Document of
The World Bank

Report No: ICR2257

IMPLEMENTATION COMPLETION AND RESULTS REPORT
(IDA-39790 IDA-H1240 TF-54236 TF-54237)

ON A

CREDIT

IN THE AMOUNT OF SDR 26.9 MILLION
(US$ 39.48 MILLION EQUIVALENT)

AND A

GRANT

IN THE AMOUNT OF SDR 0.4 MILLION
(US$ 0.52 MILLION EQUIVALENT)

TO THE

REPUBLIC OF UZBEKISTAN

FOR THE

HEALTH II PROJECT

June 26, 2012

Human Development Sector Unit
Central Asia Country Unit
Europe and Central Asia Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective June 2012)

Currency Unit = Sum
Sum 1.00 = US$0.0005
US$ 1.00 = 1,881.31 Sum

FISCAL YEAR
January 1 – December 31

ABBREVIATIONS AND ACRONYMS

ADB	Asian Development Bank	KPI	Key Performance Indicators
CAS	Country Assistance Strategy	MDG	Millennium Development Goals
CAR	Central Asia Region	M&E	Monitoring and Evaluation
CD	Communicable Disease	MIS	Management Information System
COM	Cabinet of Ministers	MM	Maternal Mortality
CME	Continuous Medical Education	MOF	Ministry of Finance
CRA	Central Rayon/District Hospital	MOH	Ministry of Health
DFA	Development Financing Agreement	MTR	Mid-Term Review
DHS	Demographic Health Survey	NCD	Non-communicable Disease
DOTS	Directly Observed Treatment Strategy	OPIB	Oblast (Region) Project Implementation Bureau
ECA	Europe and Central Asia	PAD	Project Appraisal Document
EE	Energy Efficiency	PDO	Project Development Objectives
EU	European Union	PHC	Primary Health Care
FAP	Feldshersko-Akusherski Punkt (Feldsher or Obstetrics Post)	RF	Results Framework
FM	Financial Management	RMU	Regional Management Unit
FP	Family Physicians	SOE	Statement of Expenditures
GDP	Gross Domestic Product	SVA	Selskaya Vrachebnaya Ambulatoriya (Rural Outpatient Clinic)
GIZ	Gesellschaft fur Internationale Zusammenarbeit	SVP	Selskii Vratch Punkt (Rural Primary Health Care Unit)
GP	General Practice/Practitioner	TA	Technical Assistance
HIV/AIDS	Human immunodeficiency Virus/Acquired Immunodeficiency Syndrome	TB	Tuberculosis
IDA	International Development Association	TIAME	Tashkent Institute of Advanced Medical Education
ICR	Implementation Completion Report	TTL	Task Team Leader
IM	Infant Mortality	U5	Under 5 Years Child Mortality
IP	Implementation Progress	USAID	United States Agency for International Development
JICA	Japan International Cooperation Agency	WHO	World Health Organization
JPIB	Joint Project Implementation Bureau		

Vice President: Philippe Le Houérou
Country Director: Saroj Kumar Jha
Sector Manager: Daniel Dulitzky
Project Team Leader: Susanna Hayrapetyan
ICR Team Leader: Ana Holt

UZBEKISTAN
Health 2 Project

CONTENTS

MAP IBRD 33508R

Data Sheet

A. Basic Information			
Country:	Uzbekistan	Project Name:	Health 2 Project
Project ID:	P051370	L/C/TF Number(s):	IDA-39790,IDA-H1240,TF-54236,TF-54237
ICR Date:	06/26/2012	ICR Type:	Core ICR
Lending Instrument:	SIL	Borrower:	
Original Total Commitment:	SDR 27.3M	Disbursed Amount:	SDR 27.1 M
Revised Amount:	SDR 27.3 M		
Environmental Category: C			
Implementing Agencies: Joint Project Implementation Bureau (JPIB) and Ministry of Health			
Co-financiers and Other External Partners: N/A			

B. Key Dates				
Process	**Date**	**Process**	**Original Date**	**Revised / Actual Date(s)**
Concept Review:	02/06/2003	Effectiveness:	12/20/2004	12/20/2004
Appraisal:	02/06/2004	Restructuring(s):		06/22/2010
Approval:	09/09/2004	Mid-term Review:		05/14/2007
		Closing:	06/30/2010	12/31/2011

C. Ratings Summary	
C.1 Performance Rating by ICR	
Outcomes:	Moderately Satisfactory
Risk to Development Outcome:	Negligible
Bank Performance:	Moderately Satisfactory
Borrower Performance:	Moderately Satisfactory

C.2 Detailed Ratings of Bank and Borrower Performance (by ICR)			
Bank	**Ratings**	**Borrower**	**Ratings**
Quality at Entry:	Moderately Satisfactory	Government:	Moderately Satisfactory
Quality of Supervision:	Satisfactory	Implementing Agency/Agencies:	Moderately Satisfactory
Overall Bank Performance:	Moderately Satisfactory	**Overall Borrower Performance:**	Moderately Satisfactory

C.3 Quality at Entry and Implementation Performance Indicators			
Implementation Performance	**Indicators**	**QAG Assessments (if any)**	**Rating**
Potential Problem Project at any time (Yes/No):	Yes	Quality at Entry (QEA):	None
Problem Project at any time (Yes/No):	Yes	Quality of Supervision (QSA):	None
DO rating before Closing/Inactive status:	Moderately Satisfactory		

D. Sector and Theme Codes		
	Original	**Actual**
Sector Code (as % of total Bank financing)		
Compulsory health finance	2	2
Health	98	98
Theme Code (as % of total Bank financing)		
Child health	16	16
HIV/AIDS	17	17
Health system performance	33	33
Nutrition and food security	17	17
Tuberculosis	17	17

E. Bank Staff		
Positions	**At ICR**	**At Approval**
Vice President:	Phillipe Le Houerou	Shigeo Katsu
Country Director:	Saroj Kumar Jha	Denis de Tray
Sector Manager:	Daniel Dulitzky	Armin H. Fidler
Project Team Leader:	Susanna Hayrapetyan	John Langenbrunner
ICR Team Leader:	Ana Holt	
ICR Primary Author:	Ana Holt	

F. Results Framework Analysis

Project Development Objectives (from Project Appraisal Document)
The project Development Objective was to improve the quality and overall cost-effectiveness of health care services in Uzbekistan. This was to be achieved through:

(a) completion of the primary care program in 8 regions (Samarkand, Sukhandarya, Namangan, Andijon, Djizzak, Ferghana, Navoiy, and Syr Darya) and other regions as agreed, and institutionalization of general practitioners nationally;

(b) extending financing and management reforms related to efficiency and effectiveness of service delivery;

(c) improving public health services, including surveillance, training in public health and control of communicable disease; and,

(d) building capacity in the Ministry of Health to better monitor and evaluate the reforms, and better manage the restructuring process.

Revised Project Development Objectives (as approved by original approving authority)

The PDOs were not revised.

(a) Original PDO Indicators

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
Indicator 1 :	Increase number of pregnant women covered by prenatal care by 10% (Indicator dropped at Restructuring on June 22, 2010)			
Value quantitative or qualitative	99.3%	100%		99.7%
Date of achievement	09/09 2004	06/30/2010		12/31/2011
Comments (incl. % achievement)	**ACHIEVED**			
Indicator 2 :	Increase number of newborns who receive hepatitis B immunization by 10% (Indicator dropped at Restructuring on June 22, 2010)			
Value quantitative or qualitative	No baseline in 2004 8% in 2001 99.2% in 2005	100%		99.3%
Date of achievement	09/09 2004	06/30/2010		12/31/2011
Comments (incl. % achievement)	**ACHIEVED.** In 2001 this indicator made 8%. On this basis the target was set to increase the coverage of immunization by 10%			
Indicator 3 :	Increase primary care utilization by 10% (Indicator dropped at Restructuring on June 22, 2010)			
Value quantitative or qualitative	3.8 visits per capita to SVPs	Increase by 10%		4.7
Date of achievement	09/09 2004	06/30/2010		12/31/2011
Comments (incl. % achievement)	**OVERACHIEVED**			
Indicator 4 :	Training of 2700 general practitioners who work in SVPs (Indicator moved from PDO indicator to Intermediate Outcome Indicator at Restructuring on June 22, 2010)			
Value quantitative or qualitative	898	2700		3770
Date of achievement	09/09 2004	06/30/2010		12/31/2011
Comments (incl. % achievement)	**OVERACHIEVED**			
Indicator 5 :	Increase availability of essential pharmaceuticals at primary care level as measured by number of essential drugs stocked (Indicator dropped at Restructuring on June 22, 2010)			
Value quantitative or qualitative	38.9%	Increase by 10%		64%
Date of achievement	09/09 2004	06/30/2010		12/31/2011

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
Comments (incl. % achievement)	**ACHIEVED** according to Surveys conducted in 2007 and 2011			
Indicator 6 :	Decrease hospital referrals and admissions by 10% (Indicator dropped at Restructuring on June 22, 2010)			
Value quantitative or qualitative	20%	15%		12%
Date of achievement	09/09 2004	06/30/2010		12/31/2011
Comments (incl. % achievement)	**OVERACHIEVED**. Surveys conducted in 2007 and 2011			
Indicator 7 :	Training of 520 health policy experts and financial managers (Indicator dropped at Restructuring on June 22, 2010)			
Value quantitative or qualitative	0	520		1769
Date of achievement	09/09 2004	06/30/2010		12/31/2011
Comments (incl. % achievement)	**OVERACHIEVED**			
Indicator 8 :	Recurrent expenditures for primary care at least 20% of all expenditures (Indicator dropped at Restructuring on June 22, 2010)			
Value quantitative or qualitative	16%	20%		18.3%
Date of achievement	09/09 2004	06/30/2010		12/31/2011
Comments (incl. % achievement)	**SUBSTANTIALLY ACHIEVED**			
Indicator 9:	Share of expenditures for primary and outpatient care at least 40% (Indicator continued at Restructuring on June 22, 2010)			
Value quantitative or qualitative	41.7%	40%		45.2
Date of achievement	09/09 2004	06/30/2010		12/31/2011
Comments (incl. % achievement)	**OVERACHIEVED**			
Indicator 10 :	100% pregnant women have access to HIV testing and have access to Mother-to-Child treatment (Indicator dropped at Restructuring on June 22, 2010)			
Value quantitative or qualitative	0%	100%		n/a
Date of	09/09 2004	06/30/2010		12/31/2011

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
achievement				
Comments (incl. % achievement)	**N/A** Obtaining data on this indicator would require a study/survey			
Indicator 11:	Increase of coverage of groups at risk by HIV prevention activities by 10% (Indicator dropped at Restructuring on June 22, 2010)			
Value quantitative or qualitative	0%	Increase by 10%		14.3%*
Date of achievement	09/09 2004	06/30/2010		12/31/2011
Comments (incl. % achievement)	**ACHIEVED**, *activities on HIV prevention targeted risk groups: injecting drug users (IDU), commercial sex workers (CSW) and men having sex with men (MSM), through prevention programs on delivery of disposable syringes, HIV testing, voluntary counseling, condoms use, informative education materials, medical care.			
Indicator 12 :	Adoption o f a National Strategic Plan and scaling-up Directly Observed Treatment Strategy (DOTS) throughout the country (Indicator dropped at Restructuring on June 22, 2010)			
Value quantitative or qualitative	4 regions	14 regions		14
Date of achievement	09/09 2004	06/30/2010		12/31/2011
Comments (incl. % achievement)	**ACHIEVED** (100% - DOTS program was expanded nationwide)			
Indicator 13:	Training of 50 public health specialists and public health nurses (Indicator dropped as PDO indicator, modified and moved to Intermediate Outcome Indicators at Restructuring on June 22, 2010)			
Value quantitative or qualitative	0	50		54
Date of achievement	09/09 2004	06/30/2010		12/31/2011
Comments (incl. % achievement)	**OVERACHIEVED**			
Indicator 14:	Number of community-based grant projects implemented (Indicator dropped at Restructuring on June 22, 2010)			
Value quantitative or qualitative	0	5		0
Date of achievement	09/09 2004	06/30/2010		12/31/2011
Comments (incl. % achievement)	**NOT ACHIEVED.** Activity designed and planned in close collaboration with USAID, which stopped all activities in the country as of May 2006			
Indicator 15:	M&E system established with a minimum of 2 facility surveys and 2 household surveys (Indicator dropped as PDO indicator, modified and moved to Intermediate Outcome			

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
	Indicators at Restructuring on June 22, 2010)			
Value quantitative or qualitative	0	2 facility surveys 2 household surveys		2 facility surveys and 2 household surveys were conducted (2007 and 2011)
Date of achievement	09/09 2004	06/30/2010		12/31/2011
Comments (incl. % achievement)	**ACHIEVED**			

(b) Formally Revised PDO Indicators[1]

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
Indicator 1 :	% share of expenditures for primary and outpatient care at least 40% (Indicator introduced at restructuring on June 22, 2010)			
Value quantitative or qualitative	41.7%		40%	45.2%*
Date of achievement	09/09/ 2004		06/30/2011	12/31/2011
Comments (incl. % achievement)	**OVERACHIEVED** * Summarizing the results of 9 months of 2011			
Indicator 2 :	% of women who receive antenatal care in the early stage of pregnancy (up to 12-week pregnancy period) (Indicator introduced at restructuring on June 22, 2010)			
Value quantitative or qualitative	77%		85%	87%
Date of achievement	09/09/ 2004		06/30/2011	12/31/2011
Comments (incl. % achievement)	**OVERACHIEVED.** According to data provided by the Main Department for Mother and Child Health Strengthening, MOH			
Indicator 3 :	% of target groups provided with iron supplementation (in Bukhara, Navoi and Tashkent oblasts) (Indicator introduced at restructuring on June 22, 2010)			
Value quantitative or qualitative	0		Bukhara oblast – 90%; Navoi oblast –	Bukhara oblast – 98.5%; Navoi oblast – 97.8;

[1] As defined during restructuring on June 22, 2010 and stated in Supplemental Letter No.2 to the Amendment to Development Financing Agreement of May 14, 2010 and Annex 1 to the Restructuring Paper for the Health II Project, Report No. 52602-Uz of May 5, 2010.

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
			90%; Samarkand oblast – 90%; Tashkent oblast – 90%.	Samarkand oblast – 96%; Tashkent oblast –95.1%.
Date of achievement	09/09/ 2004		06/30/2011	12/31/2011
Comments (incl. % achievement)	**OVERACHIEVED.** No target value was given as the value was zero at baseline. The following overachievement relates to the target values given at restructuring (in Bukhara oblast 109.4%, in Navoi oblast 108.7%, in Samarkand oblast – 106.7%, in Tashkent oblast 105.7%)			
Indicator 4 :	Number of visits to PHC facilities (SVPs, FAPs) per capita of rural population (Indicator introduced at restructuring on June 22, 2010)			
Value quantitative or qualitative	3.8		5	4.7*
Date of achievement	09/09/ 2004		06/30/2011	12/31/2011
Comments (incl. % achievement)	**SUBSTANTIALLY ACHIEVED**. Indicator shows a clear trend of increasing due to improvement in the provision of basic health services at rural medical centers and institutionalization of GP based primary health care nationally.			
Indicator 5 :	Hospitalization rate among rural population (Indicator introduced at restructuring on June 22, 2010)			
Value quantitative or qualitative	11.1%		10%	10.5%*
Date of achievement	09/09/ 2004		06/30/2011	12/31/2011
Comments (incl. % achievement)	**SUBSTANTIALLY ACHIEVED**. There is a clear tendency for decreasing. % of hospitalization of rural population has decreased from 11.1% in 2005 to 10.5% in 2011.			
Indicator 6 :	% of SVPs stocked with (for at least 75% of) essential medicines for emergency care (Indicator introduced at restructuring on June 22, 2010)			
Value quantitative or qualitative	38.9% SVPs stocked with 75% essential medicines		50% SVPs stocked with 75%essential medicines	64%*SVPs stocked with 50% essential medicines
Date of achievement	09/09/ 2004		06/30/2011	12/31/2011
Comments (incl. % achievement)	**NOT ACHIEVED.** Administrative rigidity in transition from decentralized to centralized procurement and distribution of drugs caused delay in implementing new procurement system leading to delayed supply of a number of essential drugs. However, 64% of SVPs have been provided with 50% of drugs from the list.			
Indicator 7 :	% urban pilot PHC facilities converted to per-capita financing and management system in pilot areas (Indicator introduced at restructuring on June 22, 2010)			
Value quantitative or qualitative	86.2%		100%	100%
Date of	09/09/ 2004		06/30/2011	12/31/2011

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
achievement				
Comments (incl. % achievement)	**ACHIEVED**			
Indicator 8 :	% of rural PHC facilities converted to per capita financing and management system (Indicator introduced at restructuring on June 22, 2010)			
Value quantitative or qualitative	21.5%		100%	100%
Date achieved	09/09/ 2004		06/30/2011	12/31/2011
Comments (incl. % achievement)	**ACHIEVED**			
Indicator 9 :	% of patients referred from SVPs to hospitals (Indicator introduced at restructuring on June 22, 2010)			
Value quantitative or qualitative	20%		15%	12%*
Date of achievement	09/09/ 2004		06/30/2011	12/31/2011
Comments (incl. % achievement)	**OVER-ACHIEVED**. According to the findings of the survey conducted by the independent consulting firm "Expert Fikri".			

c) Original Intermediate Outcome Indicator(s)[2]

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
Indicator 1 :	Primary care utilization increases (Indicator kept at restructuring June 22, 2010)			
Value (quantitative or Qualitative)	3.8 visits per capita of rural population	5 percent per year increase over previous year		4.7
Date of achievement	09/09/2004	06/30/2010		12/31/2011
Comments (incl. % achievement)	**SUBSTANTIALLY ACHIEVED.** Showing clear tendency towards reaching the target			
Indicator 2 :	GP Training programs established (Indicator dropped at restructuring June 22,2010)			

[2] Annex 1 of the PAD (attached to this ICR as Annex 11) lists 42 indicators, not all explicitly linked to the PDOs. However, per ICR Team findings only 4 Intermediate indicators have been monitored and regularly updated prior to Mid Term Review in October 31, 2007 when new Results Framework was agreed upon with the Government and results monitored and updated. Due to lengthy Government administrative procedures, the request for restructuring was delayed and this Results Framework has been formally revised during Restructuring on June 22, 2010.

Value (quantitative or Qualitative)	Draft initial plan developed	MoH Decree to endorse the Plan		Plan developed, endorsed by the MoH, implemented.
Date of achievement	09/09/2004	06/30/2010		12/31/2011
Comments (incl. % achievement)	**ACHIEVED**			
Indicator 3 :	Average increase in annual expenditures for primary care as a share of all expenditures in 8 regions under the project			
Value (quantitative or qualitative)	41.7% in 2005 45.5% in 2006 46.8% in 2007	5 percent per year increase from previous year		n/a
Date of achievement	09/09/2004	06/30/2010		12/31/2011
Comments (incl. % achievement)	**N/A.** Indicator not monitored after Mid Term Review in October 2007.			
Indicator 4 :	Adoption of National Strategic Plan (Indicator dropped at restructuring June 22,2010)			
Value (quantitative or qualitative)	0	Government Resolution outlining strategic plan and use of DOTS Protocol		DOTS Strategic Plan approved in 2005
Date of achievement	09/09/2004	06/30/2010	06/22/2010	12/31/2011
Comments (incl. % achievement)	**ACHIEVED**. Strategic Plan approved in 2005			

(d) Formally Revised Intermediate Outcome Indicator(s)[3]

Intermediate Result Indicators (Component 1): Primary Health Care Development

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
Indicator 1 :	SVPs fully equipped under the Project (Indicator revised - dropped as PDO indicator and			

[3] The Results Matrix agreed at Mid Term Review in October 2007 and formally revised at restructuring in June 2010 proposed smaller number of revised and new intermediate indicators for each component, that were also more clearly linked to PDOs. Accordingly, revised Component 1 had 6 indicators as compared to 16 in the PAD; revised Component 2 had 4 indicators as compared to 6 in the PAD; revised Component 3 had 5 indicators as compared to 8 in the PAD, and revised Component 4 had 3 indicators as compared to 12 in the PAD.

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
	monitored as Intermediate Outcome Indicator as of restructuring on June 22, 2010)			
Value (quantitative or Qualitative)	87.5% (1925)		100% (2200)	108.5% (2389)
Date of achievement	06/22/2010		06/30/2011	12/31/2011
Comments (incl. % achievement)	**OVERACHIEVED**			
Indicator 2 :	% of SVP physicians retrained or 2700 physicians retrained (Indicator revised - dropped as PDO indicator and monitored as Intermediate Outcome Indicators as of restructuring on June 22, 2010)			
Value (quantitative or Qualitative)	19.2% (898)		58% (2700)	74.9% (3770)
Date of achievement	09/09/2004		06/30/2011	12/31/2011
Comments (incl. % achievement)	**OVERACHIEVED**			
Indicator 3 :	% of SVPs with one or more GP on staff who has passed a 10-month GP training or has graduated from University as a GP (Indicator revised at restructuring on June 22, 2010)			
Value (quantitative or qualitative)	23.7% baseline in 2004 55.8% at restructuring 2010		70%	92.5%
Date of achievement	09/09/2004		06/30/2011	12/31/2011
Comments (incl. % achievement)	**OVERACHIEVED**			
Indicator 4 :	% of SVPs in pilot oblasts with specialists trained under the program of medical equipment maintenance (New indicator introduced at restructuring June 22, 2010)			
Value (quantitative or qualitative)	0%		100%	98.3%
Date of achievement	06/22/2010		06/30/2011	12/31/2011
Comments (incl. % achievement)	**ACHIEVED**. (98.3%)708 SVP managers (out of 718 planned) trained			
Indicator 5 :	SVPs equipped with modern dental equipment (New indicator introduced at restructuring June 22, 2010)			
Value (quantitative or qualitative)	0%		4%	7.3%
Date of achievement	06/22/2010		06/30/2011	12/31/2011
Comments (incl. %	**OVERACHIEVED**			

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
achievement)				
Indicator 6 :	% central policlinics equipped with modern dental equipment (New indicator introduced at restructuring June 22, 2010)			
Value (quantitative or qualitative)	0%		100%	100%
Date of achievement	06/22/2010		06/30/2011	12/31/2011
Comments (incl. % achievement)	**ACHIEVED**			
Intermediate Result Indicators (Component 2): Financing and Management Reforms Expansion				
Indicator 1 :	% of recurrent costs, not related to salary relative to actual expenses of SVP/urban pilot PHC facilities (Indicator revised at restructuring on June 22, 2010)			
Value (quantitative or qualitative)	9.9% in 2004 15.6% in 2010		20%	9.6% /8.9%
Date of achievement	06/22/2010		06/30/2011	12/31/2011
Comments (incl. % achievement)	**NOT ACHIEVED**. The financing capacity for recurrent costs was not reduced and it increases annually in accordance with redistribution of released budget funds from phased implemented optimization of inpatient facilities. The rate of salary growth does not take the lead over allocation of funds for current expenses.			
Indicator 2 :	% share of Oblast/city health budget allocated for PHC (New indicator introduced at restructuring June 22, 2010)			
Value (quantitative or Qualitative)	14.6%		20%	18.3%
Date of achievement	06/22/2010		06/30/2011	12/31/2011
Comments (incl. % achievement)	**SUBSTANTIALLY ACHIEVED.** When defining this indicator only data approved in estimated costs of SVP expenses were taken into consideration. Recognizing considerable supplies by Central Rayons, humanitarian line and donor aid through the Board of Guardians to SVP. Hence, the volume of funds directed to SVP is higher.			
Indicator 3 :	% of urban PHC facilities converted to per capita financing and management system (New indicator introduced at restructuring June 22, 2010)			
Value (quantitative or qualitative)	86.2%		100%	100%
Date of achievement	06/22/2010		06/30/2011	12/31/2011
Comments (incl. % achievement)	**ACHIEVED**			
Indicator 4 :	% of Central Rayon Hospitals involved in case-based payment pilot (Indicator revised at restructuring on June 22, 2010)			
Value	53.1%		100% in pilot	100%

