gradually extended to Navoi and Syrdarya oblasts in 2000, and to Karakalpakstan and Khorezm during the project extension phase in 2004, in addition to the originally envisaged number of 3 pilot oblasts.
(ii) A total of 637 SVPs, established as independent legal entities, with own bank accounts and covering a total of 3.4 million people, are following the new financing system by the end of Health 1. Again, this number exceeded the originally envisaged number of SVPs to be covered by the project quite considerable. Initially, the component envisaged the introduction of two financing models, one for per-capita based funding of SVPs, the other for a modified 'fund-holding' system purchasing specialist care at the first referral level from oblast and central rayon hospitals. However, introduction of the latter financing model turned out to be too ambitious during the First Health Project, given that necessary rationalization at the secondary level has not yet taken place.
(iii) In support of component implementation, the Project trained 678 financial managers in the five project oblasts, and held 25 orientation workshops for specialists at rayon and facility level as well as 56 workshops on financing and management reforms. A number of specialists visited the US and Kyrgyzstan to learn from primary care finance experience elsewhere.
(iv) Furthermore, a comprehensive Management Information System for morbidity and general population data was established, including the required infrastructure in 5 oblast and 42 rayon computer centers, which were equipped with IT equipment and training of 118 information specialists to process population and health care data. The system includes client/server software and financial information protocols, which provides for a future extension to process information on clinical protocols and a referral system for specialized care.
(v) Rationalization plans including computer modeling of the anticipated financial impact to support decision-making were developed for three pilot oblasts. (vi) Training activities and study tours were accompanied by changes in the legislative framework allowing facilities more flexibility in the hitherto strictly norm-based recruitment of personnel and some limited virement of funds between budget lines, albeit still short of full financial autonomy. In line with the provisions of the loan agreement, the share of funds allocated to primary health care as compared to the total oblast health budget increased in all pilot oblasts.
This component was marked by excellent donor cooperation with the USAID-funded ZdravPlus Project, which has provided most consulting services for the development of the new financing model.

Component D: Project Management (total actual costs US$m 1.56, of which US$m 1.43 Bank financing):

During the project, the Ministry of Health (MOH) established and retained a Central Project Implementation Bureau (CPIB) for day-to-day management of project implementation and coordination of activities at the central level and with the oblasts. The CPIB built substantial capacity in procurement and financial management as well as technical expertise in various areas of primary health care, training and financing and management. Furthermore, the Project established and maintained oblast project implementation bureaus, assisting with project management and M&E tasks at the oblast and rayon levels. The JPIB also managed the Japanese grant for the preparation of Health 2 as well as the preparation technical assistance for the ADB Women and Child Health Development Project, which was prepared in parallel with the Bank's Health 2 Project from 2003.

4.3 Net Present Value/Economic rate of return:

N/A

4.4 Financial rate of return:
N/A

4.5 Institutional development impact:
Overall institutional development impact is rated *modest*. At the regional (oblast) level, the project supported the establishment of legally independent SVPs, which are given financial and decision autonomy to enable provision of cost-effective health care. Hence the project has clearly contributed to establishing primary health care facilities as an important pillar of the health care system at this level. However, in the course of project implementation the MOH has omitted to strengthen its own capacity for policy making and management in the area of PHC by shifting tasks to the staff of the CPIB which added to their burden and contributed to delay in project implementation. The MOH is supposed to develop those functions inside its own institution in order to create sustainable capacity and guarantee adequately focused work by the CPIB.

Development of institutional capacities of the Central Project Implementation Bureau is seen as successful. It has built capacities and expertise that will manage the further roll-out of Health 2 to the remaining oblasts (not covered under Health I) and a new ADB-funded Women and Child Health Project. Besides this, several other institutions for training, quality improvement or licensing have been established or strengthened during the Health 1 project implementation. However, a number of challenges do remain for Health 2: Institutional cooperation, particularly with regard to service planning and health technology assessment will have to be improved to adopt more custom-made and less complicated solutions, e.g., for communications problems for SVPs in general, and in remote areas in particular. With regard to Health Promotion and Strengthening Public Health Services, the Health 2 Project will also have to focus on the firm establishment of a sound institutional framework and priority setting to improve health promotion and public health services, particularly with a view to the increasing burden of non-communicable diseases and life-style induced diseases. This has not been achieved under Health 1 despite original plans.

5. Major Factors Affecting Implementation and Outcome

5.1 Factors outside the control of government or implementing agency:
During implementation of the project, the macro-economic framework in Uzbekistan deteriorated significantly, and the country has now lost access to IBRD funding due to a fall in its per capita income and unsatisfactory credit ratings. This undoubtedly has had an impact on the absolute amount of funding from government resources available to the health sector.

5.2 Factors generally subject to government control:
The demographic situation, with a young population, is generating high pressure on the labor market. It also generated political pressure and somewhat restricts opportunities for rationalization and reduction of excess staff in health facilities. It has lead to high unemployment, which is, unfavorably, countered partly by increasing the training capacity in the health sector. As a result, the number of medical colleges for nurse training have been increased without improving the quality of the students enrolling in the training programs and accepting them at a too young age.

The project was extended twice to allow for full implementation of the originally planned project activities. This reflects implementation delays caused by low institutional capacity of government agencies, and some resistance by the Government to address cumbersome government regulations and implementation procedures, particularly in the area of procurement and delivery of goods and services. On a positive note, a number of reallocations between expenditure categories and between components were made during the

project lifetime, reflecting savings from the procurement of equipment and coverage of activities by other sources of funding, especially for training of doctors and nurses and the establishment of a financial management system through DFID and USAID. In addition, during the extension period project activities were also rolled out into Karakalpakstan and Khorezm. These reallocations were in line with the project's development objectives and supported the efficient use of available resources for attainment of these objectives.

The project benefited from stability in Government leadership, with main counterparts, such as the Minister of Health and deputy ministers being involved in the project for a substantial period of time. This is considered positive for implementation and advocacy of the necessary political reforms. Having said that, there were some delays in implementation, caused by a lengthy decision making processes and owing to the high number of institutions involved in the process. Project effectiveness was slightly delayed as the required decrees and government orders took a long time to prepare. These problems continued during project implementation and should have been addressed more proactively to improve efficiency of project implementation. The project also faced some minor delays in, and probably lack of, counterpart funding. Furthermore, the initially plan to rehabilitate SVPs got delayed at the beginning of the project, and impacted somewhat negatively on the first round of procurement. The delay, however, was made up for later during the project. Another important factor within the control of the government was a certain lack of willingness to implement swift reforms and provide appropriate legal basis and legal framework accompanying the reforms at the oblast level. Some important issues, such as the legal recognition of GPs should have been introduced at a much earlier stage.

The government also did not fully direct savings from infrastructure rationalization into primary health care. Most of the savings were apparently used for establishing a network of emergency hospitals, while a more general rationalization plan for inpatient care and for outpatient specialized care is still missing. Initial rationalization focused on the closing of beds, but staffing norms are still too high and inflexible. There was also some lack of progress in pushing through envisaged reforms crucial for full implementation at the oblast level, such as full pooling of funds. GPs are not yet legally recognized and therefore no adequate status or career perspective for the future GP's, including lack of adequate remuneration. This goes along with an apparent lack of human resources management capacity and tools and opting for increasing staff quantity instead of quality.

There were a considerable number of delays in procurement, owing to the slow and lengthy procedures for procurement of goods and services employed by the Ministry of Health and other agencies, such as AFER and the Ministry of Finance. The performance of the project procurement agent and distribution agent were below expectations, and led to the CPIB taking over a larger share of procurement activities than originally planned. This somewhat questions the role of a separate procurement agent. Furthermore, there are no sufficient provisions for funding a steady supply with lab reagents, supplies and drugs needed for the provision of quality health care.

There is some lack of clarity of roles of the Ministry of Health and other agencies, leading to efficiency losses, failure to enforce decisions, and a lack of supervision and leadership. For example, there is confusion about the exact tasks of the Republican Center for Licensing and Certification of doctors and pharmacists, which does testing of doctors and providing "attestation" which qualifies for higher grades of doctors or for staying at a certain grade level with corresponding salaries, and the role of MOH in providing licenses for doctors to work privately outside of the public system. Health II is supposed to help clarifying these roles and mandates. In the meantime, the current role of the center is comparable with what in other countries is done by licensing bodies: examining medical staff, thus providing for incentives to keep knowledge up to date and participate in continuous professional development.

The establishment of a comprehensive Health Management Information System has not yet been achieved. While the project did start with the establishment of computer centers at the rayon and oblast levels, the current system is insufficiently linked among the involved institutions, and is suffering from years of under-investment in its structure and systems. A lack of common standards, combined with insufficient training of specialists has impacted unfavorably on the development of a comprehensive system, and is only slowly being addressed through the project. A more comprehensive and thorough reform is needed to build an information system that will eventually satisfy the needs of decision makers.

5.3 Factors generally subject to implementing agency control:

Overall, project implementation conducted by the CPIB was done well. There were some deficits in the accounting and financial management system, impacting on accuracy and timely availability of financial information, but those were solved in the latter half of the project. Moreover, the CPIB's performance was at times affected by staff fluctuation, long vacancies and insufficient personnel capacity. Last but not least, overall monitoring and evaluation capacities were affected by a delay of almost 2 years to establish a baseline for the Project's M&E system.

5.4 Costs and financing:

Original costs for this project were estimated at US$m 69.8, with a planned IBRD contribution of US$m 30, and co-financing from other sources in the amount of US$m 3.34. Actual costs for the Health 1 project amounted to US$m 82.33, or 137% of the appraisal estimate, of which US$m 29.55 (98.5% of appraisal estimated) were disbursed from the loan. The increase in overall costs mainly resulted from a larger than envisaged coverage of the project, in particular with regard to the much higher number of SVPs reconstructed / rehabilitated and equipped under the project.

There were some problems during implementation with ascertaining the exact amount of counterpart funds for the construction and rehabilitation of SVPs. While the Government made a substantial effort in financing the SVP infrastructure exceeding original estimates, it is not completely certain whether the officially stated counterpart funding amount is completely accurate. Nonetheless, contribution was high and exceeded the estimated amount.

Excellent donor cooperation and coordination of project activities allowed the borrower to win DFID/KHF support for financing consulting services and training activities that were originally envisaged for Bank funding, particularly in components B and C. Hitherto, training of GP trainers was paid from DFID. Further support in the form of technical assistance services and training was provided by the USAID-funded ZdravPlus program, particularly in the area of quality assurance and establishment of the financing and management system.

Additionally, savings from the procurement of equipment through international tenders and by reducing the number of items on, and complexity of, the equipment list for SVP allowed the Borrower to equip more than double the number of SVPs than originally envisaged. A total of 653, as compared to the originally planned 266 to 320, SVPs were equipped under the project.

6. Sustainability

6.1 Rationale for sustainability rating:

On balance, sustainability is rated *likely*. The project is clearly owned and supported by the government, as was demonstrated with the continuation of primary health care reforms beyond the implementation of Health 1 into Health 2, and the efforts of the Government to establish a legislative basis for long-term improvement of primary care service delivery. The population accepts and uses primary care facilities, and

staff in the facilities appears to be dedicated and committed. Some challenges, however, do remain for the future. The government so far has been slow in committing all necessary resources for sufficient financing of primary care reforms, and especially for improving the remuneration of SVP doctors thus preventing the SVPs from becoming an attractive working place for family physicians. It appears that parts of the savings from rationalization of the infrastructure network were reinvested into emergency hospitals instead of primary health care facilities.

In addition to the Bank-financed operation, the ADB will support primary care reforms with the Women and Child Health Development Project, which is complementary to the Health 2 Project. This coordinated procedure will provide necessary investment into primary care to create sustainability in the medium term. The government, however, will need to show that institutional development started under Health 1 is fully sustainable in the long run, with continued adequate funding, legislation and enforcement during the Health 2 project. Specifically:

Component A: A network of upgraded and well-equipped SVPs was created in the pilot oblasts, and the Government is following its investment program to rehabilitate SVPs throughout the country, which will be equipped under Health 2. There are a number of issues that will have to be addressed under Health 2, such as regular maintenance and replacement of equipment after its useful life, and improvement in the supply of drugs and consumables, but overall the sustainability of this component is considered likely.

Component B: A cadre of trained professionals has been established and is now working in the pilot facilities. The project will continue with the training programs for doctors, and under the ADB loan, nurses to increase skilled workforce throughout the country. Health 2 will continue the work to fully institutionalize training programs and curriculum reform as well as licensing and accreditation of doctors.

Component C: The financial management system has been established in all SVPs covered by the program, and was refined and adapted during the roll-out. While the outputs and achievements of this component have been generally satisfactory and path-breaking for the introduction of a more needs-oriented financing system, a number of challenges remain for Health 2. This refers particularly to deployment and retaining of staff, especially financial managers, at SVPs. Financial incentives and salaries are still too low to make the employment attractive, particularly in more urban areas. Furthermore, the overall financial situation of primary health care needs to be improved further, and pooling of funds at the oblast level needs to be fully implemented. Training of financial managers also will continue and need to be fully institutionalized during Health 2.

Component D: This component has established satisfactory and skilled managerial capacities for project implementation in the CPIB, which will been extended under Health 2 to also manage implementation of the ADB WCHD project. The M&E system developed for Health 1 is in operation and will be further developed into a comprehensive health management information system. However, integration of these capacities into the Ministry of Health and mainstream work in the health sector remains an issue that should be addressed in the context of the nation-wider roll-out under Health 2.

6.2 Transition arrangement to regular operations:

While it was clear at the outset that comprehensive health care reform require more than the planned project duration of four years, the project from the beginning was designed as a pilot to test approaches that would possibly be rolled out during a subsequent operation if successful. Keeping this in view, institutional strengthening and capacity building was started through a network of training schools and curriculum development in the pilot oblasts. The Bank's policy dialogue concentrated on creating awareness, and sensitize policy makers to learn from international experience and lessons learnt in the Former Soviet Union

(Estonia) as well as in Western Europe, particularly the UK, where the GP model has been successfully implemented. Implementation of the reforms has by now gained sufficient momentum, and initial expectations that primary health care reforms will be rolled out and implemented at the national level have been confirmed by the Government of Uzbekistan requesting further Bank assistance. The Health 2 project, which has just started implementation, is the appropriate vehicle to institutionalize reforms and create a sustainable primary health care service provision and financing system within the envisaged time frame. It will, however, require the continued efforts of the government to follow prudent fiscal policies and to maintain its commitment for sufficient budget funding for primary health care. Otherwise, medical students will not choose to be trained as family physicians (FP) and trained FPs will opt for other career perspectives.