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
(quantitative or qualitative)			oblasts	
Date of achievement	06/22/2010		06/30/2011	12/31/2011
Comments (incl. % achievement)	**ACHIEVED.** All the 16 Central Rayon Hospitals of Fergana Oblast are involved in case-based payment pilot. Contract based payment is tested (block contract, cost and volume contract) during transition period to case-based payment system.			
Intermediate Result Indicator (Component 3): Public Health Services improvement				
Indicator 1 :	Strengthening and improvement of the Public Health Strategy (Indicator revised at restructuring on June 22, 2010)			
Value (quantitative or Qualitative)	Draft Public Health Strategy developed		Draft Public Health Strategy developed and adopted	The project of Strengthening and improvement of the Public Health (PH) Strategy was developed and being approved by relevant Ministries and Agencies
Date of achievement	06/22/2010		06/30/2011	12/31/2011
Comments (incl. % achievement)	**SUBSTANTIALLY ACHIEVED**. The Draft National Strategy of Public Health was developed in 2008. Legislation foresees acceptance of the document and large scale of planned activities by 22 Ministries and agencies. Currently the updated version of document has been agreed with 19 out of 22 Ministries and agencies. Final agreement of all institutions is expected in the coming months.			
Indicator 2 :	Establish one School of Public Health (Indicator continued at restructuring on June 22, 2010)			
Value (quantitative or qualitative)	0%	PH School is established and operational: curricula have been developed, the faculty has been staffed and students are enrolled at the SPH	continued	SPH established under Tashkent Medical Academy (2006)
Date of achievement	09/09/ 2004	06/30/2010	06/30/2011	12/31/2011
Comments (incl. % achievement)	**OVERACHIEVED**. In addition to the School of Public Health, the Project provided the Tashkent Institute for Advanced Medical Education (TIAME) Department of Public Health with training equipment and educational literature.			
Indicator 3 :	Number of PH specialists trained in two-year Public Health program((Indicator continued at restructuring on June 22, 2010)			
Value (quantitative or qualitative)	0	50	continued	54*
Date of achievement	09/09/ 2004	06/30/2010	06/30/2011	12/31/2011
Comments	**OVERACHIEVED**. *Including graduates of "Organization and management in nursing"			

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
(incl. % achievement)	department of the School of Public Health			
Indicator 4 :	Establish Information System (IS) for Electronic Monitoring of Infectious Diseases (EMID) (New indicator introduced at restructuring on June 22,2010)			
Value (quantitative or Qualitative)	0% (Project documentation on software development prepared)		Software on Electronic Monitoring of Infectious Diseases (EMID) developed	Software developed and operational
Date of achievement	06/22/2010		06/30/2011	12/31/2011
Comments (incl. % achievement)	**ACHIEVED**. All the stages of elaboration of IS EMID have been achieved			
Indicator 5 :	Develop plan to improve training programs for PH specialists (Indicator revised at restructuring on June 22, 2010)			
Value (quantitative or qualitative)	Draft initial plan developed		MoH Decree to endorse the Plan	Plan developed, endorsed by the MoH, implemented.
Date of achievement	06/22/2010		06/30/2011	12/31/2011
Comments (incl. % achievement)	**ACHIEVED.** Analytical Report "The System of Training Public Health Specialists in Uzbekistan: Ways of Improvement" including the "Action Plan on Improvement of Training Programs in Public Health for 2012-2020" developed under the Project and endorsed by the MoH.			
Intermediate Result Indicator (Component 4): Project management ,monitoring and evaluation				
Indicator 1 :	Timely conduct of health facility and household surveys (Indicator revised at restructuring on June 22, 2010)			
Value (quantitative or qualitative)	One health facilities' survey and one household survey conducted		One survey in two years: results incorporated in Progress Reports	Implemented, surveys were conducted in 2007 and 2011
Date of achievement	06/22/2010		06/30/2011	12/31/2011
Comments (incl. % achievement)	**ACHIEVED**			
Indicator 2 :	Timely conduct of financial audits (New indicator introduced at restructuring on June 22,2010)			
Value (quantitative or qualitative)	The Audit on Financial Statements for 2008 conducted		Annual Audit Reports submitted to the Bank	The reports on Annual Audit regularly and timely submitted to The Bank
Date of achievement	06/22/2010		06/30/2011	12/31/2011
Comments	**ACHIEVED**			

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
(incl. % achievement)				
Indicator 3 :	Timely submission of Project Progress reports with updated Monitoring Indicators (Indicator revised at restructuring on June 22, 2010)			
Value (quantitative or qualitative)	E&M report updated in 2009		Updated Project M&E reports submitted twice a year	Implemented
Date achieved	06/22/2010		06/30/2011	12/31/2011
Comments (incl. % achievement)	**ACHIEVED**			

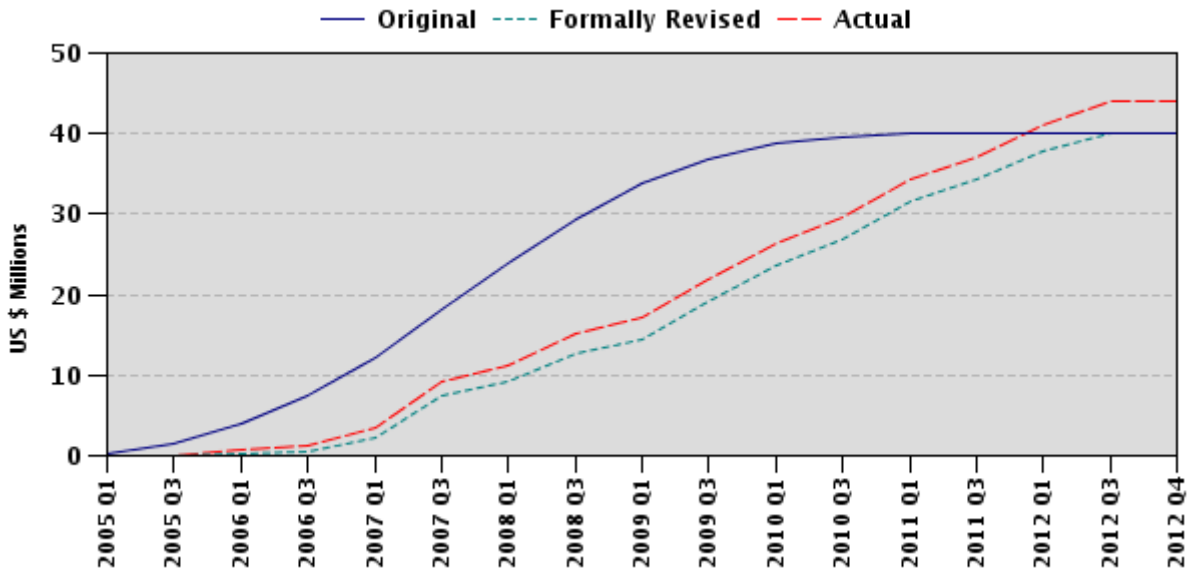
G. Ratings of Project Performance in ISRs

No.	Date ISR Archived	DO	IP	Actual Disbursements (USD millions)
1	11/30/2004	Satisfactory	Satisfactory	0.00
2	06/04/2005	Moderately Satisfactory	Moderately Satisfactory	0.12
3	06/23/2005	Moderately Satisfactory	Moderately Satisfactory	0.12
4	11/23/2005	Moderately Unsatisfactory	Moderately Unsatisfactory	0.34
5	04/19/2006	Moderately Unsatisfactory	Moderately Unsatisfactory	1.03
6	12/13/2006	Moderately Unsatisfactory	Moderately Unsatisfactory	5.02
7	06/21/2007	Moderately Unsatisfactory	Moderately Unsatisfactory	8.10
8	06/29/2007	Moderately Satisfactory	Moderately Satisfactory	8.14
9	06/04/2008	Moderately Satisfactory	Moderately Satisfactory	13.18
10	02/02/2009	Moderately Satisfactory	Moderately Satisfactory	16.13
11	10/13/2009	Moderately Unsatisfactory	Moderately Unsatisfactory	24.78
12	03/29/2010	Moderately Unsatisfactory	Moderately Satisfactory	26.93
13	06/29/2010	Moderately Satisfactory	Moderately Satisfactory	29.00
14	01/10/2011	Moderately Satisfactory	Moderately Satisfactory	33.45
15	08/15/2011	Moderately Satisfactory	Moderately Satisfactory	36.90
16	12/27/2011	Moderately Satisfactory	Moderately Satisfactory	39.58

H. Restructuring (if any)

Restructuring Date(s)	Board Approved PDO Change	ISR Ratings at Restructuring		Amount Disbursed at Restructuring in USD millions	Reason for Restructuring & Key Changes Made
		DO	IP		
06/22/2010		MS	MS	29.00	The restructuring included: (a) Adding new activities and reallocation of the corresponding credit proceeds from the unallocated category to include (i) procurement of dental equipment for dental cabinets of Primary Care Centers and of rayon and oblast polyclinics where there are the greatest demand on dental care; and (ii) technical assistance for the development of a medical equipment maintenance system for SVPs; (b) Extension of the closing date by 12 months to allow for completion of implementation; and (c) Revision and fine-tuning of the results framework to better monitor and report on project progress.
06/08/2011		MS	MS	35.15	The restructuring included: (a) Reallocation of funds to include procurement of information technology equipment and software to strengthen the management information system (MIS) in the Ministry of Health; and (b) Extension of the closing date by 6 months to allow for equipment and software to be procured, installed and tested.

I. Disbursement Profile



1. Project Context, Development Objectives and Design

1. ***The Health 2 Project was approved on September 9, 2004. The Development Financing Agreement was signed on October 3, 2004 and became effective on December 20, 2004***. The Project was the second health supported project to Uzbekistan by the International Development Association (IDA). The Project continued Bank's support to the next stage of Government's health sector reform program initiated by Health 1[4]. It was co-financed by an IDA Grant aimed at supporting the HIV/AIDS prevention and care. The Grant was also signed on October 3, 2004 and became effective on December 20, 2004.

1.1 Context at Appraisal[5,6]

2. **Uzbekistan's transition experience was somewhat unique among former Soviet countries in that it experienced a milder and less protracted recession relative to many of its neighbors.** Output declined in the early 1990s, but was still 81 percent of its 1991 level by 1995. In 2001, Uzbekistan's Gross Domestic Product (GDP) per capita, at the official exchange rate, was $552. In real terms, per capita GDP in US dollars was 84 percent of per capita GDP in 1990. Most of the population (63 percent) lived in rural areas, and most of the poor were found in rural regions. Since 1995, the economy has been growing at about 4 percent annually, according to official statistics. Yet, living standards appear to have stagnated.

3. **At the time of Appraisal, approximately 28 percent of the population lived below the poverty line, and a third of them could have been considered extremely poor.** Some regions were particularly worse off. Access to basic public services and utilities, such as water and sewerage, was low, particularly in the rural areas and for the poorer strata of the population. Despite a historical legacy of relatively favorable human capital outcomes, these non-income dimensions of poverty were under stress and there was evidence of serious disparities between regions, and income groups. Large segments of the population were vulnerable to risks from loss of income, natural disasters, and ill health and employed counterproductive coping strategies. Many, but especially the poor, were negatively affected by corruption and informal payments, including payments for social services.

4. **Uzbekistan suffered from a double burden of disease**, with both communicable diseases (CD) re-emerging, particularly with the post-Soviet transition, and non-communicable diseases (NCD) typical to developed countries. Despite improving vaccination coverage against tuberculosis (TB), pertussis, measles, diphtheria, tetanus and poliomyelitis remained a major problem. Acute respiratory infections among children remained the primary cause of death and morbidity leading to several outbreaks of infectious diseases, including TB, diphtheria, viral hepatitis, and typhoid.

5. Although the Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) epidemic was in the early stages in Uzbekistan, there were signs of quick spread of infection, especially among young people as **t**he number of cases doubled in less than one year in 2003.

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[4] Implementation Completion and Results Report. First Health Project. Report No.32410-UZ. [June 17, 2005]

[5] Country Assistance Strategy (CAS) 2002: FY02 – FY 05. Report No.23675-UZ.

[6] Project Appraisal Document. Health II Project. Report No.28485-UZ. [August 5, 2004]

6. NCDs, ischemic heart disease, chronic digestive system and chronic liver disorders showed increasing trends, exceeding EU and Central Asia Republic (CAR) rates. This could have been attributed to poor diet, tobacco and alcohol consumption and sedentary lifestyles.

7. **Millennium Development Goals (MDGs) indicators such as infant mortality (IM), under 5 (U5) years mortality, and maternal mortality (MM) were high.** IM was among the highest of the former Soviet republics. Although below the Central Asia Republics (CAR) average, the country had 22 infant deaths per 1,000 live births in 1998 and 19 in 2000 according to official data. However, the Demographic and Health Survey (DHS, 1996) placed IM much higher - at 44 infant deaths per 1,000 live births in 1996. The U5 was 55 per 1,000 live births in 1996. The overall trends for MM were similar, although differing widely between different geographical regions and between rural and urban areas. For example, a rate of over 90 was reported for Navoi in 2000. Excessive rates of MM were generally associated with lower income areas of the country.

8. **Even though significant improvements have been achieved in three pilot oblasts (Fergana, Navoi and Syr Daria) through the Health 1 Project, the Quality of Primary Health Care (PHC) nationwide was poor, especially in rural areas**. The PHC facilities were scarce, underequipped and understaffed thus resulting in high referrals to secondary level. Limited medical skills and diagnostic back-up along with the shortages of drugs and evidence based approaches to diagnostics and treatment remained a challenge. The continuation of the reforms initiated by the Government Strategy from 1996 called for new and rehabilitated PHC facilities and rationalization of the health network, which originally contained four levels of care: PHC centers (SVPs or *Selski Vratch Punkt* in Russian), feldsher or obstetrics posts (FAPs or *Feldshersko-Akusherski Punkt* in Russian), rural outpatient clinics (SVAs or *Selskaya Vrachebnaya Ambulatoriya* in Russian), central rayon/district hospitals (CRH) and regional hospitals. Continuous Medical Education (CME) and general practitioner (GP) training had been piloted and financed through the IDA-supported Health 1 Project (SCL-43960, which closed on December 31, 2004) and the United Kingdom Department for International Development (UK DfID). The outcome of this training was successful and led to a clear need for its institutionalization.

9. **During the transition period the health care system in Uzbekistan had been moving from central planning and Government financing to a mixed public and out-of-pocket payments system.** There was a growing public-private mix as well. The old Soviet system was characterized by too many facilities, too many staff, and an imbalance between hospital-based specialized care versus more cost-effective primary care. The 1996 National Strategy established the basis for a progression towards primary health care (PHC). The reforms aimed at reducing several tiers of health facilities into a flatter two level structure. Furthermore, issues such as the unequal distribution of physicians, with over an 8-fold difference between urban and rural areas, remained a challenge.

10. **PHC was retained by the public sector and remained free of charge except for pharmaceuticals**. Key management and financing reforms piloted through the Health 1 project were to be replicated, including legal independence, greater financial and organizational autonomy at all levels, incentive-based financing, and closure of redundant facilities. Limited medical skills and diagnostic back-up in the remaining eight regions of the country, particularly in rural areas, shortages of drugs, and the need to more fully introduce evidence-based approaches to diagnosis and treatment remained a challenge. With the experience from the pilot areas achieved through the Health 1 Project, the MoH was committed to extending the reforms to the rest of the country, i.e. another nine oblasts. The MoH further wanted urban primary care models to be developed as the next step of reforms to ensure universal access to health care through the services of a general practitioner (GP).

11. **The set of reforms, supported by the Health 1 project, had encouraged efficiency**. Patients shifted to lower cost services on an outpatient basis as the reforms also helped orient facilities towards local needs and improve accountability. In the pilots supported by the Health 1 project, relative funding for recurrent expenditures such as pharmaceuticals and supplies had increased, while referrals and staff inputs per capita have decreased by 5-15 percent depending upon the region. Hundreds of facilities were closed as well. Nevertheless, staffing was unequally distributed, and budgetary inputs in some regions were skewed towards hospital-based care.

12. **A 10-month retraining program for SVP doctors in pilot areas supported under the Health 1 project had been a widely acknowledged success and apparently upgraded skills have led to a reduced rate of referrals and better patient satisfaction.** The training was financed through close collaboration between the Bank and the UK Department for International Development (DfID) grant funding for technical assistance (TA) and training. National replication required expanding the number of clinical training centers to meet the demand for practical training, as well as expanding the number of trained trainers, and supportive agreements between the training institutes and authorities towards institutionalization of trainings. Incorporating the Family Medicine (FM) curricula into graduate studies and establishing FM specialization remained a challenge.

1.2 Original Project Development Objectives (PDO) and Key Indicators

13. The project Development Objective was to improve the quality and overall cost-effectiveness of health care services in Uzbekistan. This was to be achieved through:

(a) completion of the PHC program in 8 regions (Samarkand, Sukhandarya, Namangan, Andijon, Djizzak, Ferghana, Navoi, and Syr Darya) and other regions as agreed, and institutionalization of GP nationally;

(b) extending financing and management reforms related to efficiency and effectiveness of service delivery; and

(c) improving public health services, including surveillance, training in public health and control of communicable disease; and, (d) building capacity in the Ministry of Health (MoH) to better monitor and evaluate the reforms, and better manage the restructuring process.

14. The achievement of the PDO was to be measured by the following performance indicators as identified in the main text of the Project Appraisal Document (PAD, Report No. 28485-UZ) and Supplemental letter No. 2 of the Minutes of Negotiations:

Component 1

- Increase number of pregnant women covered by prenatal care by 10 percent;
- Increase number of newborns who receive hepatitis B immunization by 10 percent;
- Increase primary health care utilization and access by 10 percent;
- Training of 2,700 GPs who work in SVPs; and
- Increase availability of essential pharmaceuticals at the PHC level as measured by number of essential drugs stocked.

Component 2

- Decrease hospital referrals and admissions by 10 percent;
- Training of 520 health policy experts and financial managers;
- Recurrent expenditures for PHC is at least 20 percent of total public expenditures for health; and
- Share of expenditures for primary and outpatient care at least 40 percent.

Component 3

- 100 percent pregnant women have access to HIV testing and have access to Mother-to-Child treatment (MTCT) prevention;
- Increase of coverage of groups at risk by HIV prevention activities by 10 percent;
- Adoption of a National Strategic Plan and scaling-up Directly Observed Treatment Strategy (DOTS) throughout the country;
- Training of at least 50 public health specialists and public health nurses; and
- Number of community-based grant projects implemented.

Component 4

- M&E system established with a minimum of 2 facility surveys and 2 household surveys.

1.3 Revised PDO (as approved by original approving authority) and Key Indicators, and reasons/justification

15. The PDOs were not revised.

16. Although attempts were made to fine-tune the indicators throughout the life of the project, none were formally revised prior to the formal restructuring of June 2010. Some of the PDO Indicators and Intermediate Outcome Indicators were modified and/or dropped due to data unavailability during implementation.

17. The final Results Framework was developed and agreed with ECA Quality during the Mid-Term Review on October 31, 2007, but was only formally revised at the restructuring in June 22, 2010 (see para. 45 and Table 4) as shown in the amended Supplemental letter No. 2 of the Amendment to the Development Financing Agreement. The revised indicators were:

Component 1

- Increase number of pregnant women who receive antenatal care in the early stage of pregnancy (up to 12-week pregnancy period) by 10 percent;
- Number of visits to PHC facilities (SVPs, FAPs) per capita of rural population; and
- Increase availability of essential pharmaceuticals for emergency care in SVPs

Component 2

- Decrease hospitalization rate among rural population;
- Decrease percent of patients referred from SVP to hospitals
- Convert urban pilot PHC facilities to per capita financing and management system in pilot areas;
- Convert rural PHC facilities to per capita financing and management system; and
- Share of expenditures for primary and outpatient care at least 40 percent;

Component 3

- Increase percent of target groups provided with Iron supplementation (in Bukhara, Navoi, Samarkand and Tashkent oblasts).

Component 4

- None

1.4 Main Beneficiaries

18. **Direct beneficiaries of the project investments were the following:**

a) communities benefiting from scaling up of the PHC development program. The project effectively targeted poor individuals and households as improvement of PHC services in rural areas was the principal way of providing basic services to poor and vulnerable households. Moreover, women and children who use PHC facilities to a greater extent, benefited particularly from improved access.

b) better equipped and staffed PHC facilities and functional integration in the treatment of priority health problems helped patient flows towards appropriate levels of care, adding indirect benefits including reduced travel time for patients, improved social welfare and productivity of the population.

c) family physicians (FP), nurses and managers benefiting from re-training and introduction and establishment of the FM specialization.

d) improved management of the pharmaceutical sector supply chain helped to serve the end-users of drugs and reduced frustration in health workers.

1.5 Original Components

The Project had the following four components[7]:

19. **Component 1. Development of the primary healthcare sector** (US$ 98.1 million or 83.1 percent of total project costs) was to support: (a) construction and provision of equipment, technical telecommunications and vehicles to SVPs not covered by the Health 1 project; (b) improved provision and use of basic medications and preparations in the SVPs; (c) development and implementation of the experimental urban PHC model, including provision of medical and laboratory equipment, training and consultancy; (d) strengthening the GPs training program, including provision of equipment for the three new clinical training centers and clinical laboratories, conducting training, study visits and provision of consultancy services; and (e) the creation and operation of the Evidence Based Medicine Centre and Centre for Continuous Medical Education, including provision of equipment, library materials, training and consultancy services.

20. **Component 2. Financing and management reforms** (US$ 5.4 million or 4.6 percent of total project costs). The component was to support: (a) the nationwide implementation of rural PHC sector financing and management reforms, including provision of computer equipment, training and consultancy services; (b) piloting reforms of financing and management in the urban primary healthcare sector, including provision of computer equipment, training and consultancy services; (c) implementation of provider payment and management reforms and rationalization of secondary healthcare services through provision of computer equipment, training and consultancy services; and (d) strengthening the management capacity of the health sector management through provision of equipment, training materials and consultancy services.

[7] Allocations by component changed during project implementation. See Annex 1 of this ICR

21. **Component 3. Improvement of public health services** (US$7.51 million or 6.4 percent of total project costs) was to support: (a) the further development and improvement of the national public health strategy; (b) strengthening the Public Health School; (c) expanding the scope of the programs for promotion of healthy lifestyles and sanitary education; and strengthening first aid and nutrition programs amongst the local population; (d) modernization and strengthening of the public health infrastructure through provision of training, consultancy services, computer equipment and re-equipping several sanitary-epidemiology laboratories; (e)the National HIV/AIDS Strategy and the National TB Strategy, including provision of equipment, training and consultancy services.

22. **Component 4. Project management, procurement, monitoring and evaluation** (US$2.9 million or 2.5 percent of total project costs). The component was to support: (a) planning procurement activities in accordance with the project's objectives; (b) conducting procurement and implementing financial controls over rational use of the project's funds; (c) training of Joint Project Implementation Bureau (JPIB) staff; (d) provision of consultancy services (including audit services); (e) strengthening the JPIB's and Oblast Project Implementation Bureau's (OPIB) capacity for implementing project activities; and (f) monitoring and evaluation of the project's results.

1.6 Revised Components

23. Per Government's request during the restructuring in June 2010, Component 1 was revised to include the following additional activities: provision of dental equipment and creation of a system for maintenance of medical equipment at PHC institutions.

1.7.1 Other significant changes

There were two amendments to the Development Financing Agreement:

24. **The first amendment,** letter of May 14, 2010, countersigned on June 22, 2010, included reallocation of funds and extension of the closing date (see below). Unallocated funds in the amount of US$ 4.178 million were reallocated for: (a) procurement of dental equipment for dental cabinets of PHC Centers and of rayon and oblast polyclinics with the greatest demand for dental care; (b) technical assistance for development of a medical equipment maintenance and repair system for SVPs; (c) revision and fine-tuning of the results framework to better monitor and report on project progress, and (d) TA for support of Health 3 project preparation. The Government's decision to allocate US$ 698,000 of the Credit proceeds for the preparation and design of the Health 3 project enabled the launching of preparation activities for the Health 3 project.