7. Bank and Borrower Performance

Bank

7.1 Lending:

While the ICR rates Bank performance at lending as *satisfactory*, the team would have preferred to rate it as marginally satisfactory, had it had the possibility. The project took a relatively long time to prepare. Starting from the initial dialogue in 1993, it took five years for the Project to be presented to the Board. Given the early experience with lending and projects in ECA the approach to pilot-test interventions were correct, though smaller and more time-bound pilots could have led to a faster roll out over the rest of the country. The Bank cooperated extensively with other donor organizations, particularly DFID and USAID, which helped to address the Government's resistance to borrowing for technical assistance and allow for sufficient consulting services and training to support investment in infrastructure. However, especially because of this long preparation period, the Bank could have made a more comprehensive diagnosis of all the defining elements in the health care sector and could have paid attention to the need to rationalize the system of secondary and tertiary care as to make its investments in PHC sustainable. It could also have done a more thorough review of the public health (protection) system (SANEPID). Mental health has also not been a topic. The same holds for the upcoming HIV/AIDS epidemic. Furthermore, although the Bank did see the need for a public information strategy to prepare the general public as well as the health community for the changes, there was no adequate vehicle and understanding of the client to create a comprehensive public information framework.

7.2 Supervision:

The Bank carried out regular supervision missions. The Bank's supervision team comprised a good mix of specialists attending to technical as well as project management, financing and procurement issues. Although there have been some changes in the team, there was *grosso modo* continuity on the side of the Bank, which is seen as beneficial for project implementation. Furthermore, the Bank emphasized technical and policy dialogue throughout project implementation, which was an important factor in maintaining a good and cordial working relationship with the government in the light of its reluctance to borrow for technical assistance. The Bank also showed flexibility in its approach by agreeing on providing assistance (in the form of vaccines and emergency medicines) to the drought stricken areas as well as by agreeing to covering two more Oblasts then originally planned. The use of UNICEF for the procurement of vaccines and drugs has proven to be an effective action which could be replicated during Health II with the planned procurement of equipment. Furthermore, the Bank put much effort into organizing technical assistance, policy dialogue and technical discussions during project implementation, which is deemed to have had a positive impact on shaping government views. One example was support to the international conference on family medicine in 2002, which was supported by the project and the Government, and was a good regional forum for debate and expert exchange. The Bank, however, did not manage to get more sustainable and increased funding for the primary care sector and a more steady supply of drugs, lab reagents and other

supplies.

7.3 Overall Bank performance:

Overall Bank performance is rated as *satisfactory* as it managed to flexibly react to changing circumstances and needs and was realistic in its expectations about what can be done in the country context.

Borrower

7.4 Preparation:

The Government's performance at preparation is rated *satisfactory*. The project took a long time to prepare, and the government initially focused on project alternatives which were deemed either unsustainable or for private investment by the Bank. Also, administrative difficulties such as pending government clearances of the Negotiations team to travel to Washington for several months did cause further unnecessary delays in preparation. Having said this, the Government did support investment on primary health care development once the legal framework was enacted in 1996. However, the issue of outdated norms for infrastructure investment is seen as not having been addressed adequately, and attempts to downsize the structural layout of facilities to improve long-term sustainability was not supported by the Government. The Government did make efforts to win sponsors for the construction and rehabilitation of health facilities in areas where government budget was insufficient, which the ICR considers as a positive sign of government commitment.

7.5 Government implementation performance:

Government performance at implementation is deemed as *marginally satisfactory*, however, the ICR is limited to rating the performance as *satisfactory*. There were a number of problems during implementation, particularly with regard to procurement and management due to the number of different agencies and ministries involved. The project started off from a weak institutional basis, and facilities and structures for adequate implementation management were not established at the anticipated speed. Many petty legislative and regulatory issues also inhibited using the full capacity of the Central Project Implementation Bureau, as staff time was tied up with solving institutional issues rather than implementation tasks. The Government furthermore insisted that Uzmedtechnica and Uzmedexport be involved in the Project as Procurement Agent and Distributor. While the Bank generally supported this move to ensure that existing capacities in the country be used to the extent possible, it appeared that the regulatory framework and cooperation among the government institutions was weak and often conflicting. Procurement services were reorganized several times during implementation, with the CPIB taking over an increasing workload for the preparation of bidding documents and procurement for consulting services from Uzmedexport a year into the project. Interference by AFER, the Agency for Economic External Relations, in the procurement process to conduct so-called "price verification" after the award of contract threatened to violate the Bank's procurement rules, and unnecessary delayed the procurement process on a number of occasions. The Bank also warned the government on a few occasions that investigations regarding potential misprocurement would have to start if such behavior continued. With regard to the project content and planned activities in Component A, the government did not follow through the Bank's request and efforts to establish a public information campaign, and the area of further developing public health capacities and systems is neglected in comparison to investment in hardware, equipment and facilities.

7.6 Implementing Agency:

Performance of the Central Project Implementation Bureau, the Ministry of Health's implementation agency, is rated *satisfactory*. The CPIB did manage to build substantial capacity in the technical conduct and shaping the policy dialogue surrounding the project. The component coordinators were generally skilled specialists who championed the technical discussion in their area of expertise. In this way, the CPIB

compensated a general lack of these skills in the Ministry of Health itself. Likewise, although there were a number of delays leading to lengthy procurement and financial management procedures, the CPIB has established capacity in these areas to further project implementation. On a more general note, the implementing agency's performance was impacted by interference form outside agencies and, in the last year of the project, by a personnel change in the Ministry of Health.

7.7 Overall Borrower performance:

Overall borrower performance is rated *satisfactory*, with performance during implementation at the oblast levels and of the CPIB being somewhat higher than performance of the Ministry of Health and other high-level government agencies.

8. Lessons Learned

Critical approach to pilots. Pilot projects are necessary and useful to test new ways of doing business. However, the objectives, questions or implementation issues to be answered and tested, the scope of such activities, expected outcome and the political willingness to accept and support these outcomes with a view to overall regulatory and macro-economic conditions should be carefully assessed at the outset, and re-confirmed during piloting. The experience with the Health 1 pilots points at the need to limit the scope and time-frame of such activities to prevent divergence of the health system in general. While investment in primary health care allowed the Government to re-direct savings to other levels, the Government did not fully follow-through and deviated savings into emergency hospitals instead of further rationalization. Thus if the complex links are not taken into account carefully, pilot approaches may not yield representative results. In addition, general systems performance needs to be considered, too. The pilots under Health I had more the character of a gradual roll-out of especially the SVP and GP models than really testing different service models in search of answers to specific questions. There is a tendency that different approaches within a system create confusion in the administration. A bi-furcated system pertaining over several years does also create a potential for deeper systemic imbalances and may lead to unequal provision of services to the population country-wide as well as create confusion among the health professionals about their future and what to aim for in their careers.

Impact of decision-making processes and commitment of the Government on project success. In the current government set-up, line ministries have a very limited role in decision making. The Ministry of Health is not actively involved in the policy debate, which is led by the Cabinet of Ministers and the Presidential Administration. This impacts unfavorably on the Ministry's capacity to influence policy decisions and technical discussions in support of coherent reforms. Organizational weaknesses in the government apparatus and public administration also impacted unfavorably on synchronization of project activities and the timely provision of counterpart funding, which are crucial for project success. There is a need to enact a comprehensive legal framework across government institutions with a view to ensure sustainability. In addition, better cooperation among the ministries and agencies directly involved in project activities, such as the Ministry of Health, Ministry of Finance, AFER, Uzmedtechnica and Uzmedexport, is important for efficient governance. Different, and often conflicting, strategies, regulations and directions followed by these institutions do at present limit the impact of changes initiated by the project. Likewise, there is the need for consistency once a certain direction and model of health care have been chosen. This is especially apparent in the lack of clarity about the future position of pediatricians in primary care.

Importance of government perseverance for prudent spending and comprehensive sector financing versus incomplete reforms. The Government re-directed some of the savings from rationalization into emergency care instead of using the opportunity to address the overcapacity and duplication in the system of secondary and tertiary care. The Bank should have either negotiated a more comprehensive approach to

health care reform before the start of the Project, or could have used adjustment lending to set the proper conditions for such reforms. Taking into account the situation in the country context at appraisal, however, the ICR understands that the frame conditions at the time of preparation were difficult and characterized by strong donor competition with 'easy money'. Also, at that time the Human Development sectors had a more difficult standing vis-à-vis macro-focused operations in the Bank. Incentives for re-trained staff to stay in the sector (low pay, little incentives and options to improve work environment for trained staff) as well as a perspective for the GP trainers were and are still lacking.

Need for comprehensive and systemic planning to improve management and efficiency of infrastructure investment. Further improvements need to be made in coordinating different government organizations involved in health care and support service delivery. The lack of planning for drugs, lab reagents and other consumables led to absence of drugs in some SVPs as well as to lab equipment standing idle. Uztibtechnica, the agency in charge of delivery, installation and maintenance of equipment provided to SVPs and corresponding supplies, has not yet established sufficient monitoring, manpower and follow-up mechanisms to guarantee timely installation and regular maintenance of equipment. This is a major factor limiting the efficient and effective use of equipment provided. Furthermore, the government's capabilities to conduct comprehensive health technology assessment before making major investment decisions needs to be strengthened, to ensure that services are provided with the help of efficient and effective technology, and should be more cautious in deploying high-tech solutions to rural areas, where use and maintenance of such equipment continues to be problematic.

Framework for effective Monitoring & Evaluation. A lack of back of baseline data at the beginning of the project impacted unfavorably on monitoring capacities. The project would have benefited from an earlier development of focused indicators and regular evaluation of data. On a positive note, the project design originally envisaged a facility survey taking into account comprehensive qualitative and quantitative output and outcome evaluation at mid-term review from the beginning, but this survey was eventually delayed until almost the end of the project. Due to a lack of usable information, the project was therefore not in a good position to provide the information required for thorough evaluation and to influence decision making at the higher government levels. However, the early creation of information support systems and structures is crucial for sustainability and setting the policy agenda at an early stage. As a lesson for the Bank, emphasis should be placed on following through with agreed loan conditions, and on acting early on non-compliance with establishing a M&E system.

Integration of project management functions into line ministries. More emphasis should also be given to long-term sustainability of investments in project management staff, and to integrating this staff as much as possible and as soon as feasible into the ministries and/or their regular, permanent implementation agencies. This requires the Ministry of Health to take a more active role in M&E as well as at the same time to improve its general capacity for policy analysis. At the end of Health 1, the CPIB has built valuable expertise which would be lost if the Ministry does not manage to develop a strategy to integrate project management functions into the regular government set-up in M&E and technical departments. Such integration should take place in the overall context of government reform as issues such as low payment and lack of appropriate staff incentives do seem to be major obstacles to strengthening the government's policy making capacity.

Better integration of and efficiency gains from information systems. Computer centers at the rayon level basically conduct census tasks that would be better managed by the rayon administration in line with general statistics and government information needs. Although the ICR acknowledges the need for accurate population data as the basis for a capitation-oriented payment system, this work seems to duplicate tasks that should be the prime responsibility of local authorities and the census bureaus. Hence the collection,

verification and processing of such data should be conducted by the general rayon administration and not the rayon health administration. This will require better coordination of various branches of the rayon and oblast administration.

9. Partner Comments

(a) Borrower/implementing agency:

Brief Information
On the Outcomes of Implementation of IBRD Project "Health I"

According to the Loan Agreement # 4396-UZ between the Republic of Uzbekistan and the International Bank for Reconstruction and Development (IBRD) Health I Project is being implemented in the Republic of Karakalpakistan, Fergana, Syrdarya, Navoi and Khorezm oblasts and aims to strengthen and reform primary health care. The Republic of Karakalpakistan and Khorezm oblast were included into Health I Project in March 2003 in compliance with the Amendment to the Loan Agreement owing to the funds saved without increasing liabilities of the Republic. IBRD had extended the Loan Closing Date till 30 June 2004.

1. Strengthening Primary Health Care Services

The following main initiatives are being implemented under this component:
(a) furnishing with medical equipment and medical consumables of 677 rural medical centers (SVPs) that totaled 253% of the initial plan (266), 115 FAPs or 92% (125), 59 laboratories of central district hospitals (CDH) or 188% (32). In the context of regions, in particular:

Regions	SVP number	FAP number	Number of Laboratories at CDH
Republic of Karakalpakistan	108	0	12
Fergana oblast	214	0	16
Syrdarya oblast	121	22	10
Navoi oblast	89	93	9
Khorezm oblast	121	0	12
Samarkand oblast	20	0	0
Tashkent oblast	2		
Bukhara oblast	2		
TOTAL	677	115	59

(a) Radio communication equipment in Navoi and Syrdarya oblasts between SVPs, FAPs located at the hardly accessed areas, and regional, district and national emergency centers was installed and the works completed in 2003. There were established 115 radio stations, including 95 fixed stations (Tashkent city - 1, Navoi - 55, Syrdarya - 39) and installed 20 mobile stations in the vehicles (Navoi –16, Syrdarya - 4).
(b) 70 units of high pass vehicles of UAZ model were supplied to remote SVPs in pilot regions and

CDH of the Republic of Karakalpakistan and Khorezm oblast, as well as to the Institute of Health and its three branches in Fergana, Navoi and Syrdarya oblasts. 26 vehicles for Fergana, Navoi and Syrdarya obalsts are to be procured by the end of the project. See the following vehicle distribution by the regions:

Regions and institutions	Number of vehicles
Republic of Karakalpakistan	17
Fergana oblast	9
Syrdarya oblast	10
Navoi oblast	18
Khorezm oblast	12
Institute of Health and its three branches in pilot regions	4
TOTAL	70

(a) Emergency medical supplies, Hepatitis B vaccines with self-destructive syringes, obstetrics instruments, X-ray films, anesthesia apparatus, ESG set, reagents for laboratories of KKP and Khorezm oblast for the total amount USD $2.1 mln were supplied according to the Government's request to the World Bank regarding assisting the regions with low water.

(b) Moreover, the Institute of Health, established with the project's support, had conducted the program on introducing the European Health Schools system in Uzbekistan to teach the growing generation at schools to healthy life-style. Training workshops for teachers and directors of the pilot schools from five regions, training tour to Scotland, drafted and published methodological materials in the Russian and Uzbek languages were organized with the participation of the WHO experts. The Institute of Health had also published booklets to work with the population on preventing frequently occurred diseases and rendering first pre-doctor care, six editions of informational bulletins for population on prevention of tuberculosis, flu, atypical pneumonia, enteric infections and viral hepatitis.

(c) The program on management of quality of health care services was carried out with the support from ZdravPlus Project (USAID) in Uzbekistan. There was established the Working Group on management of quality of health care services at the Ministry of Health. Experimental works at SVPs in Fergana oblast were completed; the evidence-based medical center was established; the personnel were trained. The standards on prevention and treatment of anemia, arterial hypertension and IMCI were prepared based on the updated technologies.

2. Training of General Practitioners and Universal Nurses

The State Program of Health Care Reforms envisages the amendment of curriculum for medical personnel training including those for primary health care facilities. The core element in primary healthcare reforms is the training of GPs and nurses as the main supplier of health care services.