25. **The second amendment,** letter of June 11, 2011 related to: (i) a reallocation of funds to include procurement of information technology equipment and software to strengthen the Management Information System (MIS) in MoH; and (ii) a second extension of the closing date (see below).

26. **The closing date of the Credit and the Grant were extended twice for a total of 18 months.**

27. **The first extension** (amendment letter of May 14, 2010) was for 12 months (from the original date of June 30, 2010 to June 30, 2011) and was part of the first amendment of the Development Financing Agreement (June 22, 2010). The extension of the closing date was required to allow for the implementation of the remaining and newly introduced activities.

28. **The second extension** (amendment letter of June 8, 2011) was for six months (from June 30, 2011 to December 31, 2011). The second and final extension allowed for the effective completion of

procurement, delivery, installation, configuration and testing of the computer hardware and software for oblast, city and rayon IT centers, IT equipment for MoH, sanitary and epidemiological centers, dermatovenerological centers, as well as training specialists from IT centers on database management.

2. Key Factors Affecting Implementation and Outcomes

2.1 Project Preparation, Design and Quality at Entry

29. **The ICR team rates Design and Quality at Entry as Moderately Satisfactory** on the basis of the following features:

30. **Assessment of Project design.** The technical design of the first two components reflected the Government's own policy model stemming from the 1996 Rural Social Infrastructure Initiative. It had been piloted and refined through the Health 1 project. Over a dozen technical work groups reviewed its experience and impacts, and developed refinements for Health 2. Development of PHC and financing and management reforms initiated and piloted by Health 1 continued in Health 2, while Component 3 (Public Health) included the application in the specific conditions of Uzbekistan of well proven health strategies such as the DOTS and other interventions to contain TB and HIV/AIDS epidemics, as well as nutrition interventions. The design was appropriate to the health sector's needs and consistent with the country's development strategy to implement programs for poverty alleviation. The Project did not have a Quality at Entry Review (QER).

31. Project preparation activities were supported by the Japanese-funded PHRD grants TF-54236 and TF-54237. **The project objectives, scope and institutional arrangements were appropriate**. The project design incorporated the main lessons of Health 1 on policy, sustainability and implementation capacity issues. Furthermore, as the Health 1 had been implemented in very close collaboration and with TA from USAID, the design of Health 2 envisioned the same level of TA to be provided by USAID[8]. The project aimed to build institutional capacity in the areas of public health and pharmaceuticals. It was designed in close collaboration with a complementary project financed by the Asian Development Bank (ADB), which aimed at strengthening primary health care, especially maternity and child services and blood safety to complement activities under the IDA-supported Health 2 Project. From the point view of the ICR team, the Government's decision to have the Joint Project Implementation Bureau (JPIB) coordinate the implementation of both projects was appropriate and led to more efficient use of funds, better planning and synchronization of activities. In addition, the efforts to plan and carry-out joint supervision missions are commendable and led to synchronization of activities and efficient use of funds.

32. **Lessons learned.** As stated above, the project design incorporated lessons from the implementation of the Health 1 project. While the project design duly identified many areas needing improvement in the health system of the country, the ICR team finds that given the institutional constraints, the design was overly ambitious. The design was comprehensive, addressing multiple reforms, and introducing numerous changes in the health sector, covering a large area of the system. The limited institutional capacity in the country in general and in the health sector in particular, was in fact duly recognized in the PAD.

[8] However, this assistance did not materialize due to the USAID's activities being pared down very early in the life of Health 2 (2006) due to registration issues with the Government of Uzbekistan. This could have not been envisaged during the project preparation. Similarly, it was not possible to foresee whether reduction of USAIDs activities would be temporary or permanent.

33. Furthermore, the ICR Team notes that putting project proceeds and in-kind Government contribution under the same category of expenses (therefore subject to auditing), led to problems since it imposed auditing of the overall State annual budget. Auditing of the State annual budget was unacceptable for the Government and caused repeated issues with audit performance and acceptance of audit reports.

34. **Risk assessment**. The PAD identified four risks from outputs to objective and two risks from components to outputs, ranking from Modest to High. Substantially, the assessment of risks related to: (i) weak institutional capacity, and (ii) insufficient political will to right-size health care services in terms of number and quality of health care providers (having new GPs and nurses trained), number of beds in the facilities, and the size of the health facilities. Capacity in project management was rated as Modest in relation to procurement, given the experience from the previous project. As explained elsewhere in this ICR, in time, capacity in the JPIB increased in both quality and quantity as complexity of activities increased. However, capacity oscillated over the life of the project as JPIB leadership changed three times. Likewise, during the first two years of implementation, from September 2004 until December 2006, as well as from July 2009 to April 2010, JPIB was without an M&E specialist[9], thus unable to monitor progress against key performance indicators. Similarly, inflexibility of legislation and state procedures, especially related to procurement and lengthy administrative procedures led to delays in project implementation and monitoring. The complex government procedures caused significant delays in the amendment of the Results Framework after the Mid Term Review (MTR) of October 2007. In fact, the Bank received a formal request from the Government for restructuring only in June 2009 with an actual restructuring that only materialized in June2010 due to additional Government requests related to extension (see para. 45 and Table 4).

2.2 Implementation

35. **The ICR Team rates implementation as Moderately Satisfactory.** It has to be noted that the project was implemented in a very challenging environment burdened by a rigid and robust bureaucracy and punitive system. While the Project was successful in delivering most of the outputs under the four components (see Annex 2), there were delays that made the extension of the closing date by 18 months necessary. The Project was successful in achieving or substantially achieving all but one PDO indicator and almost all intermediate indicators, over-achieving several of them (see details in Tables 6-9, Annex 2, Section 3.2, and data sheet). Throughout its life, the Project went through oscillations, being rated Moderately Satisfactory or Moderately Unsatisfactory in terms of both PDO and implementation progress (IP). The first downgrading to Moderately Unsatisfactory rating was documented: (i) between November 2005 and June 2007 due to absence of implementation progress caused by the slow and rigid procedures impacting procurement and absence of M&E[10] ; and (ii) between October 2009 and June 2010 due to the JPIB being left without an M&E specialist from July 2009 to April 2010, thus unable to monitor and document implementation progress[11].

36. Some delays in implementation are discussed in paras. 38-40. Delays with procurement greatly affected implementation at various stages. The most crucial procurement delays were due to reasons

[9] ISRs No. 1,2,3,4,5 and 6

[10] ISR No. 4 [October 23, 2005]

[11] ISR No. 11 [October 13, 2009]

beyond the control of the project or even the health sector, such as the required price verification imposed by the Government after contract signing.

37. The Mid-Term Review took place from October 31 to November 5, 2007 and identified several issues:

a) Implementation of planned activities and progress towards meeting the project development objectives were on track;
b) US$10.8 million were un-programmed, coming from US$6.6 million savings from earlier procurements and US$4.2 million unallocated from the beginning of the project. Together with the Government, the Bank team re-appraised and re-costed the project adding additional activities, maintenance of medical equipment and supplying dental equipment to SVPs;
c) Need for refinement of Results Framework (RF) was identified in order to better reflect the progress towards achievement of development objectives and include newly added activities. New RF was developed and agreed with ECA Quality and applied as a monitoring tool; and
d) Need for a first one-year extension of the closing date along with the refinement of the RF called for Vice President level restructuring and appropriate steps were undertaken.

38. Several other factors affected implementation progress, both in positive and negative ways.

Positive factors and events that influenced project achievements

39. **The Project has contributed to the successful implementation of the Government of Uzbekistan's Strategy on Development of PHC.** Implementation of GP and PHC reforms in the country has been successful. With support from the Project, the transition phase of moving the PHC system from the previous system to SVP accelerated substantially. By the closing date, utilization rate of PHC increased considerably, from 3.8 to 4.7 visits to SVPs per capita. The Project successfully supported Government's efforts to accelerate the pace of health reforms in general and most specifically of SVPs, particularly to: (i) expand the retraining and institutionalize GP training for physicians (complemented by retraining and institutionalization of nurses training under ADB financed WHCD Project); (ii) broaden the role of GPs and the scope of services they deliver; (iii) improve access, performance, quality, and provide additional health promotion, prevention and extended PHC services; (iv) reinforce the gate keeping function of SVPs with GP acting as the first point of contact for patients (see Table 1); (v) build the financial management capacity through trainings and appointment of financial managers in SVPs; and (vi) strengthen the SVP infrastructure, through civil works, and provision of medical equipment, supplies, and vehicles (see Tables 2 and 3).

40. **Changes in overall management of the sector and the Project positively influenced the performance of the Project.** At the initial stage of the Project, it was closely supervised by the MoF while MoH had limited ownership and influence. JPIB had technical leadership, but was managed very poorly. Initially, the JPIB Director was appointed by the MoF without MoHs influence. The overall situation progressively improved through changes in JPIB leadership (JPIB Director changed three times over the life of Project and Curator of the Project changed once). There were only two Ministers of Health during project implementation. Initial problems with the management of the project by the MoH were gradually solved with the change of "Curator" (Deputy Minister of Health in charge of the Project) in 2005, appointment of respective Heads of different departments in MoH, who became in charge for corresponding Project components and sub-components and finally the new Minister in 2009. Gradually, MoH demonstrated increased capacity, strong commitment to the Project with an increased sense of

project ownership. This resulted in notable progress in the completion of planned activities leading towards achieving and overachieving project objectives.

Table 1. Referral of patients from SVPs to Central Rayon Hospitals, 2004

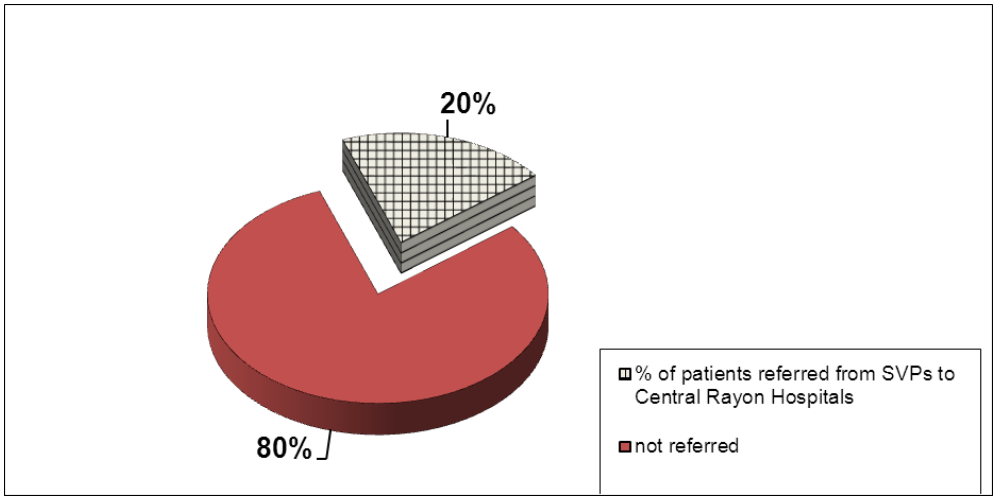


Table 2. Referral of patients from SVPs to Central Rayon Multi-field Polyclinics, 2011

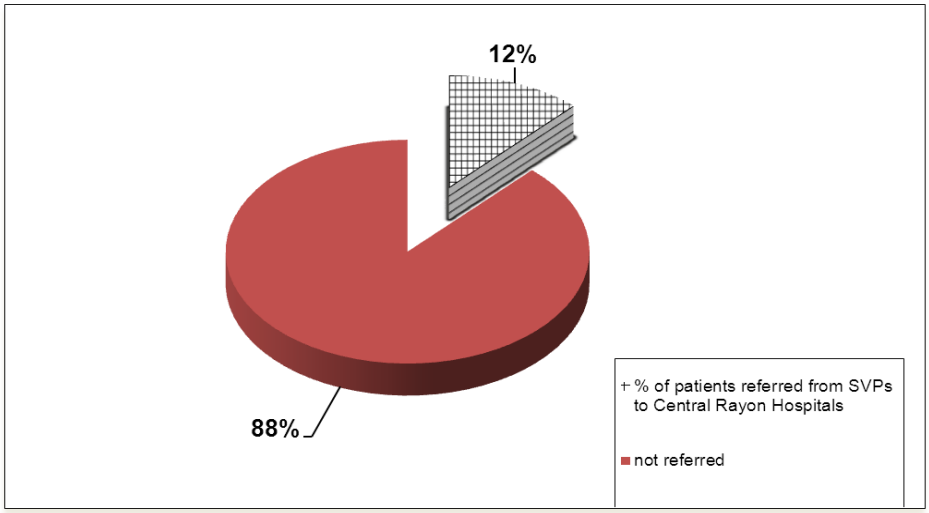
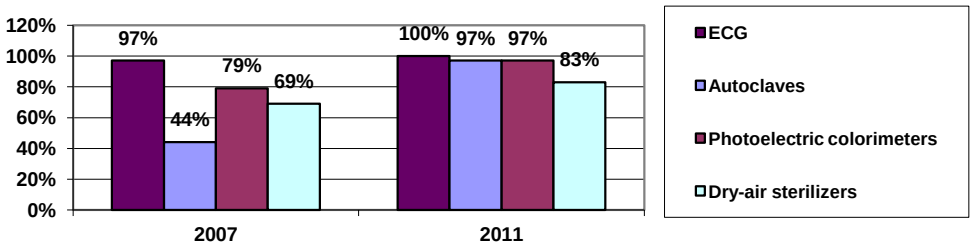


Table 3. Share of SVPs supplied with equipment



41. **The Project played an important role in strengthening the Public Health Sector** by: (i) developing and strengthening the institutional capacity through the establishment of the School of Public Health; (ii) supporting a number of important national public health initiatives such as the development and implementation of the Public Health Strategy 2008-2020, National Health Promotion Plan, and the Republic of Uzbekistan Law "On Restriction of distribution and consumption of alcohol and tobacco products"; (iii) introducing Iron Supplementation Program in four regions; (iv) enabling training of health professionals on HIV/AIDS prevention and treatment; (v) improving the Sanitary and Epidemiological Services (SES) Laboratories Network; and (vi) developing an Information System for Epidemiological Monitoring of infectious diseases.

42 **The Project used both financial and human capacities efficiently and managed to keep the momentum by preparing a new operation during implementation of Health 2.** Per Government's request, the Health 3 Project was included in the CAS 2008-2011[12]. Right after receiving a request for a new operation from the Government on September 3, 2008, the Bank team advised the Government that PHRD grants for project preparation were no longer available, therefore the Government needed to make a decision on whether to use a portion of unallocated funds from Health 2 or state resources for international and local TA needed for preparation. It took several months, i.e. from September 2008 to June 2009 for the Government to make the decision to use unallocated Health 2 funds for preparation of the new operation. Nevertheless, preparation was successful and timely. Health 3 was approved by the World Bank Board of Directors in April 2011.

Less effective factors and events which influenced project achievements

43. **Insufficient capacity and poor JPIB leadership and staffing in the earlier stages of the Project had a negative impact on project implementation**. Changes of JPIB Directors (3 over the life of project), staffing problems, especially in Procurement and M&E (Project was with understaffed Procurement and without M&E unit during its first year of implementation and without an M&E Specialist for almost full year in 2009) reflected on the project performance, including M&E as reflected in the ISRs[13] and Aide Memoires. Staffing problems were gradually resolved by new hires and intensive training of both newly

[12] CAS FY08-FY11 Report No. 43385-UZ [May 14, 2008]

[13] ISRs No. 1 [October 30, 2004], 2 [June 4,2005], 3 [June 23,2005], 4 [October 23,2005], 5 [April 19, 2006], 6 [December 13, 2006] and 7 [June 21, 2007]

recruited and existing staff. Towards the second half of project implementation, the JPIB became a highly competent and professional unit, which resulted in continuous and significant progress during the last years of implementation, as well as achievement of project development objectives.

44. **Inflexible legislation, especially regarding procurement significantly delayed project activities during the first two years.** The Uzbek practice (according to country legislation) of lengthy (four months or more) price verifications, comparisons and negotiations after contracts are signed greatly affected implementation. The same issues had also affected implementation of Health 1 project, other Bank-financed project, and other internationally-financed projects. The JPIB staff found themselves having to choose between adhering to local procurement rules and risk mis-procurement and cancellation of credit funds by the Bank or following Bank procurement guidelines and facing local prosecution[14]. Frequent on-site revisions of fiduciary and management processes by the Uzbek authorities contributed to JPIB's passive management style for fear of reprimand. These issues were resolved by the signing of a Memorandum of Understanding between the Bank and the Government to allow for Bank procurement guidelines to be followed, but not before the third year of project implementation, thus affecting timely completion of planned activities.

45. **Lengthy and complex Government's administrative procedures led to delays in restructuring thus affecting project implementation.** Even though the need to restructure the Project to refine the RF, reallocate unallocated and saved proceeds, and extend the closing date was addressed during the Mid-Term Review in October 2007, the actual restructuring took place only in June 2010 because, inter alia, of numerous delays by the Government to make and confirm a decision on the use of unallocated funds. Even though the refined RF agreed by the Government and the Bank and reviewed by ECA Quality was adopted as a monitoring tool during the Mid-Term Review, it was only formalized two and a half years later. Table 4 shows the chronological order of events leading to the restructuring.

Table 4. Restructuring process from initiation (2007) to completion (2010)

October 31, 2007	Mid-term Review revised indicators and identified need for reallocation of unallocated/saved proceeds and for extension of closing date.
March 2008	MoH sent the Letter expressing the need for restructuring in order to reallocate project proceeds to the Prime Minister and the MoF.
September 3, 2008	The Bank received Government's Request for a new Health 3 Project.
June 2009	The Bank received formal Request for Reallocation Letter from MoF (delay caused by lengthy discussions within the Government on the use of unallocated/saved funds for procurement of dental equipment for SVPs and TA for preparation of the Health 3 project) and proposed amendments to Development Financing Agreement. The letter did not include the Request for extension of Closing Date. The Bank team initiated restructuring immediately upon receiving the Request.
October 6, 2009	The Bank team pointed out to MoH of the need for extension of Closing Date in order for the Project to complete all planned activities and advised the Government to send the request for for a one-year extension to be processed together with restructuring
December 15, 2009	The Bank received Request for extension from the Government. However, discussions on refinement of the Results Framework continued during following months.
May 14, 2010	The Bank sent Letter of notification regarding restructuring and extension of the Project up to June 30, 2011including Supplemental letter No. 2 of the Amendment to the Development Financing Agreement revised PDO and Intermediate Outcome Indicators.
June 22, 2010	Project restructured

[14] ISR No.5 [April 19, 2006]

2.3 Monitoring and Evaluation (M&E) Design, Implementation and Utilization

46. **Design, implementation, and utilization of M&E are rated Moderately Satisfactory** for reasons elaborated below.

47. **Design.** The PAD defined a rather comprehensive set of PDO and intermediate outcome indicators, which reflected well the PDO and project components. As the reform progressed some of the indicators became less relevant and introducing new activities created the need to make changes to better reflect the new situation. A new RF comprising of 9 PDO and 18 intermediate outcome indicators was introduced in agreement between the Government and the Bank after the Mid-Term Review. The new RF became the monitoring tool until the end of the Project, even though the RF was only formally revised during the restructuring of June 2010.

48. **Implementation** was a weak link at the beginning of the project. As indicated earlier, the M&E Unit in the JPIB, who was responsible for this activity, was both understaffed and undertrained[15]. This led to difficulties in defining baselines for some indicators and preparing monitoring progress reports. This issue was addressed and overcome through hiring and training of staff, but got worsened when JPIB was left without an M&E Specialist in July 2009 for nine months, resulting in the downgrading of the Project to Moderately Unsatisfactory due to monitoring not being possible[16]. A new staff was hired in April 2010 and significant improvement has been noted since.

49. **Utilization.** M&E was used under the Project as a management tool to evaluate the status of implementation of activities. In addition, it was used to inform policy makers for decision-making purposes and help prioritize activities to support the reform agenda. The PDO indicators of the Project have been integrated into the Government's Official Monitoring Agenda and are being monitored even to date, which demonstrates their relevance in measuring the performance of the health sector.

2.4 Safeguard and Fiduciary Compliance

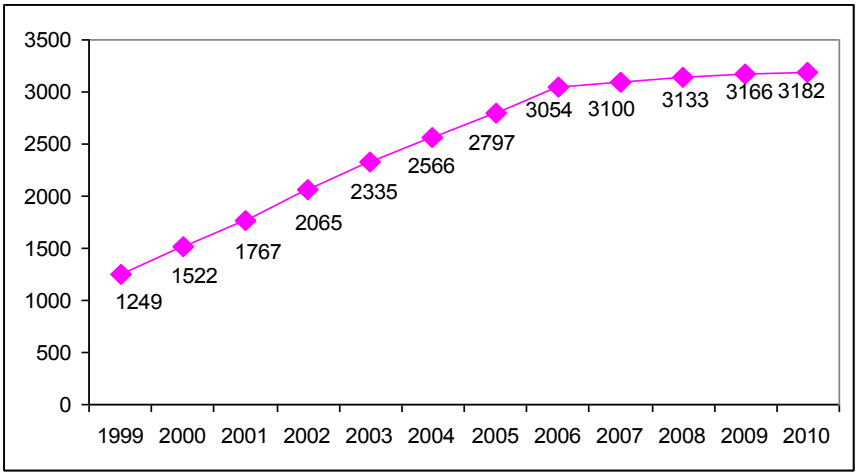
50. **The environmental impact of the Project at the time of preparation was rated C.** Originally, the Project focus was on developing systems and structures, the supply of equipment and minor rehabilitation. No civil works were planned to be financed under the Credit. However, over the life of the Project, the Government's originally planned contributions to civil works multiplied almost nine times and were aimed towards reconstruction and construction of existing and new SVPs (see Table 2)[17].

[15] ISRs No. 4 [October 23,2005], 5 [April 19, 2006] and 6 [December 13, 2006]

[16] ISR No. 11 [October 13, 2009]

[17] Number of SVPs to benefit from Government's own resources increased from 1249 in 1999 to 3182 in 2010.

Table 5. Number of rural health facilities (SVPs) 1999 - 2010



51. The PAD Review conducted in December 2008 found that the project was assigned the Environmental Category C based on the prevailing practice and OPCS guidance at the time that projects involving only small scale construction with no special risk aspects (for example, no sensitive sites, no land acquisition) should be classified as Category C. While more recently, all projects involving new construction are classified as Category B to ensure the preparation of at least a simple Environmental Management Plan, the practice adopted for the PAD review at that time was that Category C projects would only be upgraded to Category B if either: (i) there were environmental or social issues raised by construction undertaken up to the time of the Review; or (ii) further new construction was planned under the project in the future. Neither of these circumstances applied to this project.

52. The Health 2 Project was built on the accomplishments of the Health I project by providing additional support for the restructuring of primary care and outpatient services in rural areas. The Government, for its part, had undertaken rehabilitation of selected facilities already in operation and the building of new primary care centers. At the time of the Review, all construction had been completed and no additional construction was envisioned.

53. The issue has been documented[18] and management guidance sought. Upon recommendation of the ECA safeguards coordinator, in June 2009 the team visited a sample of sites constructed under the project and found no issues regarding compliance with local construction regulations, land acquisition or resettlement. The new construction had been carried out with due diligence and in an environmentally sound manner. The team reported these findings to the ECA safeguards coordinator and it was agreed that there was no need to change the environmental rating at this stage since all works financed by the Government were done in compliance with Bank standards and no additional construction was planned under the project. This conclusion had also been discussed and agreed on with the ECA Quality Unit.

[18] ISR No. 10 [February 2, 2009]

54. **Financial Management (FM) arrangements at JPIB, including accounting, reporting, planning and budgeting, and staffing is rated Moderately Satisfactory.** Overall, the JPIB had acceptable budgeting and planning capacity. The annual budgets were prepared on a timely basis by the JPIB, approved by the MoF and entered into the accounting system by the FM staff of the JPIB.

55. JPIB's internal controls system was assessed on a regular basis by the Bank's FM Specialist and was found in general to be reliable and capable of providing timely information and reporting on the project. In particular, the JPIB performed monthly formal reconciliation of disbursement data with project's accounting records. This was done using the Bank's Client Connection system. Proper data back-up arrangements were followed. The JPIB utilized the 1C accounting software that was specially designed for Bank-financed projects. The software was able to generate Financial Management Reports (FMR) and statement of expenditures (SOEs). At the end of each quarter, the JPIB developed FMRs and submitted them to the Bank. Usually these reports were submitted on time and found Satisfactory.

56. The audits reports for the project's financial statements were usually qualified (either **except fo**r or **adverse** opinions). The reason for qualification of the auditor's opinion was as follows: counterpart funds disbursed as in-kind contribution by reports of Regional Project Implementation Bureaus (hereinafter referred to as RPIB – Oblast Project Implementation Bureau in Russian) were usually understated in the financial statements of the Project due to the non submission of the information from RPIB. For several years, the JPIB tried to get reports on the co-financed shares from regional Treasury offices, but failed as Treasury was only allowed to provide such information to the Project with the permission of the Cabinet of Ministers (CoM) or MoF. In 2010, this problem was partially resolved with the Bank's involvement, when the MoF obliged Treasury to provide the JPIB with information on amounts disbursed. However, audit opinions still were qualified as the auditor was not provided with supporting documentation to confirm disbursements and expenditures. Disbursement applications were generally prepared accurately and submitted regularly. By the end of the grace period (April 30, 2012), disbursements under the IDA Credit and IDA Grant reached 99% of the total Credit and Grant amounts.

57. **Lessons learned.** There was a risk that similar issues would arise in regard to the in-kind contribution spending under the Health 3 project. To avoid such potential problems, it was agreed that in-kind contributions will not constitute part of the Government of Uzbekistan's co-financing for the Health 3 Project, which was declared effective on November 2, 2011.

58. **The ICR team rated the procurement performance under this project as Moderately Satisfactory.** There were no significant deviations or waivers from the Bank procurement policies and procedures, although the project faced numerous challenges in getting experienced staff on board at the initial stage of implementation.

59. Two issues were identified as major ones affecting the project procurement. First, it is a principle agreed between the Bank and any borrower that under Bank-financed projects, procurement procedures and rules of the Bank should prevail when there is a discrepancy between the government public procurement procedures and the Bank's procurement guidelines. In practice, this principle cannot always be easily followed. The Bank team had to remind and persuade the Government to do so throughout the project life. Each time when the Government would not accept Bank's comments on the bidding documents or bid evaluation reports, discussion on which procedure should be followed had to be repeated. JPIB had to shuttle between the Bank and MOH trying to find a balance by incorporating some of the Bank's comments while answering to Government requests. In many cases, the process could drag on for weeks and months, resulting in delays of contract awards and delays in project implementation. It is worth noting that this is not a project specific issue. Most of the projects in other sectors and on-going projects financed by the Bank are still facing similar challenges to a certain degree. It is clear that country public

procurement reforms remain a priority in Bank's support to public sector reforms. More efforts should be made to bring the national procurement systems in line with good international practices. Second, the contract registration requirement by Government agencies was a second bottleneck in procurement and project implementation. All signed contracts had to be registered and price verified and the process could take as long as six to eight months. Again this is a country requirement which applies to all sectors and all projects. The health project may have suffered more than other sectors because health projects normally have many more contracts with very small values in money terms. This could be part of the reason why a lot more staff time was needed to address administrative requirements.

2.5.1 Post-completion Operation/Next Phase

60. **Support to the health sector is continuing through the Health 3 operation.** The project complements the current and planned support from Government and other donors and international agencies. As such, Health 3 addresses in a more systemic way the challenges of the provision of quality hospital services to the country's rural population, reforming the way those services are organized and paid for, general public health education and promotion, and behavioral change of the population. The Health 3 project aims at bringing together the various interventions among donors while focusing on integrating and scaling up major public health actions through deepening ongoing health sector reforms within the context of the Government Welfare Improvement Program. It responds to two of the CAS's[19] four pillars, specifically to: (i) enabling an environment for shared growth (under "increasing the efficiency of public financial management for more effective service provision"), and (ii) improving human development and social protection through improved basic services delivery. The objectives of the Health 3 Project are to: (1) improve access to quality health care at the primary level and at Rayon Medical Unions, and (2) strengthen the Government's public health response to the rise in Non Communicable Diseases (NCDs)[20].

3. Assessment of Outcomes

3.1 Relevance of Objectives, Design and Implementation

61. **The ICR team rates relevance of objectives, design and implementation Substantial.** At the time of approval on September 9, 2004, the Project was relevant and consistent with development priorities of both the Government (as confirmed through several strategic documents) and the Bank (the 2002 CAS). The Project design addressed important Government's priorities and followed the footsteps of the previous Bank-supported health operation in the country as well as other health reform projects in the ECA Region taking into account key lessons learned. At the time of this ICR, the PDOs are not only relevant, but integrated into the Government's monitoring matrix as a monitoring tool and are in line with the Bank priorities (the 2012 Country Partnership Strategy [21]). The Project has had significant impact in supporting implementation of health reforms in the country and was used strategically to actively support health reform activities and build up capacity in the MOH. Furthermore, reforms initiated by Health 1 and Health 2 are now rolled out and brought to the next level by the ongoing Health 3 Project.

[19] CAS FY08-FY11 (Report No. 43385-UZ) [May 14, 2008]

[20] PAD Health 3Report No.56632-UZ [March 10, 2011]

[21] CPS FY12-FY15 Report No. 65028-UZ [November 1, 2011]

3.2 Achievement of Project Development Objectives

62. **PDOs have remained the same throughout the life of the Project; however, RF has undergone modifications that were formally restructured in June 2010.** The ICR Team applied the methodology found in Appendix B of the ICR Guidelines (rev. October 2011) by OPCS in evaluating the overall achievement of the PDOs.

Rating: ***Substantial*** for the original PDO Indicators and ***Substantial*** for the revised PDO Indicators.

63. Evaluation of outcomes against the PDOs was challenging due to changes in the RF. The RF has been refined to better reflect the progress towards the PDOs and agreed by the Government and the Bank at the 2007 Mid-Term Review. However, as indicated earlier, the RF was formally revised in June 2010 and by that time the Project had disbursed 63 percent of the credit proceeds.

64. It was possible to evaluate the progress for 14 out of 15 original PDO Indicators. The project made substantial achievements against the benchmarks prior to the formal RF revision (Tables 6 and 7). Moreover, despite the delay in formally revising the PDO indicators as explained in paras 43 to 45 and Table 4, there was a dialogue to restructure the project and to refine RF well before the formal revision.

Table 6. Achievement of Original PDO Indicators as stated in PAD

PDO INDICATOR (Baseline)	ACTUAL VALUE ACHIEVED (December 31, 2011)	LINKS TO INDIVIDUAL PDO [22]
1. Increase number of pregnant women covered by prenatal care by 10% (99.3%)	ACHIEVED. Percent of pregnant women covered by prenatal care: 99.7%	PDO 1
2. Increase number of newborns who receive hepatitis B immunization by 10% (99.2%)	ACHIEVED. Percent of newborns who receive hepatitis B immunization: 99.3%.	PDO 1
3. Increase primary care utilization and access by 10% (3.8 visits per capita)	OVER ACHIEVED. (236%) Number of visits per capita to SVPs: 4.7	PDO 1
4. Training of 2,700 general practitioners who work in SVPs (898)	OVERACHIEVED. (129%) 3770 GPs trained	PDO 1
5. Increase availability of essential pharmaceuticals at primary care level as measured by number of essential drugs stocked (38.9%)	ACHIEVED. Increased availability of essential pharmaceuticals at primary care level as measured by number of essential drugs stocked: 64%	PDO 1
6. Decrease hospital referrals and admissions by 10% (20%)	OVERACHIEVED. (160%) Hospital referrals and admissions: 12%	PDO 2
7. Training of 520 health policy experts and financial managers (0)	OVERACHIEVED. (340%) 1769 health policy experts and financial managers trained	PDO 2
8. Recurrent expenditures for primary care at least 20% of all expenditures (16%)	PARTIALLY ACHIEVED. Recurrent expenditures for primary health care increased to 18.3%	PDO 2
9. Share of expenditures for primary and outpatient care at least 40% (41.7%)	OVERACHIEVED. (113%) Share of expenditures for primary care is 45.2%.	PDO 2
10. 100% pregnant women have access to HIV testing and have access to Mother-to-Child treatment and prevention	N/A. Obtaining data on this indicator would have required a special survey	PDO 3
11. Increase of coverage of groups at risk by HIV prevention activities by 10% (0%)	ACHIEVED. Increase from 0% to 14.3%.	PDO 3
12. Adoption o f a National Strategic Plan and scaling-up Directly Observed Treatment Strategy (DOTS) throughout the country(No program)	ACHIEVED. DOTS program expanded nationwide	PDO 3
13. Training of 50 public health specialists and public health nurses (0)	ACHIEVED. 54 public health specialists trained.	PDO 1
14. Number of community-based grant projects implemented	NOT ACHIEVED. Implementation of the program ceased due to absence of organizations which have an experience in community development on primary health care.	PDO 3
15. M&E system established with a minimum of 2 facility surveys and 2 household surveys (None)	ACHIEVED. 2 facility surveys and 2 household surveys were conducted in 2007 and 2011	PDO 4

65. Out of the 15 original PDO indicators, 12 have been achieved (5 of which overachieved), 1 partially achieved, 1 not achieved, and 1 impossible to measure as it has not been monitored since 2007 and obtaining data on this indicator would require a survey.

[22] PDO1: completion of the primary care program in 8 regions (Samarkand, Sukhandarya, Namangan, Andijon, Djizzak, Ferghana, Navoiy, and Syr Darya) and other regions as agreed, and institutionalization of general practitioners nationally; PDO2: extending financing and management reforms related to efficiency and effectiveness of service delivery;
PDO3: improving public health services, including surveillance, training in public health and control of communicable diseases
PDO4: building capacity in the Ministry of Health to better monitor and evaluate the reforms, and better manage the restructuring process

Table 7. Status of Progress Against Original Project Indicators

Status	15 PDO Indicators	% of Total
Achieved	**12**	80%
Not Achieved	**1**	6.6%
Partially Achieved	**1**	6.6%
Progress not attributable to Project		
N/A	**1**	6.6%

66. Regarding the revised PDOs, the Project has achieved its development objectives to a large extent (see Tables 8 and 9). Five outcome indicators out of nine have either reached the end of the project targets or exceeded them. More specifically, the share of women who received antenatal care in the early stage of pregnancy increased form baseline 77 percent in 2004 to 87 percent in 2010 , exceeding end of the Project target of 85 percent. Furthermore, share of patents referred from primary health centers (SVPs) to hospitals decreased from the 20 percent baseline in 2004 to 12 percent in 2011 showing greater improvement as compared with the end of Project target of 15 percent, which is actually quite high by itself and comparable to other countries. Likewise, end of the Project targets have also been reached for key indicators related to financial and management reforms. Thus, the share of State expenditures for primary and outpatient care gradually increased from 41.7 percent in 2004 to 45.2 percent in 2011. All rural PHC facilities and urban pilot PHC facilities have been converted to per-capita financing and management system.

67. Two outcome indicators have substantially reached agreed targets: 94 percent achievement in the increase of the number of visits to PHC facilities and 96.3 percent achievement in the decrease in hospitalization rate among the rural population. These results show a significant improvement in the provision of basic health services at rural clinics and in the institutionalization of GP based PHC nationally.

68. However, the Project failed to reach its target in the provision of essential pharmaceuticals to rural clinics. The percent of SVPs which were provided by at least 75 percent of essential pharmaceuticals has not improved during the life of the Project despite Government's efforts during the last 2 years to allocate additional resources for procurement of medicines. The situation with the availability of essential drugs at SVPs is a reflection of two major factors: (i) insufficient volume of financing for non-salary expenditures of health facilities, and (ii) insufficient administrative flexibility in the transition from decentralized procurement of drugs to their centralized procurement and distribution. The latter action was aimed at increasing cost-efficiency. However the implementation of the new procurement system was not properly administered, which resulted in delays in the supply of a number of items from the list of essential drugs. Meanwhile, 64 percent of SVPs are being provided with 50 percent of the drugs from the list.

69. The final assessment of the Project conducted by an independent consulting group (see Annex 5) has revealed positive developments in patients' satisfaction with the quality and accessibility of SVP services as well as in population awareness on disease prevention measures. The survey data shows that complex measures on upgrading physical conditions of rural health clinics, providing them with modern medical equipment and supplies, and improving knowledge and skills of doctors and nurses have reduced the need of the population in rayon hospital to seek specialists' services.

Table 8. Achievement of Revised PDO Indicators

PDO INDICATOR (Baseline)	ACTUAL VALUE ACHIEVED (December 31, 2011)	LINKS TO INDIVIDUAL PDO
1. % of women who receive antenatal care in the early stage of pregnancy (up to 12-week pregnancy period) (77%)	ACHIEVED. Increase to 87%	PDO 1
2. Increase number of visits to PHC facilities (SVPs, FAPs) per capita of rural population (3.8)	SUBSTANTIALLY ACHIEVED. (94%) Number of visits increased to 4.7	PDO 1
3. % of SVPs stocked with (for at least 75% of) essential medicines for emergency care (38.9%)	NOT ACHIEVED. Increase to 64%.	PDO 1
4. % share of expenditures for primary and outpatient care at least 40% (41.7%)	OVERACHIEVED. (120%) Share of expenditures for PHC 45.2%	PDO 2
5. Decrease hospitalization rate among rural population (11.1%)	SUBSTANTIALLY ACHIEVED. (96.3%) Decrease to 10.5%	PDO 2
6. % of urban pilot PHC facilities converted to per-capita financing and management system in pilot areas (0%)	ACHIEVED. 100% urban PHCs converted to per capita financing and management system	PDO 2
7. % of rural PHC facilities converted to per capita financing and management system (21.5%)	ACHIEVED. 100% rural PHCs converted to per capita financing and management system	PDO 2
8. Decrease % of patients referred from SVP to hospitals by 10% (20%)	OVERACHIEVED. Decrease to 12%	PDO 2
9. % of target groups provided with iron supplementation (in Bukhara, Navoi and Tashkent oblasts) (0%)	OVERACHIEVED. Over 95% in all four oblasts (Bukhara 98.5%; Navoi 97.8%; Samarkand 96%; Tashkent 95.1%)	PDO 3

Table 9. Status of Progress Against Revised Project Indicators

	9 PDO Indicators	% of Total
Achieved	**6**	67%
Substantially Achieved	**2**	22%
Not Achieved	**1**	11%
Progress not attributable to Project		

3.3 Project Efficiency

70. **Efficiency is rated Substantial.** The Project has had a significant impact in the frame of ongoing health reforms in the country. In particular, the Project has made significant achievements in: (i) implementing PHC reform with emphasis on the GP model, (ii) institutionalizing CME, (iii) increasing utilization and efficiency of health care in rural areas, and (iv) strengthening the public health system through training, surveillance and control of CDs. The comprehensive nature of the reforms, with changes in the legal basis of the health system, organizational arrangements, financing, provider payment systems, and service provision, has meant that strong platforms have been established to expand and sustain the changes achieved. The reforms have been welcomed by all key stakeholders. The Project has been successful as demonstrated by improved key indicators on: (i) utilization of rural PHC, (ii) population satisfaction with the quality and access to PHC services, and (iii) efficiency of outpatient services provision. The survey conducted by an independent consulting group at the end of the Project (see Annex 5) has revealed positive developments in patients' satisfaction with the quality and accessibility of SVP services as well as in population awareness on disease prevention measures. The utilization of outpatient services among the rural population increased from 3.8 visits in 2004 to 4.7 visits to SVPs in 2011. Equally, the referral rate from SVPs to hospitals in project target areas decreased from 20 percent in 2004 to 12 percent in 2011.

3.4 Justification of Overall Outcome Rating

71. **The ICR Team rates Overall Outcome of the Project as Moderately Satisfactory.** As per ICR Guidelines (rev. October 2011), the ICR team weighed the overall outcome both against the original and revised Key Performance Indicators (KPIs) based on amounts disbursed at the time of formal restructuring (Table 10). The Project's overall outcome is considered **Moderately Satisfactory** based on the Project's significant achievements, its continued relevance, its contribution towards strengthening Uzbekistan's health sector program, and making it more accountable and efficient. While the ICR team has rated outcome as Moderately Satisfactory, it is worth debating whether the project's strong outcomes merit a higher rating (for reasons noted in para. 45, the formal restructuring did not take place in 2007, as might have been desirable). As Uzbekistan continues its challenges regarding continuation of financing reforms and further expansion of family medicine, especially in urban settings, the Project's contributions will continue to be highly relevant having in mind that the Government has incorporated the project's Results Framework into its regular monitoring schedule. The Project's contributions are being further supported under the Health 3 Project, which is under implementation.

Table 10. Combined Overall Project Achievement Rating

Rating/Scale	Against Original KPIs	Against Revised KPIs
1. Rating	Moderately Satisfactory	Satisfactory
2. Rating value	4	5
3. Amount disbursed	24.87 out of 39.48	14.61 out of 39.48
4. Weight (% disbursed before/after KPI change)	63%	37%
5. Weighted value (rating by disbursement	4*.63= 2.52	5* .37=1.85
6. Final rating (rounded and weighted)	**4 .37 *Moderately Satisfactory***	

Source: OPCS, ICRR Guidelines (rev. October 2011), Annex B.

3.5 Overarching Themes, Other Outcomes and Impacts

(a) Poverty Impacts, Gender Aspects, and Social Development

72. While the Project was not explicitly classified as a poverty-targeted operation, it has had a positive impact on the poor as it targeted the rural population, where most of the poor live. The 2002 CAS Report No. 23675-UZ and the PAD identified that: (i) most of the country's population lived in rural regions (63 percent), (ii) 28 percent of the population lived below the poverty line, (iii) a third of them could be considered extremely poor, and (iv) many, but especially the poor, were negatively affected by corruption and informal payments including payments for social services. Furthermore, PHC was predominantly used by women and children. Data on utilization of PHC services was monitored throughout the life of the Project and showed the impact of improved access and quality of care of populations of all socio-economic groups, including the poor and women, especially in rural areas. During ICR discussions, patients noted that with the improved access, quality of care and physical condition of SVPs, they did not have to travel (and spend money on transport) and could obtain diagnostics and needed treatment from their GP instead of being referred to hospitals (thus potentially spending more money for medications and informal payments/gifts). In addition, poor people have benefited from policy interventions that included targeting rural communities through the SVP improvement program.

73. The PAD also identified and addressed MM rates that were overall high and excessive in poor regions (over 90 deaths per 100,000 live births in 2000 in Navoi region and 48 deaths per 100,000 live births in 1999 in Karakalpakstan). Data on the share of women who received antenatal care in the early

stage of pregnancy were monitored throughout the project and showed significant increase from baseline (77 percent in 2004 to 87 percent in 2010). Longer term benefits are expected for the whole society from improved governance, public health policy making, and replication of best practices.

(b) Institutional Change/Strengthening

74. **It is not possible to attribute success in capacity building to a single project having in mind the presence of other intervening factors such as the ADB[23] health project, the Japan International Cooperation Agency (JICA), World Health Organization (WHO), United Nations Development Program (UNDP), United States Agency for International Development (USAID), Deutsche Gesellschaft fur Internationale Zusammenarbeit (GIZ), and other agencies, which also contributed to strengthening institutional capacities.** On the other hand, during ICR discussions with MoH, MoF, the Tashkent Institute for Advanced Medical Education (TIAME), Medical Academy, and the Institute for Health and Medical Statistics, National AIDS Center, Regional Training Centers and SVPs, managers and staff recognized that Project investments, including investments in capacity building and technology, have resulted in substantial institutional development at different levels of the health system. Significant progress was made through the Project in improving the capacity of MoH and health care institutions staff to deal with modern management and policy analysis methods. The strong focus on management training and capacity building under the Project has served to entrench modern approaches as part of the general management culture on the health sector, thus helping to ensure that the PDO was achieved and could be sustained beyond the closing date.

(c) Other Unintended Outcomes and Impacts (positive or negative)

75. **Close coordination and synergies with activities financed by ADB, JICA, WHO, UNDP, GIZ have resulted in better outcomes for the sector.** ADB has supported efforts towards improvement of PHC through civil works, equipment and capacity building. WHO has provided technical assistance towards improving public health, mental health, nursing, nutrition and GPs capacity building, GIZ on capacity development of nurses and maintenance health services and UNDP provided technical assistance on renewable energy sources and integrated Energy Efficiency (EE) requirement standards.

3.6 Summary of Findings of Beneficiary Survey and/or Stakeholder Workshops

76. The final assessment of the Project was conducted by an independent consulting group[24] and has showed positive developments in patients' satisfaction with the quality and accessibility of SVP services, as well as in population awareness on disease prevention measures. The survey data showed that complex measures on upgrading physical conditions of rural health clinics, providing them with modern medical equipment and supplies, and improving knowledge and skills of doctors and nurses have reduced the need of the population in rayon hospital to seek specialists' services. The assessment and its methodology are discussed in more detail in Annex 5.

23 ADB Loan of US$40 million was closely coordinated with the WB Health 2, both in design and implementation stage. The two projects were complementing each other as ADB was supporting renovation and equipment of SVPs, and training for GP nurses. The ADB and WB projects were implemented by the same agency, JPIB and were also jointly supervised by the Bank and ADB teams.

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4. Assessment of Risk to Development Outcome

77. The risk at the time of the ICR that development outcomes will not be maintained is rated **Negligible.** The Government's and related institutions' ownership and commitment to sustaining gains are strong. In addition, the ongoing Health 3 Project continues to provide financial support for the various areas addressed by this Project.

5. Assessment of Bank and Borrower Performance

78**.** Team leadership changed three times over the life of Project, causing some adjustments in the way the Bank guided implementation (see below).

5.1 Bank Performance

(a) Bank Performance in Ensuring Quality at Entry

79. **This evaluation rates the Quality at Entry as Moderately Satisfactory.** As described in Section 1.1, in the view of the ICR team: (i) the project objectives and scope were appropriate for the stage of development of the sector in the country, (ii) the Project built on the findings of the functional review of the health system conducted prior to appraisal by the Bank and 12 respective Government Working Groups, experience with implementation of the previous Bank-financed health operation in Uzbekistan and elsewhere in the ECA Region, (iii) the Project addressed the Government's objective of cost-containment while promoting improvement in quality and access to PHC, and (iv) it supported key elements of the CAS by promoting the institutional development of the MoH. Nonetheless, as noted earlier, this evaluation finds that while selected objectives were appropriate for the status of reforms and addressing all the areas for improvement in the system at the design stage, perhaps a less ambitious scope of design would have been more appropriate given the limited institutional capacity and weak legal framework appropriately identified in the PAD and what could have reasonably been expected to be achieved within a limited timeframe. The targets set at the time of preparation were neither easy nor a foregone conclusion. The fact that several of them were overachieved is a testament to the commitment of the Government to addressing these issues.

(b) Quality of Supervision

80. **The ICR team rates the quality of supervision as Satisfactory.** From the outset it was recognized that given the limited institutional capacity of both MoH and JPIB, the Project would require close monitoring and a hands-on supervision approach to ensure successful implementation. Supervision was intense with frequent technically adept missions, ensuring consistency of the policy dialogue and the messages delivered to the Government. The Task Team Leader (TTL) responsible for processing the Project for approval, continued as TTL for two and a half years after Credit effectiveness. The second TTL guided project implementation for eighteen months, i.e. up to September 2008. The third and last TTL stayed with the Project to the closing date, i.e. for over three years and is the TTL for Health 3 project. The engagement of the Bank staff in the country office was very helpful in ensuring continuity in the Bank team.

81. For the most part, teams were responsive to client needs and demonstrated flexibility in adapting to evolving priorities within the parameters of the PDOs. Equally, teams were diligent in their communication with Government and Bank management, providing up-to-date information and analysis

on the status and impact of project activities, issues encountered, and suggesting options to address issues that arose as a result of evolving needs. In the view of this ICR, the fact that the last TTL is fluent in Russian, who understands the Soviet and Post-Soviet systems helped build trust with the client and made it easier for the Bank to convey challenging messages.