The following initiatives were carried out to achieve these objectives:

(a) 14 training centers at medical higher institutes or 140% of planned number, 8 training SVPs instead of 5 planned (160%) and 15 medical colleges (schools) or 214% of the initial plan (7) were furnished with medical and training equipment.

(b) Jointly with the international experts there was developed a 10-month (1 academic year) training program on training the teachers of medical institutes and SVP physicians as GPs. These curriculum was reviewed and approved by the Ministry of Health and the Council on Coordination of

Qualification Improvement and Re-training under the Ministry of Higher and Secondary Special Education of the Republic of Uzbekistan. Teachers were mainly trained by British trainers at the expense of DFID grant. The internet site with training program and other information on GPs training was established with the technical assistance of DFID.

(c) The following number of GPs was trained at special training courses:

- 105 teachers of medical higher institutions or 164% of the planned number (64), out of them 38 were included into the list of Honorable Teachers of the London University. One of the teachers was elected as a member of editorial board of "International Medical Magazine" issued in the UK. All 105 teachers had a 2-week probation in the Great Britain and Estonia.
- 959 GPs of SVPs and municipal policlinics or 480% of the planned number (200), out of them 96 had passed probation in Estonia. The employment of the trained specialists in the context of the regions looks as follows:

Regions	SVP	Municipal polyclinics
Republic of Kakrakalpakistan	20	5
Fergana oblast	279	5
Syrdarya oblast	150	-
Navoi oblast	197	-
Khorezm oblast	21	4
Andijan oblast	37	3
Bukhara oblast	15	5
Djizzakh oblast	37	-
Kashkadarya oblast	15	-
Namangan oblast	37	-
Samarkand oblast	15	11
Surkhandarya oblast	35	-
Tashkent oblast	40	-
Tashkent city	-	28
TOTAL	898	61

(d) More than 1500 SVP GPs are covered by the program of continuous medical training within the framework of Health Project and support of ZdravPlus and HOPE (USAID) projects. This initiative was conducted through short-term courses on WHO standard program such as "Integrated Management of Children Diseases", "Efficient Medication (Drugs) Use", "Reproductive Health". In addition, two editions of GP bulletin to advance GPs qualification were issued.

The program on continuous medical training also covered 599 nurses on 4-week training courses. The guidelines on nursery teaching were worked out based on the latest pedagogical technologies.

(e) The work on improvement of curriculum of undergraduate medical education for GPs, implementation new teaching technologies and students' knowledge assessment, evidence-based medicine training were carried out under DFID technical assistance and experts of medical institutes.

(f) The center on licensing of physicians and pharmacists, the commission on curriculum accreditation were established. These institutions are furnished with appropriate office and computer equipment; the informational system for licensing of physicians and pharmacists and the database of registering physicians was developed.

(g) Standards on diagnostic and treatment of the most frequently occurring diseases were developed jointly with the WHO experts at primary health care level. These guidelines were approved by the Ministry of Health, translated into the Uzbek language, published, replicated and sent to SVPs in pilot regions and those with low water.

Moreover, two editions of GP bulletin to advance qualifications of physicians were issued within the framework of the project. 27 types of booklets were drafted and published with total circulation of 270 000 copies. They contain the basic principles of prevention and rendering first aid against frequently occurring diseases.

3. Financing and Management of Primary Health Care Services

According to the terms of the Loan Agreement and the Resolution of the Cabinet of Ministers of the Republic of Uzbekistan «On Implementation of the Project on Reforming Primary Health Care Services in Fergana Oblast», dated 5 March 1999, · 100, the actions on introducing new methods and mechanisms of financing and management of the establishments of primary health care (PHC) are being carried out in the project regions of the republic.

Originally the given component of the project was realized only in three pilot areas (Besharyk, Kuva, Yazyavan) in Fergana oblast, the achieved results of which were compared with the state of establishments in the adjoining control areas of the same oblast. Taking into account positive results of the given component, according to proposal of the Ministry of Health and the Ministry of Finance of the Republic of Uzbekistan and a permission of the Cabinet of Ministers of the Republic of Uzbekistan, the pilot arrangements have been spread over all areas of Fergana, Syr-Darya, Navoi oblasts and over pilot areas (by 3 rayons) in the Republic of Karakalpakstan and Khorezm oblast.

The basic directions of the reforms being carried out are the following:

(·) granting a legal status to the establishments of primary health care;
(b) transfer of financing of these establishments from rayon into provincial budgets;
(c) determining a budget of an establishment stemming out from the number of the population attached to the establishment and the size of per capita ratio in view of correcting sex-age rates;
(·) carrying out of financing by means of one sum on monthly basis at the rate of 1/12 of the annual budget of establishments;
(·) provision of these establishments with qualified financial managers.

The following arrangements were carried out in relation to this component:

· 635 establishments of PHC received legal independence;
· 19 information centres were organized and equipped with modern computer

equipment and 28 more information centres would be equipped before the end of the current year;

- 13 seminars were conducted for 390 representatives of khokimiats, heads of departments of public health care, financial departments and other state bodies, regarding provision of explanations of the goals and tasks of the project;
- 23 training courses were conducted, where 678 financial managers were trained and prepared.

That allowed:

1. To ensure the principle of fair distribution of budgetary funds on the basis of per capita;
2. To liquidate a residual principle of financing of the activity of PHC establishments;
3. To provide equal access by the population to services of PHC establishments;
4. To improve medicinal provision of the population at the level of SVPs;
5. To transfer to a more efficient system of financing based on the number of the serviced population, instead of the old methods of financing based on capacities of establishments (number of personnel, area of an establishment and etc.);
6. To increase the budgets of establishments of primary health care owing to rationalization and reduction of expenditures for the secondary (hospital) health care services. For example, in Fergana oblast the relative share of expenditures for the primary health care services increased from 13.6 % in total expenditures for health care services up to 24.3 % in 2003, the uniform per capita ratio increased from 367 Soums in 1999 up to 1,615 Soums in 2003;
7. To direct more resources for servicing of women and children owing to application of sex-age ratios, while defining budgets of PHC establishments;
8. To optimize (to rationalize) the structure of expenditures of budgetary funds. For example, the share of expenditures for the salary of personnel was reduced from 56.3 % in 1999 to 54.8 % in 2003, and expenditures for medical products within the same period increased from 5.2 % up to 6.2 %. The share of the inefficient expenditures, connected with payment of benefits for children up to 2 years old, has decreased.

4. Project Management and Monitoring of Results

As of 12 October 2004 the amount of USD $29.1 mln. has been contracted out of allocated USD $30 million, from which USD $27,387 million have been paid out. The remaining funds in the amount of USD $ 0.9 mln represent the economy of loan funds, which would be used during the process of international shopping for procurement of medical equipment, instruments, automobiles and other goods for SVPs and Central District Hospitals of the project areas.

For duly supervision and tracking of the process of implementation of the project and evaluation of impact to the sphere of concrete reforming of primary health care services, the project has developed a monitoring and evaluation scheme. Conditionally the indicators of monitoring of the project have been divided into two blocks. The first block reflects quantitative changes as increase in number of SVPs, trained physicians, medical nurses and financial managers. The second block generates information on the process of investments by the project and its impact on the efficiency and quality of health care services and health of the population. According to the project goals the Integrated Indicators of project activity have been divided into four blocks:

A. Efficiency of health care services;

B. Accessibility of the population to health care services;

C. Quality of health care services;

D. Sustainability of PHC reforms.

The integrated indicators of project activity have been developed by the oblast Project Implementation Bereaus jointly with oblast Statistics and Information Bureaus on the basis of the database of the state and branch reporting. The base indices of the integrated analysis cover all SVPs of the pilot areas. But part of the indices, reflecting a state of health and quality of health care services, is compiled throughout the oblast territory.

Indices	Fergana oblast			Navoi oblast			Syr-Darya oblast		
	1998	2003	(+/-)	1998	2003	(+/-)	1998	2003	(+/-)
Crude death rate (per 1000 persons)	5.7	5.2	- 0.5	5.8	5.8	0	5.7	5.2	- 0.5
Infant mortality rate (per 1000 liveborn infants)	22.3	19.2	- 3.1	22.2	16.5	- 5.7	22.2	16.2	- 6.0
Number of visits per one SVPs (thousand persons)	9.9	17.0	+ 7.1	9.0	18.7	+ 9.7	7.6	10.7	+ 3.1
Number of patients' referrals from SVPs to consult with CDH (thousand persons)	34.0	21.7	- 12.3	19.0	15.9	- 3.1	22.5	11.6	- 9.9
Number of hospitalization of patients from SVPs in CDH (thousand persons)	11.0	7.8	- 3.2	14.0	13.0	- 1.0	14.0	7.8	- 6.2

A. Efficiency of Medical Services

One of the major task of the Project "Health" and the whole complex on reforming of financing and management consists in evident demonstration of that how new SVPs can successfully achieve reduction in frequency of unnecessary refferals to hospitals and district clinics owing to availability of appropriate financial stimulation and self-management of SVPs. By predicting possible variants of demand in health care services, it was supposed that the initial stage of improving of health care services would lead to revealing of diseases that could cause a demand for hospital care and an increase in hospitalization and only than in the process of enhancing sustainability of the reforms of primary health care services it was supposed to achieve a decrease in number of referrals to and hospitalization in hospitals.

At this stage we have the following information:

1. The number of visits of the population to SVPs has an obvious tendency to increase. So, in Fergana oblast the number of visits to SVPs increased in 6 times in 2003 in comparison with 1998, in Navoi oblast - in 10 times, and in Syr-Darya oblast - in 2.5 times. These figures indicate an increase in volume of health care services rendered to rural population and as a result an increased trust of the population to the work of General Practitioners.
2. In the pilot oblasts there is a positive dynamics of increase in the number of prophylactic visits that is also a positive result of the work of GP physicians, who were trained by the Project "Health".
3. In comparison with 1998 the number of home visits to patients by medical staff has increased,

connected with activization of home nursing and treating patients at home. However, not in all areas the SVP's personnel pay attention to the questions of home nursing of the population, therefore there is a significant difference between the pilot areas, so in Syr-Darya and Fergana oblasts the number of visits at home makes up 9 and more percent, whereas in Navoi oblast it does not exceed 1 percent. In other regions these indicators constitute 16.4 and 34.9 %.

4. The indicators of referrals to consultations and hospitalization of patients from SVPs to the Central District Hospitals are rather convincing in Fergana and Syr-Darya oblasts. In Fergana oblast the number of referrals for consultations to CDH has decreased in 1.5 times, the number of hospitalization of patients from SVPs has decreased in 1.3 times. In Syr-Darya oblast these indices have accordingly decreased in 1.8 and 3.8 times. A similar situation is observed in other regions covered by the project.

5. The adjusting indicator that allows to evaluate the realism of previous indices is the number of visits to FAPs. Traditionally the previous system of health care in villages was characterized by the fact that up to 70 % of rural residents received the first aid from a primary health worker at FAP and the share of visits to FAPs prevailed in the volume of services in rural health care services. Development of SVPs, their equipment with modern equipment and training of SVPs personnel to a general medical practice should have attracted and made accessible the health care services to rural population at SVPs, therefore it could be possible to forecast a decrease of the number of visits to FAPs. The index of the number of visits to FAP was introduced to the monitoring scheme for comparability. In all three oblasts there is a decrease in number of visits to FAPs and an increase in number of visits to SVPs. However, the given index requires further clarifications, because during the last years a lot of medical assistants' centers have been closed in three pilot oblasts, that could also affect the index showing a decrease in number of visits by the population to FAPs.

6. During the last years day patient facilities were opened in all SVPs, where patients could receive treatment. But, because the majority of SVPs did not have a sufficient set of medicines and equipment, they were inattractive for the population. Equipping of SVPs with the basic set of diagnostic and treatment equipment and provision of medicines for rendering emergency care facilitated a substantial increase of the number of treated persons in the day patient facilities of SVPs.

7. However, provision of SVPs with medicines remains insufficient and the majority of SVPs note in their reports a deficiency of medicines. An exception is represented by the pilot areas in Fergana, Navoi and Syr-Darya oblasts, where carrying out of the financial experiment and introducing of the new financial mechanism has allowed SVPs to make independently procurement of medicines and 279 SVPs have stated that they have sufficient sets of medicines.

8. All SVPs of pilot oblasts have stated that they have clinical reports approved by the Ministry of Health regarding the most important diseases and use new schemes of treatment.

B. Accessibility of Health Care Services to Rural Population

To provide a characteristic to this section the following indicators have been selected, such as percentage of the population residing in the radius of 1.5 km from SVPs and an average number of the serviced population by one physician and one medical nurse. However, an average radius of servicing by SVPs in pilot oblasts makes up 8-10 km, the exception is Fergana oblast, where there is a high population density, a big number of SVPs and the radius of servicing is 2-3 km. Thus, this indicator is not indicative for the evaluation of the project results.

The number of the population being serviced by one physician and one medical nurse has been reduced and can positively characterize the process of development of SVPs in relation to ensuring accessibility to medical services.

C. Quality of Health Care Services

The main result of the project should be reduction of morbidity and mortality of the population that, from the point of view of human resources, will increase value of labor force, residing in the territory of the pilot areas, and will undoubtedly bring an economic benefit to the state. However, to achieve it during a short period of project implementation is impossible, since a long enough period of time is required for obtaining some real results and only in the long-term prospect it will be possible to evaluate an economic value of life sustaining and prevented diseases. Moreover, improvement of quality of primary health care services can entail a duly examination and diagnostics of incidence of diseases and as a consequence at the initial stage it can lead to an increase in the number of diagnosed diseases with their further reduction.

While forming the indicators of quality, a certain group of diseases has been selected, which depends on a real impact of the project and represents the basic share of burden of morbidity of rural population, namely infectious diseases (diarrhea, tuberculosis, acute respiratory diseases), maternity and childhood pathology and chronic diseases (ischemia, asthma, diabetes, and etc.).

Infectious diseases

In all pilot oblasts there is a tendency of decrease of infectious diseases, including diarrhea, acute respiratory diseases, syphilis. However, tuberculosis sickness rate remains high and in a number of regions it has a tendency to increase (Fergana, Khoresm, Republic of Karakalpakstan).

Health of women and children

The State Program of Strengthening Health Care Services in Uzbekistan has highlighted the protection of health of women and children as the priority tasks. The program propagates a use of safe technology of aborning, care for newborns, breast-feeding, improvement of women's health and their preparation for delivery and postnatal care. The same issues have been highlighted among the base issues by the Project "Health". A lot of time is devoted to the improvement of knowledge and skills of medical workers on motherhood, prenatal, neonatal and infant health services in the ten-months program of training of GP physicians.

A special attention is also paid by the project to the new approach, developed by WHO and UNICEF on treatment, prophylactics and health improvement of children (IMCI – Integrated Management of Children Diseases), wide application and introduction of early breast-feeding, early medical recording of pregnant women and a methodology of regular supervision of pregnant women, prenatal preparation and postnatal health improvement of women and carrying out of timely vaccination of children.