(c) Justification of Rating for Overall Bank Performance

82. For the reasons stated above, the ICR Team rates Overall Bank Performance as **Moderately Satisfactory.**

5.2 Borrower Performance

(a) Government Performance

83. **Government's performance during project preparation and implementation was Moderately Satisfactory.**

84. Prior to the Project, the Government had introduced key pieces of legislation to create an enabling environment and to establish platforms for systemic, comprehensive, and multi-faceted health reforms to reduce inefficiencies, enhance equity and access (financial and geographic), and improve quality of care. It established supervision mechanisms at several levels, including MOH, MOF, and Ministry of Economy. Government's commitment and buy-in for the reforms may be best illustrated with the fact that Government's financial contribution by the end of the Project increased almost nine times, from an originally appraised US$ 78 million to actually spending US$ 698 million invested towards construction/reconstruction of SVPs, resulting in a significant increase in the number of SVPs from 1249 in 1999 to 3182 in 2010, thus providing even the most remote areas of the country with access to PHC. In general, the Project benefited from strong support and active interest from the relevant agencies of the Government.

85. Less satisfactory aspects of Government performance are related to: (i) inflexible procurement procedures that have significantly affected project implementation especially in its early stages; and (ii) lengthy and complex administrative procedures that, among other, affected timely restructuring of the project. The Government was less effective during the first half of the project in: (iii) enabling legal conditions for the results framework to be formally amended as per agreements reached during the 2007 Mid-Term Review; and (iv) ensuring that the implementing agency, JPIB, is appropriately staffed and trained, thus enabling for timely and satisfactory implementation and monitoring of the Project.

(b) Implementing Agency or Agencies Performance

86. **Performance of the Ministry of Health was mixed.** There were initial deficiencies in the MoH due to the lack of ownership and experience in project management and implementation. At the beginning, Project was largely managed by MoF who appointed the Director and staff of the JPIB at its own discretion, while JPIB was in charge of technical aspects of the Project. These deficiencies were gradually overcome by capacity accumulated in MoH over the life of the Project. Commitment of the MoH to the Project increased substantially and extended beyond the life of the Health 2 as the MoH is now implementing Health 3 which in many aspects builds up on achievements of the Health 2. Likewise, as stated earlier, the Monitoring Framework for Health 2 has been incorporated into MoH's monitoring and reporting schedule. The Minister of Health changed only once, three years before the closing date of December 2011. The Minister of Health took the supervision and management of Health 2 as a priority and established an organizational scheme where the Curator of the Project (Deputy Minister of Health) chaired the MoH Expert Committees comprising of Deputy Ministers, Heads of respective Departments in

the MoH in charge of different components and sub-components of the Project including (i) public health; (ii) quality of medical services; (iii) education and training; and (iv) health financing. In addition, Deputy Minister of Finance, Head of the Social Affairs Department was assigned responsibility for the Project on behalf of the MoF. The ICR Team had the opportunity to meet and have discussions with the officials of the respective Ministries and was impressed with their understanding, in-depth involvement, interest and close follow-up of the Project.

87. **The performance of JPIB is also mixed.** Due to the severe understaffing in the initial years[25], especially in the M&E and procurement units and lack of adequate procurement training of the JPIB project implementation suffered in initial years. Absence of a procurement specialist in the JPIB led to slow procurement and low disbursements. Absence of an M&E specialist resulted in failing to update progress against development objectives. As mentioned earlier, the first JPIB Director was appointed by the MoF, against the wishes of the MoH and this did not help the ease of implementation. The JPIB Director changed three times during the life of the Project. Staff salaries remained the same for almost ten years thus impairing likelihood of attracting and retaining qualified staff. All these issues have been gradually resolved in a satisfactory manner with a joint initiative of the MoH and the Bank. Appropriate staffing, vigorous and intensive training along with accumulated experience resulted in significant increase of capacity of JPIB for project implementation and monitoring, as reflected in project progress and achievements during the final years. Moreover, the issue of low JPIB staff salaries has been recognized and addressed by the Government through salary increases for JPIB staff under the Health 3 Project.

88. The MoH and JPIB participated actively in ICR discussions and prepared a remarkably good contribution to the ICR (see Annex 7).

(c) Justification of Rating for Overall Borrower Performance

89. The ICR team rates the overall Borrower performance as **Moderately Satisfactory** for reasons elaborated above.

6. Lessons Learned

90. **Strong Government ownership is critical, particularly with reform-oriented projects.** Reform does not only concern technical health-related changes, but relies heavily on the political process. Government ownership and commitment were critical in the support of the reforms through adequate legislation and strategies.

91. **Close coordination with development partners was critical.** Close coordination and collaboration with ADB and other agencies in supporting implementation aspects of the program helped keep key activities on track. Sharing the same implementation unit between two highly complementing projects ensured harmonization of interventions and efficient use of funds.

[25] ISRs No. 1 [October 30, 2004], 2 [June 4,2005], 3 [June 23,2005], 4 [October 23,2005], 5 [April 19, 2006], 6 [December 13, 2006] and 7 [June 21, 2007]

92. **Providing continuous guidance and actively engaging in the overall policy dialogue in the sector was crucial in ensuring consistency of the messages being delivered to the Government.** Bank supervision must be continuous and intensive and adequate supervision resources must be allocated particularly in the context of a limited institutional capacity as was the case in Uzbekistan.

93. **Comprehensive and careful project design greatly facilitates project implementation.** Health 2 Project built on the Government's National Strategy and on achievements of Health 1 incorporating lessons learned.

94. **Reflecting in-kind Government contribution as co-financing may lead to problems when auditing the Project**, consequently creating repeated issues with audit performance and acceptance of audit reports. These lessons learned were incorporated in the design of Health 3.

95. **Efficient use of funds and technical expertise is fully recommended and should be recognized.** This was demonstrated through preparation of Health 3 in parallel to implementation of Health 2 thus keeping the momentum and naturally scaling up activities towards the next stage of reform.

7. Comments on Issues Raised by Borrower/Implementing Agencies/Partners

(a) Borrower/implementing agencies

96. Authorities contacted by the ICR Team commented very positively on the role of the Project in supporting complex reforms in the health sector. Both the MoH and MoF noted that beyond the investments supported by the Project they saw the Bank as a strong technical partner, stressing that policy dialogue and visits were frequent, timely, and technically superior, bringing along high quality expertise. The MoH particularly highlighted the value added of the Bank's close supervision, follow-up and responsiveness to addressing bottlenecks over the last three years of the project.

97. The MOH provided very useful comments on the draft ICR, most of which were incorporated in the final report. However, there are two comments/suggestions by the MoH that the Team did not include in this ICR for the following reasons:

- One comment which was not taken into account relates to the monitoring of Intermediate Outcome Indicators before restructuring, namely Indicators No.2 (GP Training Programs established) and No.3 (Average increase in annual expenditures for primary care as a share of all expenditures in 8 regions under the project)[26]. The MoH said that the above indicators were not stated in any of the formally approved documents. However, as noted in the footnote No.1 of this ICR, Annex 1 of the PAD (attached to this ICR as Annex 11) lists 42 indicators, not all explicitly linked to the PDOs. However, per ICR Team findings only 4 Intermediate indicators including the indicators in question have been monitored and regularly updated prior to Mid Term Review in October 31, 2007 when new Results Framework was agreed upon with the Government and results monitored and updated.[27]

[26] Data Sheet, Section F. Results Framework Analysis, Part (c) Original Intermediate Outcome Indicators of this ICR.

[27] ISRs No. 1 [October 30, 2004], 2 [June 4,2005], 3 [June 23,2005], 4 [October 23,2005], 5 [April 19, 2006], 6 [December 13, 2006], 7 [June 21, 2007] and 8 [June 29, 2007

- Another is a suggestion of the MoH to upgrade revised PDO Indicator No.3 (% of SVPs stocked with (for at least 75% of) essential medicines for emergency care (Indicator introduced at restructuring on June 22, 2010)[28] from NOT ACHIEVED to PARTIALLY ACHIEVED. The target set at the Project restructuring (June 22, 2010) was to have at least 50% of SVPs stocked with 75% of essential medicines for emergency care by the end of the project. However, despite many efforts, administrative inflexibility in transition from decentralized to centralized procurement and distribution of drugs caused delay in implementing new procurement system thus leading to delayed supply of a number of essential drugs. By the end of the project, 64% of SVPs have been provided with 50% of drugs from the list. Even though the engagement of the MoH and JPIB is fully recognized, the ICR Team agreed that this indicator could not be evaluated as PARTIALLY ACHIEVED. Furthermore, it should also be noted that the upgrading of this indicator would not impact the Overall Project Achievement Rating.

Table 11: Availability of essential medicines for emergency care in SVPs[29]

% of essential medicines available	% of SVPs supplied with corresponding amount of pharmaceuticals
0-10%	0%
11-20%	0%
21-30%	3%
31-40%	10%
41-50%	23%
51-60%	45%
61-70%	13%
71-80%	3%
81-90%	3%
91-100%	0%

(b) Cofinanciers

N/A

(c) Other partners and stakeholders

98. The ICR team held discussions with ADB, UNDP, WHO and GIZ. Their respective comments are reflected in this document to the extent possible. Please also see Annex 8.

[28] Table 8,in this ICR

[29] Table taken from the Expert Fikri's Final Assessment of the Health 2 Project, July 2011, page 179

Annex 1. Project Costs and Financing

(a) Project Cost by Component

Components	Appraisal Estimate (USD millions)	Actual/Latest Estimate (USD millions)	Percentage of Appraisal
1. Primary Health Care	**97.90**	**101.38**[30]	**103.60 %**
2 Financing & Management	**5.40**	**2.52**[31]	**46.67 %**
3. Public Health	**7.42**	**11.39**[32]	**153.50 %**
4. Project Management and Monitoring & Evaluation	**3.20**	**4.01**[33]	**125.30 %**
5. Unallocated	**4.18**	**0.00**	
Total Project Costs	**118.10**	**119.30**	**101.00 %**

(b) Financing

Source of Funds	Appraisal Estimate (USD millions)	Actual/Latest[34] Estimate (USD millions)	Percentage of Appraisal
Borrower	78.10	78.10[35]	100.00 %
IDA Credit	39.48	40.60	102.90 %
IDA Grant for HIV/AIDS	0.52	0.58	111.50 %
TOTAL	**118.10**	**119.30**	**101.00 %**

[30] The increase reflects the reallocation of funds (from unallocated funds) needed for procurement of dental equipment for dental cabinets of PHC Centers and of rayon and oblast polyclinics (see para 24).

[31] The considerable lower than projected expenditures for the component reflect large savings in training costs (rental of training venues and procurement of training equipment) as a result of the construction of a Training Center by the Government in 2008. Most trainings under the component were conducted in the Training Center thereby avoiding the need for rental of facilities throughout the country and procurement of training equipment.

[32] Disbursement under the Public Health Component increased due to: (i) additional procurement of iron-bearing supplements in agreement with the Bank (procurement of iron-bearing supplements amounted to US$2.3 m instead of the planned US$0.4 m), and (ii) additional funding needed for the maintenance of the increased number of health facilities (281 health facilities instead of 95).

[33] Increase of expenditures under the component is associated with the extension of the term of the Project implementation and increase in the cost of services provided by the Procurement Agent and Delivery Agent.

[34] Differences reflect fluctuations of the SDR against the US$ dollar.

[35] In addition to the specified amount, the Government spent over US$620 m**,** including US$105.5 m for construction and US$514.5 m for maintenance of health facilities. Originally it was planned to construct/reconstruct 2200 SVPs and 180 other medical facilities for an estimated cost of US$43.7 m. However, 3044 facilities were constructed / reconstructed, including 2381 SVPs and 663 other medical facilities (see also footnote 36 below).

(c) Project Cost by Category

Categories	Appraisal Estimate (USD millions)	Actual Disbursement (USD millions)	Percentage of Appraisal
(1) Civil Works	43.71	53.13[36]	121.50 %
(2) Goods	40.10	34.57[37]	86.20 %
(3) Consultant Services	4.09	1.98[38]	48.20 %
(4) Training	6.60	6.05	91.70 %
(5) Incremental Operating Costs	23.60	23.60	100.00 %
Total	**118.10**	**119.30**	**100.0 0%**

[36] Higher amounts reflect construction of additional health facilities. As explained under footnote 35**,** the GOU financed a great deal of construction/rehabilitation of health facilities over and above the scope of the project.

[37] See also footnote 31

[38] The savings were a result of funding for consulting services from USAID financial resources.

Annex 2. Outputs by Component

Component	Planned outputs at Appraisal	Actual outputs/outcomes at ICR
Component 1 – Primary Health Care Development (US$98.10 million of total project costs)	**Equipment for oblast SVPs (1,424 SVPs)** (a) Basic package of medical and laboratory equipment for SVP constructed/renovated under GOU 1996-2005 rural health care facility program – Andijan (351), Djizzak, (158) Namangan (215), Surkhandarya (185), and Samarkand (384) (b) Basic package of medical and laboratory equipment for SVPs not equipped under Health 1 in the original pilot oblasts – Ferghana (35), Navoiy (38), and Syr Darya (58)	Equipment for oblast SVPs (2,389 SVPs) in total amount of 16 309 713,86 USD (a) Basic package of medical and laboratory equipment for SVP – Andijan (341), Djizzak (124), Namangan (236), Surkhandarya (242), Samarkand (381), Bukhara (333), Kashkadarya (261), and Tashkent region (199), (b) Basic package of medical and laboratory equipment for SVPs not equipped under Health 1 in the original pilot oblasts Ferghana (79), Navoiy (47), and Syrdarya (25), Republic of Karakalpakstan (73), Khorezm (48)
	Communications and Transport (a) Telecommunication system for remote SVPs (b) Vehicles for remote SVPs	(a) Initial plan was to equip SVPs with communication devices under Health II project. However, in 2007, Government required its local regulatory bodies (khokimiats) to use their budget to supply 97.3% SVPs with various modes of communication (wire, mobile, etc.). TA was hired to assess radio communication: 21,900 USD for international consultant and 1,411.73 USD for local consultant. (b) 542 units of vehicles were procured : 4,690, 146. 21 USD.
	Pharmaceuticals – Training and Technical Assistance to build capacity/infrastructure for sustainable availability of pharmaceuticals in SVPs to: (a) Define a basic package of drugs and supplies for individual SVPs (b) Improve forecasting and procurement of drugs and supplies at the national level. (c) Develop a standard system of inventory control and storage at the regional and SVPs' levels (d) Improve delivery of drugs to SVPs (e) Improve rational drug use through increased advisory capacity, physician training, and improved procurement practices	The task was done by "UBI Consulting" LLC firm: 487.078,29 USD. (a) The analysis on conformity of the pharmaceutical list to the volume of medical care rendered in SVP and the monitoring of adverse effect of pharmaceutical list drugs were done on the basis of 300 SVPs. Pilot survey conducted on balanced prescription of drugs in 6 SVP of 2 oblasts (Diaz and Syrdarya). (b) Regulation on centralized procurement of drugs for SVP was developed and approved by the MOH Order #290 dd. 20th October, 2011. The manual for trainings on centralized procurement of drugs was replicated in 147 copies; 85 members of regional bidding committees were trained. (c) Manual on pharmaceutical management at SVP level was developed. The manual was replicated in 6000 copies. 16 trainers were trained, 140 workshops were conducted where 5304 financial managers and nurses of SVP across the Republic were trained. (d) Drugs delivered to RMU for SVPs according to MOH Order # 290 on centralized procurement of pharmaceuticals. (e) **See additional activities (a).**
	Urban Primary Care Models (a) Technical Assistance to support program	(a) USAID "Zdravplus" provided technical

Component	Planned outputs at Appraisal	Actual outputs/outcomes at ICR
	development for the establishment of the urban primary care model. (b) Refurbishment of selected polyclinics (c) Provision of medical and laboratory equipment for selected polyclinics **General Practice Training Centers** (a) Provision of equipment for Tashkent Institute of Advanced Medical Education (b) Payment of stipends for trainees (c) Study tour for each trainee group. (d) Technical Assistance to support the program (e) Establishment of three new clinical training centers (Tashkent, Bukhara and Samarkand) (f) Annual retraining for 600 SVP and polyclinic doctors (2,700 retrained doctors) (g) Provision of medical and training equipment for three new training centers. (h) Establishment of a library in existing and new training centers (i) Study tour of trainees (possibly to Estonia) (j) Establishment and equipping of medical institutes to provide clinical training for GPs (k) Review and update of the seven-year undergraduate curriculum	assistance for the establishment of urban primary care model. (b) Model of General Practice (GP) was introduced in 29 urban polyclinics of Tashkent (13), Margilan (7), Samarkand (4), Andijan (1) and Gulistan (4). (c) 29 urban polyclinics were outfitted with medical and laboratory equipment: 790, 482 USD. **General Practice Training Centers** (a) Medical equipment for two (2) Chairs of Tashkent Institute of Advanced Medical Education (TIAME) (the Chair for GP Training and the Chair for GP Professional Development) 120, 000 USD. (b) Stipends for trainees were covered by the Government's contribution: 2,035,598 USD during 5 years. (c) Six (6) study tours to the University of Tartu (Estonia) were organized for 90 teachers of higher educational institutions: 535, 311.88 USD. (d) Two (2) local consultants provided technical assistance on monitoring and evaluation of Continuous Professional Education (CPE) including reporting on a monthly basis. The cost of the contracts is totaling 31, 395.10 USD (e) Two new Training Centers were established and equipped in Samarkand and Andijan Medical Institutes. (Training center in Andjan was established instead of the Training Center planned to be established in Bukhara Medical Institute. It was done in order to cover all physicians from Andijan, Fergana and Namangan oblasts). The 3rd Training Center in Tashkent was not established considering that 6 existing ones were sufficient. (f) By means of Government contribution for 5 years of project implementation, 3770 physicians from SVP and 712 physicians of urban polyclinics were trained for a10-month courses (total number of trained physicians is 4482) (g) Newly established 2 Training Centers were outfitted with educational and medical equipment: 87,521 USD. (h) Two new and 14 existing Training Centers were provided with medical books: 24,000 USD. (i) Study tour to Estonia was organized for 29 trainees including the Chiefs of Oblast Health Departments and their first deputies, as well as representatives of higher educational institutions and MOH to share experiences in organization of medical care in Primary healthcare facilities (cost shown under point c) above) (j) With a view to improve students practical skills, all Medical Institutes were outfitted with educational and presentation equipment: 1, 014,210.00 USD. Under the MOH Order #146 dd. April 7, 2008, two demonstration-training models of SVP were established in Tashkent Medical Academy. SVP models were provided with medical and laboratory equipment and furniture: 8,400 USD. (k) Tashkent Pediatric Medical Institute's and Tashkent Medical Academy's seven-year

Component	Planned outputs at Appraisal	Actual outputs/outcomes at ICR
	(l) Development of a medical manpower study to address excess number of doctors	undergraduate curricula were reconsidered and adapted to a 10-month program of GPs retraining. The project rendered assistance in replication of educational materials for TMA teachers' seminars: 4,500 USD. Technical assistance of the international consultant on development of the training programs content: 13,516.94 USD. Technical assistance was rendered by USAID "Zdravplus" project. (l) In 2007, a study on demand for medical manpower across the Republic was carried out: 9,935.96 USD. The report was discussed in the Ministry of Health and was recommended for implementation.
	Quality improvement and continued medical education (a) Software development (b) Provision of TA to strengthen Licensing Center (c) Introduction of a systematic CME program at the central rayon hospitals (d) Provision of equipment (TV, DVD, overhead projector and whiteboard) for CME program (e) Training of GPs through short seminars in respective rayons (rational drug use, nutrition, IMCI) (f) Establishment of a new Center for Evidence Based Medicine (EBM) (g) Provision of equipment and library materials for the Center (h) Study Tours (i) Provision of training in EBM through one major course mostly for the center's staff	**Quality improvement and continued medical education** (a) The software was developed by Republican Center for Physicians Licensing out of the budgetary funds; (b) Because of the lack of alegal framework the process of GP licensing was temporarily suspended. Due to that reason a consultant for technical assistance was not hired. (c) With trainings to be conducted, training rooms were established in 161 RMU and 10 urban polyclinics. All 171 training rooms were provided with presentation equipment: 325, 000 USD. (d) The training rooms were provided with TV-set, DVD recorder, overhead projectors, whiteboards and educational literature for training of physicians within the frame work of continuous professional education. (e) 123 seminars were conducted at oblast level and 2803 RMU specialists were trained as trainers. In their turn they conducted training for more than 25 thousand SVP physicians at rayon level on 10 topical questions of healthcare, including on rational prescription of drugs and IMCI. 1, 260, 596.00 USD were spent on the training within the framework of continuous professional education. 1064 teachers of higher educational institutes were trained within the framework of continuous professional education: 477,491 USD. Technical assistance of local consultants to develop and to translate the handbook for GPs: 5, 257.71 USD. In 2005, the Chair of Organization, Economics and Management was established under TIAME. (f) The Center for Evidence Based Medicine was established under TIAME, and (g) was outfitted with necessary computer and training equipment and high-speed Internet: 25,000 USD. (h) In 2007, involving the WHO, a study tour to Denmark on the issue of introduction of evidence medicine principles into health care was arranged for 8 persons, including the heads of the MOH leading departments:17 858,32 USD; In 2011 the MOH representatives visited South Korea to get acquainted with their health system: 48, 431.2 USD

Component	Planned outputs at Appraisal	Actual outputs/outcomes at ICR
	(j) Provision of training in EBM through an annual one-week course for medical educators. (k) Provision of TA to support training efforts.	(i)With participation of international consultants of USAID ("Zdravplus" project), staff of EBM Center was trained in basic principles of evidence-based medicine and methodology to develop clinical guidelines; (j)With participation of EBM Center, specialists and teachers from GP training centers attended a two-days training module for MOH specialists; five-days training module for teachers of medical institutes and colleges were developed and introduced; 8 training courses on evidentiary medicine and improvement of the quality of PHC medical services were conducted for specialists and coordinators of PHC managers at oblast and rayon level. The training covered 158 persons: 29, 550.74 USD; (k) TA to support training efforts was provided by USAID (Zdravplus) **See additional activities (b).**
		Additional activities. (a) Manual on rational prescription of drugs was developed and published and reproduced/distributed in 5960 copies.15 trainers trained on conducting the 89 trainings on sites, which covered 2235 SVP physicians in 13 regions. (b)With the participation of Tashkent Medical Academy School of Public Health specialists established under "Health II" project, the educational program on NCD epidemiology was introduced into the Masters' program, based on the principles of evidence based medicine; with the participation of EBM Center and School of Public Health, 14 trainings for professional and teaching staff were conducted and 284 Medical Institutes teachers were trained on clinical skills: 53, 53,116.52 USD; (c) 90 laboratories of rayon hospitals received a set of laboratory equipment and consumables, 100 rayon and city hospitals received equipment for ultrasonography and 120 CRH/CCH departments of surgery were provided with large surgical material sets : 1,336,456.17 USD. (d) Technical assistances of local consultants for training of laboratory assistants: 18,729.12 USD. (e) Project savings procured: 570 sets of dental equipment and consumables and supplies, including 314 sets of dental equipment for central rayon policlinics and 256 sets of dental equipment for SVP: 1,977,794.00 USD; (f) Under the pilot project on ":Improvement of medical equipment maintenance in PHC facilities": -7 sets of instruments for mobile maintenance teams were procured: 53,400 USD; -Technical assistance of consultants on improvement of medical equipment maintenance (International Consultant services to the amount of 19,661.23 USD and two (2) National Consultants amounting to 11,086.08 USD) were provided, -Workshops for chiefs and financial managers of SVP, Urban Family Polyclinics of pilot regions were provided: 113,623.77 USD.