D. Monitoring of Supervision over Carried Out Arrangements has revealed some achievements in this sphere:

The percentage of children, who received complete set of vaccination in pilot oblasts, makes up 97 - 99 %. A similar situation on breast-feeding of infants at the age of before one year old and the data for two years show an obvious tendency of improvement, that could be evaluated both as a contribution of the Ministry of Health, that is traditionally engaged in the issues of breast-feeding and carrying out of vaccination, and as the contribution of GP physicians, who were trained by the project and pay a significant attention to prophylactic arrangements in their work.

The recording of pregnant women, taken under supervision by SVP's physicians during the early terms of pregnancy in pilot oblasts, has increased and made up 83.7 % in Navoi oblast and up to 98.8 % in Fergana oblast. A probable consequence of it was a decrease of the quantity of complications during pregnancy. For example, the toxicoses of pregnant women with a hypertension decreased to 1.7-4.7 %, except for Navoi oblast, where toxicoses of pregnant women constituted 7.1 % However, anemia of pregnant women remains high and most likely depends not only on a level of health care services, but also on other factors. The project should further ensure that a role of the medical personnel becomes more active and they

develop a preventive program of measures against anemia, as well as pay a special attention to sure nutritional level with women and children.

Chronic diseases

The monitoring and control of prevalence of chronic pathology among rural population can not really reflect the contribution of the project, because sustainable results could be evaluated at a later stage of project implementation. As a whole the received information specifies correctness and significance of directions and requires further concentration on efforts of the project towards chosen directions. At present the inspection of SVPs was conducted and the end results of special inspection confirmed a positive impact of the project on improvement of quality of health care services and health of the population.

E. Sustainability of Primary Health Care

The project envisages opportunities to increase economic efficiency and reduction of the cost of expenditures for medical servicing owing to transfer of resources and services from hospital care to outpatient care.

(b) Cofinanciers:
N/A

(c) Other partners (NGOs/private sector):
N/A

10. Additional Information

Annex 1. Key Performance Indicators/Log Frame Matrix

Outcome/Impact Indicators:

Indicator/Matrix	Projected in last PSR[1]	Actual/Latest Estimate		
			2004	change from 2001 to 2004
Number of visits per SVP	The objective to increase productivity at SVPs is not specified in numbers	Ferghana	4,408	166%
		Navoi	2,360	124%
		Syrdarya	1,987	66%
		Khorezm	1,802	24%
		Karakalpak Republic	1,139	41%
Number of referrals from SVP to CRH for consultations	Decrease referrals to specialists as % of visits by 15%	Ferghana	18,640	-18%
		Navoi	17,843	33%
		Syrdarya	10,586	-92%
		Khorezm	8,700	20%
		Karakalpak Republic	8,067	15%
Number of hospitalized from SVP	Decreases in admissions not specified in numbers	Ferghana	7,722	-8.6%
		Navoi	12,820	-4.1%
		Syrdarya	6,496	-22.4%
		Khorezm	11,100	9%
		Karakalpak Republic	12,809	320%
Percentage of pregnant women visiting a doctor during the first 3 months of pregnancy	The target increase not defined in numbers	Ferghana	90.6	3.1%
		Navoi	94.5	0.4%
		Syrdarya	90.2	0.2%
		Khorezm	93	2.2%
		Karakalpak Republic	88.7	-0.2%

Output Indicators:

Indicator/Matrix	Projected in last PSR[1]	Actual/Latest Estimate								
			1998	1999	2000	2001	2002	2003	2004	Total
To improve access, quality and cost-effectiveness of health services										
1. Construction of SVPs	Total 266-320	Ferghana	44	30	35	45	60	0		*214*
		Syrdarya	65	31	8	11	6	9	5	*135*
		Khorezm	61	6	11	10	6	32	10	*136*
		Karakalpak Republic	37	18	6	19	16	12		*108*
		Total	*237*	*95*	*82*	*100*	*101*	*65*	*30*	**710**
2. Equipment of SVPs	Total 266-320	Ferghana			74				140	*214*
		Navoi			40				49	*89*
		Syrdarya			96				25	*121*
		Khorezm							121	*121*
		Karakalpak Republic							108	*108*
		Total			*210*	*0*	*0*	*0*	*443*	**653**
To develop new cadre of GPs										
1. Organization of training centers	5-6	**Total** 14 GP training centers, 8 training SVP and 15 medical colleges	3	6	1	0	0	1	4	
2. Trained GPs	264	From pilot oblasts			123	130	149	158	66	*626*
		From non-pilot oblasts			0	0	0	38	234	*272*
		Total GPs trained			*123*	*130*	*149*	*196*	*300*	**898**
To improve management and efficiency of delivery services										
1. Number of legally independent PHC facilities receiving financial resources through their own bank accounts (out of total number of the PHC facilities) in the pilot rayon	100% pilot primary care facilities in 9 selected rayons in oblasts of Ferghana, Navoi, and Syrdarya.	Achieved in all pilot oblasts.								

[1] End of project

Annex 2. Project Costs and Financing

Project Cost by Component (in US$ million equivalent)

Component	Appraisal Estimate US$ million	Actual/Latest Estimate US$ million	Percentage of Appraisal
Primary Care	55.36	71.38	128.93
GP and UN Training	6.74	7.35	108.96
Financing and Management	4.09	2.04	49.99
Project Management	1.61	1.57	97.26
Unallocated	2.00	0.00	0
Total Baseline Cost	69.80	82.34	
Total Project Costs	69.80	82.34	
Total Financing Required	69.80	82.34	

Project Costs by Procurement Arrangements (Appraisal Estimate) (US$ million equivalent)

Expenditure Category	Procurement Method[1] ICB	NCB	Other[2]	N.B.F.	Total Cost
1. Works	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	27.60 (0.00)	27.60 (0.00)
2. Goods	20.30 (19.40)	0.00 (0.00)	4.20 (3.85)	4.10 (0.00)	28.60 (23.25)
3. Services	0.00 (0.00)	0.00 (0.00)	5.50 (5.30)	2.00 (0.00)	7.50 (5.30)
4. Other	0.00 (0.00)	0.00 (0.00)	1.60 (1.45)	4.50 (0.00)	6.10 (1.45)
5. Miscellaneous	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)
6. Miscellaneous	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)
Total	20.30 (19.40)	0.00 (0.00)	11.30 (10.60)	38.20 (0.00)	69.80 (30.00)

Project Costs by Procurement Arrangements (Actual/Latest Estimate) (US$ million equivalent)

Expenditure Category	Procurement Method[1]				Total Cost
	ICB	NCB	Other[2]	N.B.F.	
1. Works	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	43.03 (48.97)	43.03 (48.97)
2. Goods	20.69 (21.36)	0.00 (0.00)	5.47 (4.56)	4.29 (2.65)	30.45 (28.57)
3. Services	0.00 (0.00)	0.00 (0.00)	2.46 (2.55)	1.19 (1.11)	3.65 (3.66)
4. Other	0.00 (0.00)	0.00 (0.00)	1.06 (1.08)	0.00 (0.05)	1.06 (1.13)
5. Miscellaneous	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)
6. Miscellaneous	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	 (0.00)	0.00 (0.00)
Total	20.69 (21.36)	0.00 (0.00)	8.99 (8.19)	48.51 (52.78)	78.19 (82.33)

[1/] Figures in parenthesis are the amounts to be financed by the Bank Loan. All costs include contingencies.