Component	Planned outputs at Appraisal	Actual outputs/outcomes at ICR
		(g) 14 training centers for training of SVP laboratory assistants were equipped: 52, 570. 02 USD. CRH laboratory doctors completed the training on "Mastering of new technologies in laboratory practice": 40,585.51 USD. (h) Technical assistance of international consultants on preparation of Health III project: 195,363.43 USD. (i) Manual "Instructions on technical and sanitary operation of buildings and communication systems of rural doctoral points (SVP)" was developed and replicated in 1590 copies: 9,565 USD.
Component 2 – Financing and Management Reforms (US$5.40 million of total project costs)	**Scaling-up of Health I PHC Reforms** (a) National replication of PHC reforms, Training for policy makers, health professionals and other stakeholders on the PHC model (b) Conversion of all SVPs and SVA-FAP complexes to legally independent entities (with bank accounts, pooling of funds at the oblast level, and implementing capitation provider payment systems and carve-out bonus systems for performance and unequal distribution issues (c) Streamlining of roles of practice managers (d)Training for oblast-level managers in new health financing approaches (e)Extension of computerized software on PHC financial reporting to the new regions.	(a) Local specialists on technical skills improvement, explanation and detailed elaboration of main principles and conditions of per capita financing and management, as well as methodic budget account of PHC facilities: 32 orientation and 48 technical seminars were conducted for more than 2300 managers and specialists of Health and Finance authorities of oblast at urban and rayon levels: 196,682.83 USD. (b) Nation-wide expansion of reforms on rural PHC facilities' per capita financing implemented in accordance with SVP progress plan and introduced to almost 3,192 rural medical units of the Republic. Converted PHC facilities have status of legal entity with settlement account on unified bankbook of Treasury. (c) 1. Jointly with the Ministry of Labor and Social Security, the financial manager job description was worked out; and legal framework was ensured to introduce it in all facilities. Training of managers is referred to under item (a) above. 2. Study tours to be acquainted with financing methods: 93,509.52 USD. (d) Trainings on: – Medical facilities management basis, for 2997 chiefs of SVP (financed by ADB); – Human resources management and office management in health care for 940 specialists of personnel departments; (financed by ADB); – Aspects of financial planning in health care, for 250 specialists of financial and economic service: 47,295.94 USD; (e) The computerized soft ware for PHC financial reporting was developed and implemented by "Zdravplus" project for pilot regions. With the introduction of the Treasury system in 2007, the developed software did not meet the requirements for a functioning financial management system. Currently, the Treasury uses software for budget control and utilization.
	Payment Reforms and Rationalization of Secondary Level Services (a) extension of the capitation financing approach to urban polyclinics models, (b) introduction of hospital payment systems and twinned with secondary facility level rationalization	(a) Per capita financing mechanism piloted in 25 urban Family Polyclinics (Tashkent city-10, Samarkand-4, Gulistan-4, Marginal- 7 polyclinics). Training of managers conducted in all pilot polyclinics (11 polyclinics were financed by USAID, Zdravplus and 14 others were financed out of the Government budget); (b) Preparatory work to convert inpatient facilities into case- based financing done and piloted in Fergana

Component	Planned outputs at Appraisal	Actual outputs/outcomes at ICR
	strategies, (c) development of provider participation plans for each region (d) Provision of hardware and software on the basis of the provider participation plans	oblast with technical assistance of local consultants (financed by ADB and Government budget); (c) According to a Government resolution, a program on in-patient facilities optimization was developed, including: (i) locating the facilities; , (ii) reducing the redundant number of beds and buildings; and (iii) closing of unprofitable hospitals. (d) Equipment for provider participation plan procured: 304,465.00 USD; Software to be developed within the framework of "Health III" project.
	Data Driven Reforms: Management and Information Systems (a) extension/expansion of MIS systems; (b) procurement of hardware; (c) training of users in hardware and software to implement the HMIS.	a) MIS was designed for pilot hospitals in order to collect clinical cases data necessary for development of case-based financing system (financed by USAID, Zdravplus). b) 1. 536 kits of computer equipment were procured for rayon ICT centers, including head-end, diesel-generator equipments and precision air conditioner: 1,462,956.74 USD; 2. Materials and office supplies to create the database of population: 4814,21 USD; c) RMU staff (150 specialists) trained in HMIS (financed by ADB, USAID/Zdravplus and Government budget).
	Health Management (a) procurement of training equipment, books, computers for the Tashkent Institute of Advanced Medical Education, other republican and oblast medical institutes, GP training centers and selected business and economic institutes.	Office equipment and consumables for the MOH working group: 36,348.27 USD. Packages of educational and teaching literature on medical facilities management, financial and economic activity, and health financial reports analysis: 16,508.04 USD. These were sent to Higher Educational Centers and other institutions, MOH, OHD. Educational equipment and computers for training centers procured under the Component 1. Replication of the training materials/guidelines/ manuals, etc.: 29,971.61 USD.
		Additional activities: Technical assistance of international consultants to support the preparation of Health III project: 47,080.00 USD; Technical assistance of international consultants on development and introduction of National Health Accounts (NHA) system: 30,835.69 USD; Technical assistance of local consultants on financing reforms in PHC and in pilot hospitals, development of NHA, preparation of Health III project: 45,367.54 USD.
Component 3 – Improving Public Health Services (US$7.51 million of total project costs)	**Capacity Building** (a) Development of a national public health strategy	Draft "Concept of the Republic of Uzbekistan Public Health Strategic Development for 2013-2025" was developed with technical assistance of international and local consultants: 42,866 USD.
	(b) Scaling-up health promotion and health education programs	1) The plan on Health Promotion for 2011-2015 was developed by means of technical assistance of international and local consultants: 36,274 USD. 2) Draft National Tobacco Control Program for 2007-2011 was developed. - with assistance of WHO, the training on Tobacco

Component	Planned outputs at Appraisal	Actual outputs/outcomes at ICR
		Control was conducted for 26 GPs tutors and leading nurses: 7,047USD; - social research to study the incidence of tobacco products consumption among population, as well as among hospital patients carried out at the expense of the WB Trust Fund; - 3 workshops devoted to the development of then draft document were conducted at the expense of the WB Trust Fund; - visit of 2 specialists to Washington was organized for the purpose of their participation to the World Conference on "Health and Tobacco Control" (July 11-15, 2006) and development of a report based on the findings of the social research: 6.242 USD. 3) The pilot on sociological evaluation of 'School for Health in Europe Network' was conducted through technical assistance of local consultant: 2,022 USD 4) Workshop to discuss the results of the survey and to define the further tasks was conducted for 19 employees of Health and Medical Statistics institute with its regional branches and the Ministry of Education: 6,977 USD 5) Report on "The training system of Public Health specialists in Uzbekistan: improvement ways", including "Measurement Plan on Public Health training programs development for 2012-2020" developed by technical assistance of international and local consultants: 31,131 USD. 6) The "Law on Restriction of Distribution and Consumption of Alcohol and Tobacco Products" was developed and adopted at the expense of the WB Trust Fund and local budget. 7) Draft Law "On the Republic of Uzbekistan accession to the WHO Framework Convention on Tobacco Control" was developed and submitted to the RUz Cabinet of Ministers, out of local funds. 8) Supported Social research to study prevalence of tobacco consumption among youth was conducted in Tashkent city in 2008 with assistance of WHO/CDC. 9) The MOH order dated November 17, 20122 "On approval of medical warning labels to be placed on the packaging of tobacco and alcohol products and warning signs at points of sale" was developed and issued, out of local budget. 10) Taken part in Euro WHO Regional Conference on the progress of the "WHO Framework Convention on Tobacco Control" implementation, at the expense of Euro WHO. 11) 233 copies of WHO information materials (7 types) were adapted and replicated at the expense of the WB Trust Fund.
	(c) Strengthening community-base MCH and nutrition programs	Jointly with UNICEF, the World Bank conducted two (2) conferences on coordination of nutrition improvement cross-sectoral program, at the expense of UNICEF. The "Republic of Uzbekistan population nutrition improvement strategy for 2009-2011" was developed and approved by the COM of the Republic of Uzbekistan.
	(d) Development of a School of Public Health	In 2006, at the expense of local budget, the School of Public Health under the Tashkent Medical Academy was founded.

Component	Planned outputs at Appraisal	Actual outputs/outcomes at ICR
	(e) Development and dissemination of a National Training Plan, including training in areas of relevance for the project (health policy, health promotion, and health management and financing)	1) Study tour for 12 managers and specialists of the Institute of Health and Medical Statistics and its regional branches to National Center on Health Promotion issues of the Republic of Kazakhstan, Almaty: 6,570 USD. 2) 87 employees of the Institute of Health and Medical Statistics and its branches were trained in interpersonal communication skills (5 trainings): 63,733 USD) 3) Basic training module on Health Promotion was developed trough technical assistance of international and local consultants: 31,956 USD. 4) 33 master trainers on Health Promotion were trained: 8,174 USD.
	(f) Provision of training equipment and TA for the School of Public Health	The School of Public Health under TMA and, the Public Health Chairs of TIAME were provided with equipment and educational literature: 240, 944 USD.
	(g) Support of MOH's Institute of Health to develop health promotion policy, carry out advocacy and education activities through the mass media	The Institute of Health and Medical Statistics and its 13 regional branches were outfitted with presentation and office equipment: 30,195 USD.
	(h) Reallocation of the Institute to more appropriate premises	In 2005, Health Institute was consolidated with Republican Informational and Analytical Center (RIAC), transformed to the Institute of Health and Medical Statistics and moved to RIAC building, at the expense of local budget.
	(i) In collaboration with UNICEF and ADB-financed projects: (i) support for nutrition working groups at the central/oblast levels, (ii) nutrition training and M&E, (iii) BCC counseling cards and mass media messages, and (iv) iron supplements for pregnant women and young children	Based on the MOH Order dated 23 March, 2009, Iron Supplementation Program and promotion of healthy eating habits were implemented in Bukhara, Navoi, Samarkand, Tashkent oblasts in the period of 2009-2011: 1) Iron supplements for children aged 6 to 24 months were procured: 2.259.878 USD. 2) Working groups were established at republic, oblast and rayon levels. 3) 48 trainers were trained: 10,163 USD. 4) 389 members of OHD/RMU/CMU were trained by master trainers in 26 trainings: 349,880 USD. 5) Master trainers together with trained members of OHD/RMU/CMU working groups conducted 64 conferences for 10280 representatives of khokimiyats, Public Youth Movement "Kamolot" and Fund "Makhallya" as well as health care providers of OHD/RMU/CMU, at the expense of local budget. 6) The guidance "Program for Population Nutrition Improvement and Supplementation with Iron-bearing and Folic Acid Preparations" for working group members and main specialists of OHD/RMU/CMU, as well as information and educational materials for population, were developed and replicated, totaling 65,220 USD. 7) Jointly with OHD and regional branches of the Institute of Health and Medical Statistics, the monitoring of the program implementation was conducted through local consultant's technical assistance: 15,994 USD and out of the local budget. 8) Activities were widely covered in Mass Media.
	(j) Training and TA to Mahalla Health Committees to develop needs assessment and develop an action plan	With the assistance of Counterpart International, the program "Healthy Makhallya" aimed at involving communities into Primary Healthcare development was worked out. To determine the need for health promotion the target groups (SVP personnel, Healthy
	(k) Information, education, and communication materials for the MHCs to distribute in the communities.	

Component	Planned outputs at Appraisal	Actual outputs/outcomes at ICR
		Centers, makhallya leaders, population) were interviewed in March, 2006. The employees of the Institute of Health and Medical Statistics jointly with Fund "Makhallya", Public Youth Movement "Kamolot" and other public organizations carried out on a regular basis activities to increase population awareness and to involve the population into activities on prevention of communicable and non-communicable diseases, HIV/AIDS/STI, tuberculosis; as well as into activities associated with healthy eating and healthy lifestyle.
	Essential Public Health Infrastructure (l) Development of programs to upgrade public health services throughout the country, including integration of SES into PHC	Seminars on improvement of public health laboratories network and laboratory tests technologies: 2-day seminar in Fergana (28 persons) and 1-day seminar in Tashkent (19 persons), were conducted for chiefs/specialists of laboratory service: 12,430 USD. The report "Quality improvement of laboratory diagnostics and network modernization of public health laboratories in Fergana oblast" including "Action Plan on modernization of microbiological and health laboratories " for 2010-2015, and the report "Introduction of public health laboratories network management and financing reforms" were developed trough technical assistance of international and local consultants:35,761 USD. 2-day seminar on improvement of Public Healthcare laboratories financing mechanism was conducted with participation of 20 chiefs/specialists of laboratory service, to the amount of 7,651 USD.
	(m) Development of an integrated electronic database for surveillance of communicable diseases	Created and developed introduction of information system of infectious diseases monitoring: 1) with WHO assistance, a Study Tour to Dublin (Ireland) was conducted for 5 members of the MOH working groups (MOH personnel, State Sanitary and Epidemiology Surveillance Center, Tashkent Institute of Advanced Medical Education): 16,444 USD 2) Technical documentation and software Information System for Infectious Diseases Electronic Surveillance (IS IDES) was developed trough technical assistance of a local firm: 81,029 USD. 3) Facilities involved into IS IDES were outfitted with server complex and computer equipment: 39,143 USD. 4) 31 users of IS IDES were trained **at local budget expense**.
	(n) Training of laboratory staff in modern methods of surveillance of CD	Training was conducted by suppliers of equipment upon delivery: 87,307 USD.
	(o) Refurbishment of selected labs throughout the country	Reconstruction/repair of laboratories of Public Healthcare at republic and rayon levels was conducted **by means of local budget.** 23 laboratories of State Sanitary and Epidemiology Surveillance Centers were outfitted with modern equipment, consumables, and vehicles: 2,380,290 USD.
Scaling-up of activities to prevent HIV/AIDS and STIs, and control of TB		
	In close collaboration with the GFATM, KfW and USAID/CDC the activities include: (a) Policy development of HIV/AIDS and TB, including integration of HIV/AIDS strategy into national policy for development	1) The activities were conducted out of local budget and funds from international organizations such as UNAIDS, UNODC, GFATM, CAPACITY/USAID, CDC, etc 2) Participation of 10 specialists of government institutions in the Second Moscow Conference on HIV/AIDS aimed at improvement of multi-sect oral interaction in HIV/AIDS control: 15,643USD.

Component	Planned outputs at Appraisal	Actual outputs/outcomes at ICR
		3) Participation of 2 leaders, Head of the MOH Main Department on Sanitary and Epidemiological Surveillance and Deputy Director of the Center of Quarantine and Highly-dangerous Infections, in the meeting within the framework of Shanghai Cooperation Organization (SCO) held in Moscow in order (i) to take measures on prevention of infectious diseases (HIV, tuberculosis and malaria), and (ii) to adopt the Declaration on epidemiology stability in SCO member-countries: 1,744 USD.
	(b) Further development of sentinel surveillance of HIV/AIDS in cooperation with SES and CDC, including upgrading HIV/AIDS labs	1) Activities were conducted out of the local budget and Grant funds from international organizations including CDC/CAR and the World Bank Central Asian Regional Project (CAAP). 2) 19 AIDS laboratories were equipped: 218,763 USD, 5 laboratories of dermatovenearology dispensaries were equipped: 100,852 USD.
	(c) Further development of Trust Points and support to NGOs working on HIV/AIDS control	1) Out of 64,725 USD Grant funds 13 roundtable discussions were conducted for 434 decision-makers. 2) Out of 103,500 USD Grant funds 28 trainings on HIV/AIDS prevention were conducted for 694 employees of Trust Rooms. 3) Out of 16,954 USD Grant funds the study guide "Outreach work in the programs on drug consumption harm reduction" was developed and replicated. 4) Out of 19,130 USD Grant funds 80 thousand information and education materials for the Trust Rooms were replicated. 5) Out of 51.153 USD Grant funds 2 seminars for 60 makhallya leaders and 11 trainings for 278 makhallya leaders from Tashkent city, and Tashkent, Surkhandarya, Bukhara and Samarkand oblasts were conducted. 6) Out of 9,004 USD Grant funds the training module on HIV prevention leaders was replicated in 2520 copies for makhallya leaders. 7) Out of local funds, trainers, makhalla leaders, and 10237persons were trained in HIV/AIDS prevention issues. <u>In addition to the above stated</u>: 8) Out of 136.607 USD Grant funds 40 trainings were conducted for 916 head infectious diseases specialists, head dermatovenerologists and nurses. 9) Out of 106,268 USD Grant funds 4 types of training materials were developed and replicated in the quantity of 17632 copies. 10) Out of 19,768 USD Grant funds technical assistance in planning and implementation of HIV/AIDS/STI prevention was provided. 11) Out of 13,227 USD Grant funds study tour was organized for 5 specialists to National Reference Laboratory on tuberculosis diagnostics in Great Britain and Research and Development Centre on HIV-infectious and tuberculosis of Institute of Cellular and Molecular Medicine under London Queen Mary's College of Medicine. 12) Out of 19,686 USD Grant funds 8 trainings on quality control of laboratory diagnostics were

Component	Planned outputs at Appraisal	Actual outputs/outcomes at ICR
		conducted for 132 employees of AIDS laboratories. 13)3,657 USD Grant funds were spent on monitoring of the results of training on HIV-infections diagnostics for the personnel of AIDS laboratories trained.
	(d) Extending DOTS to two additional regions (Djizzak and Navoiy), including prison system	29 laboratories of Djizak and Navoiy oblasts, including penal institutions were outfitted with equipment: **222,637 USD.** Training and communication activities were conducted at the expense of the Global Fund "Tuberculosis" Component.
	(e) Preparation of a TB grant proposal to submit to the GFATM to scale up DOTS	This activity was conducted at the expense of the Global Fund "Tuberculosis" Component.
Component 4 – Project Management, Monitoring and Evaluation (US$2.00 million of total project costs)	(a) TA in the areas of procurement, disbursement and M&E	a) Initial Procurement Plan included the hiring of an international procurement specialist. . However, given that the same task was needed under Woman and Child Health Development project (WCHD), it was agreed to employ a consultant according to ADB procedures and out of ADB loan funds to cover the ADB and IDA projects. By the completion of the contract under the WHCD project, the contract was not renewed. Technical assistance for procurement was rendered by means of staff trained in Bank procurement procedures: a. Central Asian procurement seminar in Bishkek (Kyrgyzstan), February 18-25, 2006 – 2 persons (total expenses made 1,370 USD). b. Training course "Goods procurement management, work and services International practice" in Turin (Italy), International Center "ILO" in March 9-27, 2006 – 1 person (4,635.33 USD). c. Training course "Consulting services procurement in projects funded by WB", Turin, Italy (4,096) International Center "ILO' June 1-12, 2006 – 1 person (4,096.33 USD) d. Training course "Procurement procedure quality general management" Turin, (Italy) November 6-13, 2006 – 1 person (3,166 USD) e. Training Courses "International procurement management" Turin, (Italy) International Center "ILO" June 9-23, 2007 – 1 person (2,834 USD) f. Course "International Procurement Management" Turin, Italy June 4-19, 2011 – 2 specialists (19,252 USD) g. "Contract management and monitoring of disbursements" in Kuala Lumpur, Malaysia in 2011- 2 specialists (14,944 USD) **Training on financial management**: • Training course "Financial management and disbursements of projects, funded by WB " Turin, Italy, International Center "ILO" March 10 – April 10, 2006 – 1 person (total expenses 4,636.33 USD) • Training seminar "Financial management and disbursements" Almaty, Kazakhstan in 2006 – 2 specialists of financial department (1,856 USD)

Component	Planned outputs at Appraisal	Actual outputs/outcomes at ICR
		• Regional training on financial management and disbursements Yerevan (Armenia) June 19-27, 2007 – 1 person (2,834 USD) • Training seminar on financial management and disbursement for WB credit debtors, Baku, Azerbaijan June 9-13,2008 – 1 specialist (1,062 USD) • Training and retraining of financial accounting department staff at the Center, Tashkent, Uzbekistan September 26-30, 2011 • "Introduction of financial accounting into the international standards" training, November 14-18, 2011 in Turin, Italy – 3 persons (11,182 USD) • Regional fiduciary training December 12-16, 2011 in Tashkent, Uzbekistan – 2 persons In the framework of project monitoring and evaluation, a M&E specialist was recruited in May 2010 to manage, among others, the monitoring of project indicators, including collecting data, assessing project implementation success in achieving Project objectives. To improve the monitoring and evaluation system in 2007 an international expert was employed for improving of M & E system, but the work was not completed; In 2008, a WB specialist made recommendations for improving the data collection system and revising the indicators, taking into account the objectives of the components and availability of information. Technical assistance in management and and related training on monitoring and evaluation was rendered by WB Institute, which organized the trainings on theme "Designing a Monitoring and Evaluation Plan" in Tashkent, May 21-24, 2007 for coordinators and specialists of the project –10 specialists trained. WB Institute training trained on theme "Monitoring and Evaluation for Results" in Tashkent, December 14-19, 2009 for managers and specialists of the project, as well as MOH and establishments' heads involved in monitoring of project realization --10 persons. Project personnel and MOH specialists were trained as follows: • 2 project employees participated in training seminar for teams involved in WB projects with the participation of Government, PIU and Bank staff from Central Asian countries in Almaty (Kazakhstan) May 23-31, 2005 (1,240 USD) • Study tour on conversion of in-patient hospitals to case-based financing, Republics of Kazakhstan and Kyrgyzstan in April 17-23, 2006 – 10 persons (9,407 USD) • The 3d Flagship Course on Health System improvement for Central Asian countries, the Caucasus and Moldova, in

Component	Planned outputs at Appraisal	Actual outputs/outcomes at ICR
		Bishkek (Kyrgyzstan), May 22 – June 3, 2006 – 3 persons (3,919.34 USD) • Participation in course on "Process acceleration in gaining Millennium development goals in health issues in Central Asian countries, the Caucasus and Moldova" in Bishkek (Kyrgyzstan) September 16 – 28, 2006 – 3 people (8,608.65 USD) • The 4th Flagship course on Health System improvement for Central Asian countries, the Caucasus and Moldova, in Bishkek (Kyrgyzstan) April 2-4, 2007 – 3 persons (4,490 USD) • The 4th Seminar on National Health accounts (NHA) of CIS countries, in Bishkek (Kyrgyzstan), June 17-19, 2008 – 4 persons (7,750.57 USD) • The 5th Flagship course on Health System improvement for Central Asian countries, the Caucasus and Moldova, in Bishkek (Kyrgyzstan) June 2-13, 2008 – 5 persons (3,853.56 USD) • The training workshop "Ecological and social precautionary procedures of World Bank" in Dushanbe city (Tajikistan), September 27 – October 2, 2009 – 3 persons (1,396 USD) • The 5th Regional Conference on National Health Account for CIS countries and study of the State Health Financing System of Armenia in Yerevan (Armenia) November 8-17, 2009 – 7 persons (9,622 USD)
	(b) Financing of the salaries of staff of the Central Project Implementation Bureau (CPIB) (c) Travel costs (d) Project audits (e) Office equipment for the CPIB (f) Office equipment and vehicles for the oblast Project Implementation Bureaus (g) Upgrade of the Project Financial management System (h) Regular facility surveys as a core part of the data	b) Salaries of JPIB employees were covered by 70% (305,448.84 USD) at the expense of credit funds and 30% by the budget. Allocation of funds for all expenditure categories was timely carried out timely. In addition, social expenditures were covered – 110,876.30 USD. c) Travel expenses were covered by 70% (12,080.14 USD) at the expense of credit funds and 30% by the budget. Allocation of funds for all expenditure categories was timely carried out timely. d) Project audits timely prepared: 269,812.36 USD; the amount of 30,000 USD is deposited in an escrow account for the last audit. e) and f) Expenditures to procure equipment for JPIB office , Regional Projects Implementation Bureaus, including the equipment maintenance costs, were covered by 90% (309,406.37 USD) of the credit funds and 10% from budget fund. g) For sustainable and successful control 1 C – accounting software for automatic accountancy was installed out of the credit funds (13,408.56 USD) and budget funds. h) On M&E: an independent consulting firm "Expert Fikri", which in 2007 conducted research on evaluation/inventory of PHC facilities, including

Component	Planned outputs at Appraisal	Actual outputs/outcomes at ICR
	collection process: (i) annual survey on drug availability, (ii) bi-annual survey on medical equipment availability, (iii) annual evaluation of medical records to test for quality and protocols in PHC, (iv) annual user satisfaction surveys, (v) bi-annual safe motherhood assessments, (vi) bi-annual financial manger reviews, and (vii) bi-annual lab equipment surveys.	equipment, medicines and supplies, patients satisfaction, laboratory equipment, financing and management, evaluation physicians and nursing staff knowledge in safe motherhood and management of priority communicable and non-communicable diseases, the usage of clinical protocols. A final study was carried out on these areas in 2011 to evaluate the effectiveness of project activities against its objectives (99,636 USD was disbursed from credit funds). **Additional Activities.** Within evaluation of the urban model pilot on transition of Primary Healthcare polyclinics to principles of per capita financing and General Practitioner work, a survey was carried out by independent Consultancy Firm "Expert Fikri" in 2010 to evaluate (39,893.64 USD): • The results of new financing and management reforms implementation; • Need of urban pilot primary healthcare facilities for narrowly focused specialists; • Knowledge and skills of personnel of urban pilot primary healthcare facilities in management of priority diseases and states including Reproductive Health and services on Child Healthcare, diagnostics and cure of basic infectious and non-infectious diseases; • Adequacy of personnel training (heads, Finance managers, physicians, nurses and other employees); • Equipping of facilities, including availability and usage of equipment and medicaments; • Satisfaction of suppliers and consumers of medical services. OPIB offices equipment: 4,338.8 USD); training of OPIB directors: 24,155.15 USD. Conference on the results of the mid-term review mission of Health 2 and on the preparation of "Health 3" project: 38,486.05 USD. Bank fees charged to Component 4: 56,821.44 USD Health III project preparation: International and local consultants; survey to collect baseline (firm: Shah van Tavsiya): 213,816 USD.

Information on IDA Grant Funds Disbursement for HIV/AIDS/STI Prevention and Control

Activities	Number of trained persons	Disbursed funds in USD
1. Training:	**2 536**	**406 285**
a) Health facilities medical staff training in 4 areas of HIV/AIDS/STI prevention	2 176	324 517
b) Makhalla leaders training in HIV/AIDS/STI prevention areas of focus	343	51 153
c) Training in foreign countries for the exchange of international experience	17	30 614
2. Communication materials:	**100 252**	**151 356**
a) 6 types of educational materials for the staff of Trust Points, head infectious disesase specialists of health administrating authorities, dermatovenerologists, GPs, nurses of PHC facilities, were developed and replicated.	10 697	113 138
b) Information and education materials for the risk group and the MOH Order #200 dated July 7 2011 "On prevention of parenterally transmitted nosocomial infections in medical and preventive treatment facilities providing health care to child population" were replicated.	89 555	38 218
3. Local technical assistance:		**23 425**
a) Monitoring of the results of AIDS laboratories personnel training in HIV-infection diagnostics was conducted.		3 656
b) Technical assistance in planning and implementation of HIV/AIDS/STI prevention activities was provided.		19 769
Total on HIV/AIDS/STI prevention		**581 066**

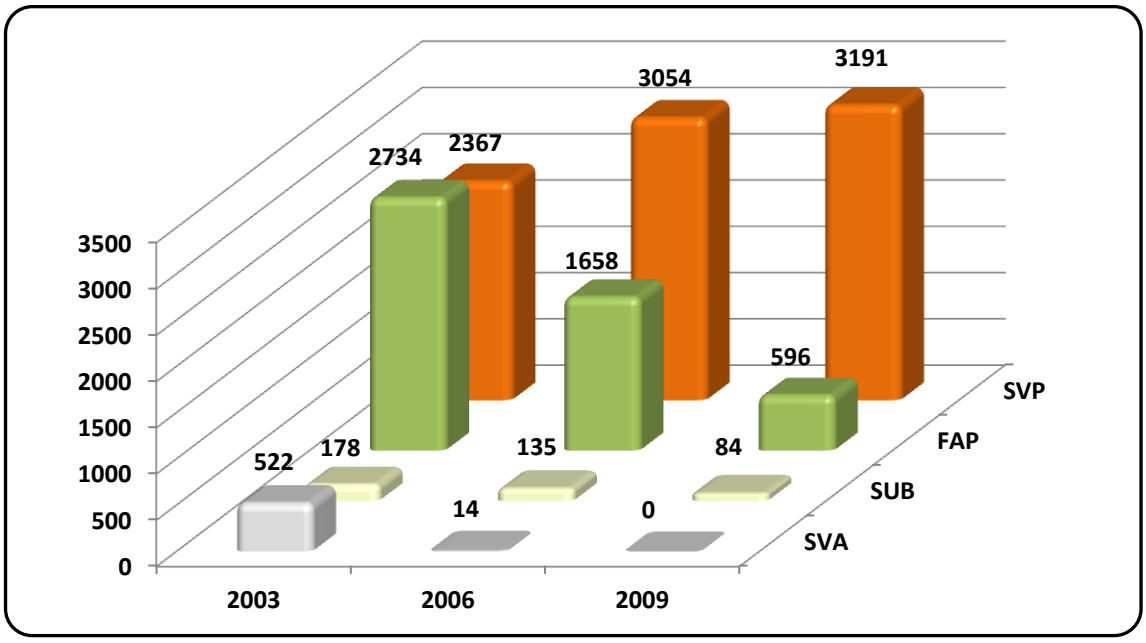
Annex 3. Economic and Financial Analysis

At the time of Project appraisal one of the main assumptions for Uzbekistan's macroeconomic environment was "*GDP increase to 5 percent by 2006 stabilizing at 2 percent during the* rest of the period". Actually Uzbekistan's economy (GDP) grew by averaging 8.17% annually from 2004 to 2011. Uzbekistan's gradual, state-led development strategy has delivered growth, somewhat reduced poverty, and maintained essential human and physical infrastructure.

The main expected benefit from the Health 2 project was to improve the quality and overall economic efficiency of the primary healthcare in the Republic of Uzbekistan. While an economic analysis was not carried out, data presented in the final evaluation of Health 2 project and Project Outcome indicators shows that there has been a positive trend in terms of greater efficiency in the health sector.

Focusing from secondary to primary health care. Starting from 1996, the Government initiated a reform to increase efficiency in the rural primary health care sector by trimming its overgrown structure and by diverting its focus from secondary to primary care. The World Bank supported reform at the same time rationalizing system by transforming almost all FAPs, SVAs, and SUBs to into SVPs. However, some SUBs and FAPs were left in the most remote and scarcely populated parts of the country.

Transformation of FAP, SVA and SUBs to SVP (based on number of health facilities)[39]



[39] Source: "Main indicators of Health sector development" Statistical bulletin 2003, 2006, 2009. National Statistics Committee of Uzbekistan

The concept of General Practitioners has been widely accepted. SVP doctor's 10-month retraining program has been acknowledged success and apparently upgraded skills have led to a reduced rate of referrals and better patient satisfaction.

All rural primary healthcare facilities and pilot urban family polyclinics were switched to per capita financing system and have been operating as independent legal entities. The share of primary healthcare and outpatient health services in the 2011 expenditures structures has reached 45.2% as compared to baseline level of 41% in 2004.

Quality of PHC services

The overall estimation of the quality of SVP services provided in the last 5 years remains quite high. In 2011, the share of the households stating the improvement of the work of their SVPs has increased from 90% up to 95%. 90% of the households are reporting to SVPs when seeking medical care for the first time, and almost all of those who are doing that are *satisfied with* the quality of services provided[40]. The share of patients referred from SVPs to hospitals reduced from the baseline level of 20% in 2004 to 12% in 2011. The number of population's visits to primary healthcare facilities has increased from 3.8 in 2005 to 4.7 in 2011.

Therefore, health expenditures of population have been economized due to easy access to the modernized primary health care facilities where General Practitioners and nurses with the upgraded skills.

[40] Report on Final Assessment of Health II project. "Ekspert fikri". 2011. (Interviewed 156 households)

Annex 4. Bank Lending and Implementation Support/Supervision Processes

(a) Task Team members

Names	Title	Unit
Galina Alagardova	Financial Management Specialist	ECSO3
Johanne Angers	Senior Operations Officer	ECSH1
Iqboljon Anhadjonov	Consultant	ECSHD
Jan Bultman	Lead Health Specialist	ECSHD
Peter Joseph Campbell	Consultant	SASHD
Agnes Couffinhal	Senior Economist (Health)	ECSH1
Dorothee B. Eckertz	Senior Operations Officer	ECSH1
Armin H. Fidler	Advisor, Policy and Strategy	HDNHE
Gabriel C. Francis	Program Assistant	ECSHD
Antonio Giuffrida	Senior Economist	ECSH1
Andrea C. Guedes	Senior Operations Officer	ECSH2
Betty Hanan	Impl. Specialist (Consultant)	ECSHD
Susanna Harapetyan	Senior Health Specialist	ECSH1
Ana Holt	Health Specialist	ECSH1
Dilnara Isamiddinova	Senior Operations Officer	ECSO1
Gulnora Kamilova	Program Assistant	ECSO2
Peyvand Khaleghian	Country Sector Coordinator	ECSH1
Naushad A. Khan	Consultant	ECSO2
Hannah M. Koilpillai	Senior Finance Officer	CTRFC-His
Zoe Kolovou	Lead Counsel	LEGOP
John C. Langenbrunner	Lead Economist, Health	HDNHE
Rekha Menon	Senior Health Specialist	ECSH1
Wezi Marianne Msisha	Health Specialist	ECSH1
Imelda Mueller	Operations Analyst	ECSH2
John Otieno Ogallo	Sr Financial Management Specialist	ECSO3
Fasliddin Rakhimov	Procurement Specialist	ECSO2
Flora Salikhova	Consultant	ECSHD
Nikolai Soubbotin	Senior Counsel	LEGEM
Lingzi Xu	Senior Operations Officer	ECSH1

(b) Staff Time and Cost

Stage of Project Cycle	Staff Time and Cost (Bank Budget Only)	
	No. of staff weeks	USD Thousands (including travel and consultant costs)
Lending		
FY01		7.71
FY02	0.93	139.06
FY03	16.45	241.12
FY04	45.20	21.55
FY05	7.98	0.15
Total:	**70.56**	**409.59**
Supervision/ICR		
FY04	0.24	161.74
FY05	41.20	190.93
FY06	58.80	168.97
FY07	52.06	143.94
FY08	43.68	50.51
FY09	52.80	77.45
FY10	51.23	88.42
FY11	48.79	54.07
FY12	22.59	12.98
Total:	**371.39**	**949.01**

Annex 5. Beneficiary Survey Results

When developing the Project, a plan of basic research was designed within the Health-2 Project, with a stipulated frequency of surveys; during the implementation of the Project, this plan was adjusted in view of the project implementation status, and stipulated conducting of surveys in 2007 and at the final stage of the Project in 2011. The consultant firm Expert Fikri has been contracted for this task. The baseline study for the assessment of Health Project was conducted in October-November of 2007. The final study for the assessment was conducted in June-July, 2011.

The objective of the survey was to obtain quantitative and qualitative data that would help evaluate the efficiency of reforms conducted in the public health system and provide useful information for improvement of the quality and efficiency of health services provided by SVPs and maternity institutions. These results were aimed to provide data for management of the public health system reforming process. The tasks of the survey were the following:

1) Assessment of consumers' satisfaction with primary health care services provided;
2) Assessment of GPs' activities, their skills included;
3) Assessment of implementation of safe motherhood in the primary health services sector;
4) Survey of the primary health care sector financial management;
5) Description of provision of SVPs with medical equipment, including photocolorimeters, autoclaves, hot-air sterilizers, electrocardiographs, and with laboratory equipment, as well as provision of SVPs with medical preparations.

Methodology. The sampling proportional to the number of SVPs in the oblasts and the probability sampling of SVPs was performed out of their total numbers according to their proportions in the surveyed regions. These regions represented the whole rural territory of Uzbekistan. The sampling scheme and the number of SVPs were done separately for Zone 1 (Health 1) and Zone 2 (Health 2), as well as for the zones that shifted to SVP per capita financing and self-management. The total number of the surveyed SVPs was 90 in 2007 and 70 in 2011. Cutting down the number of SVPs and a proportional reduction in the number of the surveyed personnel and patients was the result of the 2007-2011 inflation which limited the financial possibilities of the estimation; however, it did not affect the statistical validity and liability of the results.

The instruments for the conducted surveys included and stipulated the following:

- Structured interviews with users and suppliers of health services with the use of specially designed standardized questionnaires;
- Random studying of financial, statistical and medical documentation, including the audit of patients' charts;
- Direct observation of admission and treatment of patients from the target groups;
- Examination of facilities' premises, checking the availability of medical preparations and equipment (including its working condition) on the day of visiting, with filling out forms with lists of mandatory equipment, medicines and preparations.
- Structured interviews with financial managers and Heads of SVPs;
- In-depth interviews with Rayon Public Health System key specialists and Oblast Health Ministry Department chief accountants and economists.

Summary

In the course of the implementation of ‘Health-2’ and 'Women and Children Health Development' Projects, the SVP personnel and GPs underwent training in reproductive health, – both at 10-month GP courses and at short-term courses devoted to breastfeeding, reproductive health, antenatal care in GP’s practice, etc. These courses, attended by a significant number of personnel have improved GPs’ knowledge and skills in reproductive health issues, which has been confirmed by the results of the evaluation of personnel’s skills in newborn examination, in infant growth and development monitoring, in nutritional consultation, as well as in the increase in the share of GPs performing examination of the mammary glands in women of fertile age and administering cervical smear in at-risk women. The improvement of GPs’ knowledge and skills has resulted in a higher quality of services in breast cancer prevention and early diagnostics as well as the quality of cervical cancer screening.

Maternity and patronage nurses’ knowledge and skills have improved, too. They have shown better awareness of the signs of abdominal pregnancy and other threatening conditions which, in its turn, resulted in a higher efficiency of consultation provided to pregnant women and in an increased share of pregnant women informed on these signs.
The audit of patients’ charts has shown that the share of charts with gravidograms has increased 2 times, the share of pregnant women tested for HIV – 4 times, and the share of pregnant women tested for alpha-fetoprotein at the screening center – 4.5 times.

On the whole, the quality of antenatal care provided by SVPs has improved. In 2011, we can see a significant increase in the share of personnel with correct a) management of pregnant women with anemia; в) administration of iron preparations; c) consultation in nutritional issues and medication taking control methods.

Nevertheless, 18% of doctors have not attended training in reproductive health. In 35% of cases, pregnant women’s charts lacked gravidograms; some, – although not so many, – GPs did not know the signs of threatening abortion, abortion in progress, abdominal pregnancy and threatening eclampsia. GPs are willing to acquire knowledge and skills of conditions commonly dealt with at SVPs to be able to render assistance in such cases without gynecologists.

A tendency of nurses’ high rotation was observed: the experienced or trained under Health 2 Project nurses were being replaced by young nurses having graduated from colleges, whose knowledge and skills were evaluated by GPs as inadequate, resulting in inferior quality of services provided to the population, women and children.

Annex 6. Stakeholder Workshop Report and Results

N/A

Annex 7. Summary of Borrower's ICR and/or Comments on Draft ICR

The following activities were implemented by Health II project:

Component 1. Development of primary healthcare sector

a) construction and provision of equipment, technical telecommunications and vehicles to SVPs not covered by the Health I project:

- Constructed and provided standard furniture, medical and diagnostic equipment, consumables and reagents to 2389 SVPs as opposed to initially planned 2200 SVPs, i.e. featuring 10% increase;
- 90 laboratories at rayon hospitals received laboratory equipment and consumables;
- 100 rayon and city hospitals received ultrasonic examination equipment for 120 surgical departments at central rayon and city hospitals received extended surgical packages;
- 542 vehicles for primary healthcare institutions, ambulance services, state sanitary-epidemiology control services and medical equipment maintenance centres were procured;
- 570 packages of dental equipment procured using budget savings, including 314 packages for central rayon polyclinics and 256 packages for SVPs; and
- system for maintenance of medical equipment developed and piloted in 2011 in 4 regions (Tashkent city, Tashkent, Ferghana and Syrdarya regions).

b) improved provision and use of basic medications and preparations in the SVPs:

- standard list of basic medications and preparations for an SVP was developed. Methods of procuring medications for SVPs were improved, measures introduced to rationalise the use of medications, control the inventory at RMUs and SVPs through development of regulatory documents, training doctors (2235), nurses and financial managers from SVPs (5304).

c) development and implementation of experimental urban primary healthcare model, including provision of medical and laboratory equipment, training and consultancy:

- 29 pilot urban polyclinics provided with a standard package of medical and diagnostic equipment complete with consumables and reagents.

d) strengthening the general practitioners training programme, including creation and provision of equipment for three new clinical training centres and clinical laboratories, conducting training, study visits and provision of consultancy services:

- 171 classrooms were set up at rayon and city medical unions for training of doctors and mid-level medical personnel from SVPs and family polyclinics;
- 9 clinical laboratories were set up at 8 medical institutes and provided with mannequins and equipment for training of students in provision of first aid to patients of primary healthcare institutions;
- new teaching methods based on evidence based medicine principles were developed and introduced in medical institutions as part of undergraduate education improvement programme;
- the 7-th year curriculum for the students was improved introducing a programme similar to the 10-month GP training programme and the modules for select standards of care;
- 74 sets of computer equipment for GP training centres at medical institutions and 13 sets for regional training centres for SVP laboratory assistants were procured;

- 4638 doctors (against 2700 planned) undergone 10-month long GP training of which 3770 were SVP doctors, 712 were from city family polyclinics and 156 were teachers from medical HEIs.

e) creation and operation of the Evidence Based Medicine Centre and of the Centre for Continuous Medical Education, including provision of equipment, library materials, training and consultancy services:

- the National Evidence Based Medicine Centre and the Department for Postgraduate Training of General Practitioners were set up to provide continuous medical training services to SVP staff and workshops on continuous GP training for SVP and FP doctors were conducted throughout the duration of the project in cooperation with the Tashkent Institute for Post Graduate Medical Studies. Twenty thousand general practitioners attended these workshops (in average, general practitioners attended 3-4 workshops); and
- the Project has provided support in developing and disseminating various training materials and clinical guidelines, a total of 91 titles, in over 25 thousand total copies.
-

Component 2. Financing and management reforms

a) nationwide implementation of rural primary healthcare sector financing and management reforms, including provision of computer equipment, training and consultancy services:

- reforms introducing per capita provider payment in all SVPs were expanded nationwide.

b) piloting reforms of financing and management in urban primary healthcare sector including provision of computer equipment, training and consultancy services:

- the per capita financing model was introduced on a pilot basis in 25 urban family polyclinics.

c) implementation of provider payment and management reforms and rationalisation of secondary healthcare services through provision of computer equipment, training and consultancy services:

- preparatory activities to switch secondary healthcare facilities to case based funding were implemented, the system is being piloted in the Ferghana region.

d) strengthening the management capacity of health sector management through provision of equipment, training materials and consultancy services:

- 536 sets of computer equipment for rayon ICT centres under the RMUs were procured, training of RMU staff on using the computer equipment in healthcare sector management conducted;
- server equipment for collecting and processing information at the Ministry of Health and to aid management decision making process was procured;
- 2997 SVP directors attended training in management of medical facilities;
- 940 specialists from personnel department were trained in personnel management and workflow management in the health sector;
- 250 specialists from the financial-economic services were trained in the aspects of financial planning in the health sector;
- the training programme and 5 methodological guidelines on management and accounting of PHC facilities were developed and a print run of 5,000 copies in Russian and Uzbek languages disseminated;
- over 80 titles of training and methodological literature on financial management were procured;

- classification tables on monitoring healthcare expenditures were developed together with the State Statistical Committee are currently being implemented in accordance with the principles of National Health Accounts.

Component 3. Improvement of public health services

a) further development and improvement of the national public health strategy:

- concept of strategic management of public health development in the Republic of Uzbekistan in 2013-2025 was developed.

b) strengthening the Public Health School

- the Public Health School was established under the Tashkent Medical Academy and provided with training and presentation equipment; 54 Masters of Public Health have graduated from the school; courses to train teachers from medical institutes in evidence based medicine and epidemiological surveillance of non-communicable diseases are organised on a regular basis.

c) expanding the scope of the programmes for promotion of healthy lifestyle and sanitary education; and strengthening first aid and nutrition programmes amongst local population:

- in order to reduce the iron deficiency prevalence rate among children, iron supplements were procured and disseminated in Bukhara, Navoi, Samarkand and Tashkent regions. The impact of the programme was demonstrated in reduced iron deficiency among children in these regions from 37.9% to 14.9%;
- 87 staff members of the Institute of Health and Medical Statistics were trained in interpersonal communication skills, 33 national trainers on health lifestyle promotion were trained; and
- the Project took active part in development and endorsement of the Plan for Healthy Lifestyle Promotion; development and negotiation of the "Law On Restriction of Distribution and Consumption of Alcohol and Tobacco Products" signed by the President of the Republic of Uzbekistan on 5 October 2011.

d) modernisation and strengthening of the public health infrastructure through provision of training, consultancy services, computer equipment and re-equipping several sanitary-epidemiology laboratories:

- a set of laboratory equipment, consumables for 76 public health laboratories, including 23 laboratories of the state sanitary-epidemiological control centres, 19 AIDS centre laboratories, 5 laboratories at dermatovenerologic dispensaries and 29 TB diagnostic laboratories were procured;
- 236 sets of computer equipment for state sanitary-epidemiological control centres were procured; and
- A communicable diseases monitoring information system has been developed and is currently being introduced.

e) support to National HIV/AIDS Strategy and National TB Strategy, including provision of equipment, training and consultancy services:

- 3 training modules and 1 training manual on different aspects of HIV/AIDS/STD prevention were developed; and
- 2,218 specialists in different aspects of HIV/AIDS/STD prevention were trained.

Organization and implementation of activities within the Ministry of Health and other agencies involved in project implementation

The project was implemented by the Joint Project Implementation Bureau for the IDA Project "Health II" and ADB Project "Mother and Child Health Improvement" that was established under the Ministry of Health (Implementing Agency).

The JPIB is an independent organisation operating as a sub-division of the MoH and its staffing schedule includes the executive director, coordinator and component specialists, financial manager/chief accountant, manager and procurement specialists, accountants, administrator (office manager) and a number of other support staff.

The JPIB has managed the project's day-to-day activities whereas more broad matters related to project implementation, such as definition of policies and directions of reforming health sector were left with the Ministry of Finance and the Ministry of Health.

The role of the Ministry of Health was instrumental in attracting international donors involved in the health sector, and, in particular, the Ministry of Health managed to attract the following donors' funds:

- UNICEF involved;
- USAID (Zdravplus) was involved in implementation of the financial reforms under the project, training general practitioners aimed at improving quality and developing evidence based medicine;
- UNDP implemented a pilot project utilizing renewable energy technologies in rural medical centres;
- WHO developed public health strategies and was involved in promoting healthy life style among rural population; and
- EU's Tacis programme evaluated the existing medical equipment maintenance system and developed proposals to improve the system.

Expert committees and working groups were established involving leading experts of the MoH to focus on the following tasks: preparation and approval of technical specifications for the equipment to be purchased as well as terms of reference for international and local consultancy, evaluation of bidders' proposals, and acceptance of consultants' reports.

The Ministry of Finance acted as the Borrower on behalf of the Government and was responsible for timely allocation of co-financing in accordance with the loan agreement.

The Ministry of Economy ensured planning of the state investment programme, over-sought the project performance and controlled the municipalities' participation in construction and reconstruction of SVPs to be equipped by the project.

The Ministry of Labour and Social Protection provided legal frameworks institutionalising the specialisation of general practitioner and participated in development of the qualification requirements for the General practitioners at SVPs and FPs.

The Ministry of Justice provided legal support and approved the project's regulatory documents.
MFERIT has participated in the project ensuring registration of contracts.

The State Customs Committee registered import contracts and cleared the imported goods from customs.

The national foreign economic enterprise "Uzmedexport" acted as a Procurement Agent and conducted procurement of goods (tendering, bid evaluation, contract implementation), part of this function was later delegated to the JPIB.