[2/] Includes civil works and goods to be procured through national shopping, consulting services, services of contracted staff of the project management office, training, technical assistance services, and incremental operating costs related to (i) managing the project, and (ii) re-lending project funds to local government units.

Project Financing by Component (in US$ million equivalent)

Component	Appraisal Estimate			Actual/Latest Estimate			Percentage of Appraisal		
	Bank	Govt.	CoF.	Bank	Govt.	CoF.	Bank	Govt.	CoF.
Primary Care	22.18	31.76	2.84	22.27	46.91	2.19	100.4	147.7	77.1
GP and UN Training	4.54	2.32	0.30	4.85	2.08	0.41	106.8	89.7	136.7
Financing and Management	2.02	2.07	0.13	1.00	0.99	0.06	49.5	47.8	46.2
Project Management Total	1.27	0.31	0.08	1.43	0.10	0.03	112.6	32.3	37.5

Annex 3. Economic Costs and Benefits

N/A

Annex 4. Bank Inputs

(a) Missions:

Stage of Project Cycle	No. of Persons and Specialty (e.g. 2 Economists, 1 FMS, etc.)		Performance Rating	
			Implementation	Development
Month/Year	Count	Specialty	Progress	Objective
Identification/Preparation				
11/24/1994	*3*	MISSION LEADER (1) PRIMARY CARE SPECIALIST (1) ECONOMIST (1)	S	S
3/3/1996	*6*	MISSION LEADER (1) ECONOMIST (2) FIN. MNGMT SPECIALIST (1) PRIMARY CARE SPECIALIST (1) RM (PROJECT OFFICER) (1)	S	S
Appraisal/Negotiation				
1/25/1998	*8*	MISSION LEADER (1) IMPLEMENTATION SPEC(1) COST AND OPER. SPEC. (1) PROJ. COORDINATOR (1) PUBLIC HEALTH SPEC. (1) TRAINING CONSULTANT (1) PUBLIC HEALTH PROMOTION SPEC. (1) COMMUNICATION SPEC. (1)	S	S
Supervision				
01/22/1999	*4*	MISSION LEADER (1); PRIMARY CARE SPECIALIS (1); RM (PROJECT OFFICER) (1); FIN. MNGMT.SPECIALIST (1)	S	S
04/18/1999	*4*	MISSION LEADER,PTL (1); IMPLEMENT./PROCUREMENT (1); PRIMARY CARE SPECIALIS (1); RM(PROJECT OFFICER) (1)	S	S
11/13/1999	*6*	TEAM LEADER/ECONOMIST (1); IMPLEMENTATION SPECIAL (1); OPERATIONS SPECIAL (1); PUBLIC HEALTH (1); MEDICAL EDUCATION (GP) (1); SOCIAL SCIENTIST (1)	S	S
11/07/2000	*4*	TEAM LEADER/ECONOMIST (1); IMPLEMENTATION	S	S

		SPECIAL (1); OPERATIONS (1); PHYSICIAN/PRIMARY CARE (1)		
06/07/2001	*2*	TEAM LEADER/ECONOMIST (1); OPERATIONS (1)	S	S
09/28/2001	*4*	ECONOMIST/MISSION LEAD (1); OPERATIONS OFFICER (1); PHYSICIAN/PRIMARY CARE (1); FMS(JOINT PART OF MISS (1)	S	S
10/17/2002	*7*	TEAM LEADER (1); PROCUREMENT SPECIALIST (1); PROJECT COORDINATOR,RM (1); PRIM. CARE SP.,CONSULT (1); PRIM.CARE & MCH SP. (1); OPERATIONS SP. (1); FMS (1)	S	S
06/03/2003	*5*	TTL (1); FMS (1); OPERATIONS OFFICER, RM (1); PROCUREMENT SPECIALIST (1); PRIM. CARE SP.,CONSULT (1)	S	S
09/15/2003	*5*	TTL (1); FMS (1); OPERATION OFFICER, RM (1); PROCUREMENT SPECIALIST (1); PRIM. CARE. SP.CONSULT (1)	S	S
06/03/2004	*5*	TTL (1); PROCUREMENT (1); OPERATIONS (1); FINANCIAL MANAGEMENT (1); PHYSICIAN (1)	S	S
ICR				

(b) Staff:

Stage of Project Cycle	Actual/Latest Estimate	
	No. Staff weeks	US$ ('000)
Identification/Preparation	(Identification/ Preparation included with Appraisal/ Negotiation below)	
Appraisal/Negotiation	207	726
Supervision	228	780
ICR	22	55
Total	458	1,561

Annex 5. Ratings for Achievement of Objectives/Outputs of Components

(H=High, SU=Substantial, M=Modest, N=Negligible, NA=Not Applicable)

	Rating
☒ *Macro policies*	○ *H* ○ *SU* ○ *M* ○ *N* ● *NA*
☒ *Sector Policies*	○ *H* ○ *SU* ● *M* ○ *N* ○ *NA*
☒ *Physical*	● *H* ○ *SU* ○ *M* ○ *N* ○ *NA*
☒ *Financial*	○ *H* ○ *SU* ○ *M* ○ *N* ● *NA*
☒ *Institutional Development*	○ *H* ○ *SU* ● *M* ○ *N* ○ *NA*
☒ *Environmental*	○ *H* ○ *SU* ○ *M* ○ *N* ● *NA*
Social	
☐ *Poverty Reduction*	○ *H* ○ *SU* ○ *M* ○ *N* ○ *NA*
☐ *Gender*	○ *H* ○ *SU* ○ *M* ○ *N* ○ *NA*
☐ *Other (Please specify)*	○ *H* ○ *SU* ○ *M* ○ *N* ○ *NA*
☒ *Private sector development*	○ *H* ○ *SU* ○ *M* ○ *N* ● *NA*
☒ *Public sector management*	○ *H* ○ *SU* ● *M* ○ *N* ○ *NA*
☐ *Other (Please specify)*	○ *H* ○ *SU* ○ *M* ○ *N* ○ *NA*

Annex 6. Ratings of Bank and Borrower Performance

(HS=Highly Satisfactory, S=Satisfactory, U=Unsatisfactory, HU=Highly Unsatisfactory)

6.1 Bank performance	*Rating*			
☒ *Lending*	○ *HS*	● *S*	○ *U*	○ *HU*
☒ *Supervision*	○ *HS*	● *S*	○ *U*	○ *HU*
☒ *Overall*	○ *HS*	● *S*	○ *U*	○ *HU*

6.2 Borrower performance	*Rating*			
☒ *Preparation*	○ *HS*	● *S*	○ *U*	○ *HU*
☒ *Government implementation performance*	○ *HS*	● *S*	○ *U*	○ *HU*
☒ *Implementation agency performance*	○ *HS*	● *S*	○ *U*	○ *HU*
☒ *Overall*	○ *HS*	● *S*	○ *U*	○ *HU*

Annex 7. List of Supporting Documents

Project Appraisal Document, Uzbekistan Health 1 Project, 1998
Project Aide-Memoires, Supervision Reports and Back-to-Office Reports (various); Washington DC, 1994-2004
Mid-Term Review Report, Aug. 1998 - Sept. 2001
Project Health 1 Implementation Outputs Final Report, Ministry of Health / Central Project Implementation Bureau, 2005
Health Facility Survey, 2004
Uzbekistan Public Expenditure and Institutional Review, 2004; Washington D.C.
Strategic Assessment of Health Management Information System; Dennis J. Streveler, 2004
Various Consultants' reports for preparation of Uzbekistan Health 2 Project