The UzTibTehnika Joint Stock Company acted as a Delivery Agent and provided warehousing services and delivery of goods to final beneficiaries in accordance with the schedules approved by the Ministry of Health.

The Department for Quality Control and Medical Equipment and Medications was responsible for registration of medical equipment, furniture, consumables and reagent procured by the project.

Project design, implementation and impact

Assessment of Project Design

The Project's objectives were in line with the Government's reform priorities and strategies in the health sector, with a focus on PHC, optimisation of medical service delivery network, training of medical staff, improvement of the healthcare management system and development of the public health system. The changes made to the project components and sub-components during the course of implementation have contributed to the achievement of original development objectives. Some additional financial allocations and redistributions were made throughout the project lifecycle thus ensuring that the project's objectives were fulfilled.

Main results achieved under each of the project development objectives (i.e. key performance indicators) and each component/subcomponent

A network of new generation of medical/preventive facilities based on general practitioner services was established in rural and urban areas as a result of the Health II project implementation. The undergraduate and postgraduate general practitioner training was institutionalised. The specialisation of general practitioner was officially approved and registered as a standalone medical position.

For the first time, all primary healthcare facilities in the country have independent legal statuses. All rural primary healthcare facilities and pilot urban family polyclinics were switched to per capita financing system. The share of primary healthcare and outpatient health services in the 2011 expenditures structures has reached 45.2% as compared to the baseline level of 41% in 2004.

Five planned indicators contained in the project's results framework were achieved or exceeded; two others are close to achievement. The share of women observed by primary healthcare facilities from the early stages of pregnancy has increased from the baseline level of 79.1% to 87.7% (the target was at 85%). The share of patients referred from SVPs to hospitals reduced from the baseline level of 20% in 2004 to 12% in 2011 (the target level was at 15%). The number of population's visits to primary healthcare facilities has increased from 3.8 in 2005 to 4.7 in 2011 (the target was set at 5 visits per capita).

The final evaluation of Health II project conducted by an independent team of consultants revealed positive changes in the patients' satisfaction with the quality and accessibility of SVP services as well as in the level of population's awareness of disease prevention matters. Over 95% of the rural population

supported the choice of general practitioner method for SVP service delivery as opposed to using services provided by medical specialists at other facilities. The results of the study show that the measures aimed at improving conditions in rural clinics, providing modern medical equipment and materials as well as improving the doctors' and nurses' knowledge and skills resulted in the population relying less on the specialist assistance of rayon hospitals.

As a result of improved public health activities, preventive programmes aimed at promoting healthy lifestyle among rural and urban population were developed successfully. The coverage of laboratory screening for HIV amongst pregnant women increased (from 55% in 2007 to 85% in 2011). The percentage of voluntary laboratory tests has increased from 40% to 73% during the same period. The project has contributed to achieving stabilisation of HIV prevalence rates in the country and reducing annual disease rates by 5-6% per year in 2009-2011.

As a result of implementation of the iron supplementation and programmes and promotion of healthy nutrition habits in Bukhara, Navoi, Samarkand, Tashkent regions in 2009-2011, the iron deficiency has reduced by an average of 22.3% as compared with the baseline level (from 37.9% to 14.9%).

Project coordination and management

The Governmental Committee for healthy generations, strengthening the women's health and improving family culture created under the Cabinet of Ministers has been charged with coordinating project activities and overall management of project implementation. Regional Committees for healthy generations, strengthening the women's health and improving family culture were responsible for project implementation at regional level.

The Ministry of Finance acted as the Borrower responsible for financial matters.

The Ministry of Health, as the Implementing Agency, manages the project through the Joint Project Implementation Bureau; project Implementation bureaus of the Ministry of Health of Karakalpaksatn, Departments of Health in the regions and the city of Tashkent (OPIBs), working groups (WG) and other departments. The Ministry of Health bears overall responsibility for implementation of Projects, decisions aimed at their development, and provision of government's contributions.

Oblast level project implementation bureaus were established at the regional health departments and the Ministry of Health of Karakalpakstan to implement project activities which bureaus were comprised by one PIB director and one health, finance and management specialist. These bureaus are responsible for implementing the project in their respective regions and have dual subordination to both regional health departments and to the JPIB.

Responsibilities of the Project Coordinator and of key personnel

The JPIB is headed by its executive director responsible for managing and coordinating all project components and activities, including technical, financial, administrative aspects and procurement activities, training and work organisation. The JPIB has 4 departments: management section, financial section, procurement section, and administrative department.

The Management Section includes the executive director, the deputy executive director, project coordinator and component experts. This section was responsible for implementing activities and monitoring achievement of component targets.

The Finance Section comprises a financial manager/chief accountant, finance specialist/accountant, accountant and a disbursement specialist. The finance section was responsible for planning and disbursing the project's funds, payments, keeping records, compiling financial and accounting reports.

The Procurement Section includes a senior expert and procurement expert. This section was responsible for planning procurement, putting up procurement budget and getting necessary approvals, drafting bidding documents, coordinating and controlling the activities implemented by Uzmedexport (procurement agent) while procuring goods, selecting and hiring consultants and providers of training packages, monitoring implementation of the contracts signed, coordinating activities with Uztibtehnika (delivery agent) and the main department for controlling quality of medications and medical equipment (expert).

The Administrative Section is responsible for ensuring working conditions, labour discipline, keeping records on staff, maintaining project inventory, and workflow management.

The Project Coordinator has also acted as a specialist for the "Development of primary healthcare sector" component. The deputy executive director supported the executive director in implementing projects, particularly, in the area of healthcare in general and project coordination. The project coordinator and component specialists ensured implementation of activities aimed at achieving the project's objectives. In particular, this included development of implementation plans, compiling and coordinating the list of beneficiaries, the lists, quantities and technical specifications of the goods to be procured, terms of reference for the consultants, monitoring and evaluation of component results, delivery and installation of equipment by the suppliers, interaction with other stakeholders.

Relationship between project coordinators, decision makers, organizations responsible for implementation of activities and other stakeholders

Experts group established at the MoH comprised managers and specialists from the MoH's departments and other stakeholders, who were responsible for coordinating activities of the project participants. In general, interaction between the JPIB team and responsible institutions and international organisations was productive.

The project's impact on health sector reforms

The Health II project was implemented in the framework of the Uzbekistan's State Programme for health sector reforms (Presidents Decree Nr UP-2107 dated 10 November 1998).

The government has been implementing a comprehensive step-by-step reform package in the health sector aimed at providing the population with high quality medical services. The Health II project which was a logical follow up to Health I project was implemented in line with these reforms. The need for these project was apparent from the Resolution of the Cabinet of Ministers of the Republic of Uzbekistan No. 182 dated 21 May 1996 "On Rural Infrastructure Development Programme" which defined primary healthcare as a priority area. A concept for the development of the health sector in Uzbekistan was developed based on the objectives specified by the said resolution, and on 10 November 1998 the President of Uzbekistan signed Decree Nr UP-2107 "On State Programme for Reforms in Health Sector of the Republic of Uzbekistan". The programme of further reforms in the health sector aims at creating a system that would ensure keeping and raising the population's health levels, create conditions for upbringing healthy generations. The President's initiative was supported by the World Bank which made a

decision to invest into a project for reforming the primary healthcare sector. Implementation of Health I project aimed at strengthening of the primary health sector in five regions (Karakalpakstan, Ferghana, Navoi, Khorezm and Syrdarya). The Health II project has ensured replication and strengthening of the reforms.

A new concept of medical services delivery by the primary healthcare sector was developed and implemented nationwide in the framework of these projects in a relatively short timeframe along with institutionalisation of general practitioner based practice in the facilities.

Measures for introduction of per capita financing at primary healthcare sector have been approved by the Resolution of the Cabinet of Ministers No. 217 dated 28 September 2005 "On measures for further reforming the system of financing and management of healthcare facilities in the Republic of Uzbekistan". In accordance with the approved schedule, transition of rural PHC facilities to financing based on the expenditures per capita of population has been implemented as planned and applied to all SVPs nationwide.

Based on the priority objectives of protecting and strengthening the population's health and in accordance with the international commitments of Uzbekistan (UN Millennium Development Goals and WHO/Europe's Health21 programme) a draft Public Health Strategy has been developed covering the period until year 2025. The document is currently undergoing Government scrutiny.

In accordance with the Resolution of the President dated 27/01/2010 "On the State programme for the Year of Harmoniously Developing Generations", the Law of the Republic of Uzbekistan "On restricting distribution and consumption of alcoholic and tobacco products" was developed and adopted on 5 October 2011. The draft law of the Republic of Uzbekistan "On accession of the Republic of Uzbekistan to the WHO Framework Convention against tobacco" was prepared.

Development of HMIS under the project resulted in the creation of the Data Processing Centre under the Ministry of Health. This Centre promotes the information system for monitoring communicable diseases throughout the country and supports the creation of and IS for monitoring non-communicable diseases. In the future, the Centre shall become a major tool supporting justified decisions related to healthcare system management. Namely, under the Health III project, the Centre shall support implementation of HMIS at RMUs, thus accelerating the reforms of management and funding nationwide.

Critical analysis of actions undertaken by the World Bank, Government and technical assistance

World Bank's performance during project preparation and implementation

Despite the fact that the Task Team Leader along with the whole team managing the project has changed three times throughout the project life, the WB has ensured continuous support and direct management during project preparation and throughout the implementation period. Project preparation was supported by substantial analytical research and technical assistance provided by WB experts. The direct control implemented by the WB's project team facilitated timely identification of problems and development of solutions. Two local staff responsible for project implementation have been replaced during the life of the project, but both staff members had ensured high quality cooperation. Immediate response to requests, experienced experts' opinions and very useful comments and suggestions coming from the WB team were instrumental to the success of the project. The Ministry of Health and the JPIB very highly rate the efficient cooperation with the WB.

Assessment of the Government's actions during project preparation and implementation

The Health II project was implemented in the framework of the State Programme of the Republic of Uzbekistan on Reforming the Healthcare System.

Development and reforms of the health sector under the project have always been closely followed up and actively supported by the Government. The Government's commitment to timely construction and rehabilitation of SVPs, laboratories at central hospitals, urban polyclinics, training and information centres before any procurement of equipment under the project started was an important step. Moreover, Uzbekistan had been regularly providing co-financing for the Health II project since 2005.

Development and implementation of key/innovative changes by the project were backed by relevant Government Decrees and Resolutions.

On 28 September 2005 the Cabinet of Ministers issued resolution "On measures for further reforming the system for financing and management healthcare facilities in the Republic of Uzbekistan" that defined measures aimed at expanding the new financing mechanism to cover all rural PHC facilities and piloting the experiment at select urban PHC facilities. The volume of funding allocated for the primary healthcare sector has increased by over 4 times throughout the project life.

In December 2005, the Government issued Resolution No. 276 "On approving the improved system of remunerating medical workers", which sets the remuneration rates of general practitioners on par with other specialists in light of the complexity and difficulties of the profession.

The Ministry of Health ensured compliance with the provisions of the Loan Agreement. The Government and the WB were regularly provided with project progress reports and audited financial statements; round table meetings and information briefing sessions to cover the project progress were regularly organised. The project progress was regularly reported at Government meetings.

Assessment of the efficiency and the quality of relations between the World Bank and the Government during project implementation

The Government cooperates with the World Bank in an efficient and creative manner. The first project aimed at creating the national model of primary healthcare was implemented in 1998-2004 and has contributed significantly to successful development and implementation of healthcare reforms in the country. Further cooperation between the Government and the World Bank under the Health III project shall be aimed at improving the quality of secondary healthcare sector. Cooperation between the Government and the World Bank is characterised by substantial success of healthcare reforms.

Assessment of different stakeholders

In general, stakeholders were actively involved in project implementation thus contributing to institutionalisation of innovations.

The project's impact on the institutional structure created and supported by the project

The project has not only facilitated introduction of General Practitioners but, most importantly, has changed the psychology and attitude of both doctors and the population to the new system. The project had an impact through: (i) improving quality and accessibility of primary healthcare providers; (ii) improving the economic efficiency of the primary healthcare system; and (iii) improving the population's awareness of healthcare reforms.

The project had a substantial impact on the institutional framework and availability of resources at primary healthcare facilities in rural areas throughout the country as well on the institutionalisation of general practitioner's profession.

The data available shows that improvement of the primary healthcare infrastructure was achieved thanks to the combination of the project's impact and that of other programmes implemented by the Government with the support from donors, thus contributing to fulfilment of the main objectives of Millennium Development Goals.

The project had a significant institutional impact on improving the public health strategy, promotion of healthy lifestyle and community level and national approaches. The results of the project are used for developing and improving the efficiency of national programmes, standards and methods in further developing the PHC and GP systems.

In order to address the issue of availability of resources at PHC facilities, a system of centralised procurement of medications and consumables for the SVPs was established. A system for technical maintenance of equipment aimed at ensuring uninterrupted operation of the equipment supplied has been developed and is being piloted in several regions.

Main lessons learned

The project's activities have supported and contributed significantly to improvement of the primary healthcare system in the country.

The integrated approach used during project implementation involving construction, reconstruction and overhaul of PHC facilities, RMUs, public health laboratories, strengthening of personnel at medical facilities, introduction of new financing methods can serve as a model for future projects.

Measurability and comparability of the project's results were affected by irrelevance of indicators to the project's objectives, and indicators had to be further clarified. The monitoring and evaluation system of the project was jointly reviewed and simplified with the Ministry of Health in March 2008. More measurable indicators relevant to the project's objectives were selected. Three new indicators were added to the results framework matrix of the project in May 2010 following the restructuring of the project and introduction of new activities and extension of project term.

The reforms of financing cover not only the healthcare system but also related agencies, such as the Ministry of Finance, Ministry of Economy, State Statistics Committee and others. An Inter-Agency Committee needs to be set up to coordinate introduction of new provider payment methods.

Procurement activities under the project started with 10 months' delay. The first set of bidding documents for procurement of medical equipment and tools for 1815 SVPs was prepared and sent to the WB in February 2005 (the budget of US$ 13.1 million USD). However, the Bank recommended negotiating direct purchase of these goods with UNICEF (Aid Memoire by the WB mission in March-April 2005 and subsequent correspondence). Agreement could not be reached with UNICEF for the following reasons: (i) high prices and incomplete list of goods offered by UNICEF; (ii) unacceptable payment procedures under UNICEF contract (100% down payment requested by UNICEF); (iii) refusal by UNICEF to accept the procedures for controlling quality of medical goods as prescribed in the laws of Uzbekistan. At the same time, procurement guidelines state that UN organisations can be contracted for procurement of: "(i) **small batches** of off-the-shelf goods, mainly for education and healthcare sectors; and (ii) **specialised products with a limited number of suppliers, such as vaccines and medications**".

At the beginning of implementation, the JPIB signed a six-partite agreement with the agencies involved in project implementation: the Ministry of Health, the Ministry of Finance, Uzmedexport (Procurement Agent), Uztibtehnika (Delivery Agent) and the Main Administration for Controlling Quality of Medications and of Medical Equipment (Quality Control Expert). The Procurement agent was charged with responsibility for development and distribution of bidding documents, sending invitations to bid, evaluating bids, concluding and implementing contracts. JPIB was responsible for getting the bidding documents, evaluation reports and other documents related to ICBs/NCBs with the WB or other government institutions. The use of this scheme resulted in delays in procurement procedures. In March 2006, all functions related to BD preparation, announcing the tenders were handed over to the JPIB, later, in October 2008, the whole process from BD preparation till getting WB endorsement of evaluation report was assigned to the JPIB, and this resulted in reduced time required to finalise procurement and improved quality of procurement.

Re-tendering was necessary in some cases due to: (i) lack of compliant bids; or (ii) prolonged failure of the suppliers to perform their contractual duties (resulting in termination of contracts). Failure to deliver by the suppliers had the most significant negative impact on project implementation. Namely, some companies offer prices substantially lower (by several times) than the market price for the goods than the prices offered by competitors. The company was awarded a contract as a result of this. Once the contract was signed, the company fails to comply with contractual requirements on quality control (registration of medical goods) or fails to ship. 21 contracts with 8 suppliers were terminated under the Health II project for these reasons (one supplier holding 10 contracts, another supplier with 5 contracts and six individual suppliers having 1 contract each) for a total amount of US$ 2.61 million. The use of loan proceeds for procurement of small medical goods with low value is considered to be inefficient.

Sustainability of Project's investments

The network of outpatient PHC facilities was rationalised and access of rural population to PHC services improved as a result of project implementation thanks to: a) institutional strengthening and provision of materials and technical resources to PHC facilities; b) institutionalisation of GPs through creation of training centres and implementation of 10-month long GP training programme, reform of undergraduate education system and introduction of continuous education cycle; c) expanding the financing and management reforms introducing per capita funding mechanisms; d) improved public health functions including sanitary-epidemiological surveillance.

The reforms in the primary healthcare sector resulted in improved quality of medical services and increased patient satisfaction reduced the number of outpatient visits and the rate of hospitalisation to rayon and regional hospitals.

The sustainability of activities implemented under the Health II project was further reinforced by the Decree of the President of Uzbekistan Nr UP-3923 dated 19 September 2007 "On main directions of further reforms and on implementation of the State Healthcare Development Programme", the Cabinet Resolution Nr 48 dated 18 March 2008 "On measures for improving organisational structure and activities of regional health institutions" and the President's Resolution Nr PP-1652 dated 28 November 2011 "On measures for further deepening reforms of healthcare system".

The Health III project has been developed and is being implemented in accordance with the above regulatory acts; this is indicative of the government's commitment to institutionalisation of reforms envisaged in the project.

Conclusions

The primary healthcare sector in rural areas has been reformed in the framework of the Health II project. The project established: a) a network of new/reconstructed rural medical centres (SVPs) equipped with modern medical and diagnostic equipment that provide qualified medical services to the population free of charge; b) a sustainable system for training and retraining General Practitioners for rural medical facilities; c) the concept of family based medicine in urban areas is currently being implemented on a pilot basis; d) new mechanisms of financing and management based on per capita financing principles have been introduced at primary healthcare facilities; e) conditions were created at SVPs to introduce new approaches in promoting health, proper nutrition among rural population and to prevent diseases; f) an information system for electronic monitoring of communicable diseases has been developed and is currently being rolled out.

Rationalisation and optimisation of primary healthcare in rural areas were completed as a result of the project. Rural medical-obstetrical stations were abolished and rationalised, rural outpatient clinics have been liquidated and the number of rural district hospitals was reduced. At the end of the day, the patient referral system now has two levels instead of five: the SVP can refer to central district hospital.

Annex 8. Comments of Co-financiers and Other Partners/Stakeholders

The ICR Team met with development partners whose activities complemented or went hand-in-hand with the Project, including ADB, JICA, WHO, UNDP and GIZ. This Annex reflects some of their comments.

ADB Health Project (USD& 40 million) was designed in very close collaboration with the World Bank and addressed: (i) women and child health services; (ii) improving financial management and M&E system in MoH, and (iii) blood system safety improvement through investments in capacity building, civil works and equipment. Projects complemented each other as a result of joint planning, consultations, roundtables and sharing information in design and implementation stage. Projects shared the same implementation agency, JPIB which contributed to improved efficiency on both sides and led to savings and improvement in training, knowledge sharing and capacity building. Both sides made efforts to synchronize their schedules to have joint supervision missions. ADB evaluated collaboration with the Bank as superior.

JICA complemented Health 2 project by supplying 114 SVPs with equipment for laboratories, gynecology and with sterilizers. They evaluated joint planning and coordination very positively.

WHO assisted Health 2 by providing expertise and technical support in areas of public health, mental health, nursing, nutrition, and GPs capacity building. They described their relation to the Bank very positively, highlighting regular exchange of information and follow up meetings during every Bank's mission, and their relations to JPIB as a partnership. WHO illustrated cooperation the success and great impact of the Primary Health Conference in Tashkent in September 2010 involving all the development partners active in Uzbekistan, which was jointly organized by WHO and Health 2.

UNDP collaborated with the Bank within the Health 2 project on supporting renewable energy initiative for SVPs. Upon Bank's initiative, having experience with renewable energy, UNDPs support was carried out in four phases: (i) Feasibility Study analyzing different options for 4 regions; (ii) technical demonstration by equipping, testing, monitoring and exploring different options for 4 different buildings in respective regions – 2 of 8 pilots were SVPs; (iii) analysis of findings based on criteria agreed with the Bank, and (iv) presenting report proposing universal solution. UNDP evaluated collaboration with the Bank very highly. However, the renewable energy initiative did not materialize due to the Government's decision to opt for supplying SVPs with medical equipment instead.

GIZ started its first health related project in Central Asia in 2009 and benefitted greatly from resources such as tools and guidelines from Health 2 on capacity building of nurses and GPs. GIZ noted that the Bank-financed projects created a good platform for normative basis and institutionalization of CME which along with regular communication and information sharing created a favorable environment for other donor's participation.

Annex 9. List of Supporting Documents

1. World Bank, 2003, Project Concept Note (PCN)
2. World Bank, 2003, Minutes of PCN Review Meeting
3. World Bank, 2004, Project Information Document
4. World Bank, 2004, Minutes of Decision Review Meeting
5. World Bank, 2004, Minutes of Negotiations
6. World Bank, 2004, Development Financing Agreement
7. World Bank, 2010, Amendment to the Development Financing Agreement
8. World Bank, 2011, Amendment to the Development Financing Agreement
9. World Bank, 2004, ICR for the Health 1 Project
10. World Bank, 2004, Financing Agreement for Health 2
11. World Bank, 1999 – 2010 Aide Memoires and Back-to-Office Reports
12. World Bank, 2004 – 2011 management and other important letters and memoranda
13. World Bank, 2004 - 2011 Implementation Status and Results Reports (ISRs)
14. World Bank, 2004, Project Appraisal Document for Health 2 Project
15. World Bank, 2011, Project Appraisal Document for Health 3 Project
16. World Bank, 2002, Country Assistance Strategy
17. World Bank, 2008, Country Assistance Strategy
18. World Bank, 2006, Interim Strategy Note
19. World Bank, 2011, Country Partnership Strategy
20. World Bank, 2008, Governance Report
21. World Bank, 2010, Restructuring Paper
22. Project Implementation Unit, 2004 – 2011 – Progress Management Reports
23. Borrowers Contribution to ICR – March 2012
24. Borrowers Comments to draft ICR – June 2012
25. Expert Fikri's Final Assessment of the Health 2 Project, July 2011

Annex 10. Original Key Performance Indicators

UZBEKISTAN: Health II Project [41]

Hierarchy of Objectives	Key Performance Indicators	Data Collection Strategy	Critical Assumptions
Sector-related CAS Goal:	**Sector Indicators:**	**Sector/ country reports:**	**(from Goal to Bank Mission)**
Enhance the efficiency of resource allocation and use in services	Rationalization of outpatient and hospital services extended to new regions; new payment systems replicated for primary care and new payment systems piloted for specialty and hospital services; facility-type resource allocation formulae are refined		No major economic crisis; adequate institutional capacity
Improve the policy framework for liberalization; improved governance and transparency	Capitation formula simplified; decisions for input mix and allocation for services are decentralized to regional and rayon levels; community organizations more involved in management of local facilities		No major social crisis or civil conflicts, especially at central level
Strengthen environment for private sector development	Primary care facilities obtain independent juridical status, establish bank accounts, have flexibility over management of input mix		Adequate regulatory framework, including capacity to do business planning at facility level, and adequate regulatory monitoring by state

[41] Uzbekistan Health 2 Project. Project Appraisal Document (Report No. 28485-UZ), August 5, 2004.

Project Development Objective:	Outcome / Impact Indicators:	Project reports:	(from Objective to Goal)
Improve the quality and overall cost-effectiveness of health care services through (a) completion of the primary care program in designated regions (Samarkand, Sukhandarya, Namangan, Andijon, Djizzak, Ferghana, Navoiy, Syr Darya, and others as agreed), and institutionalization of general practitioners nationally; (b) extending financing and management reforms related to efficiency and effectiveness of service delivery; (c) improving public health services, including surveillance, training in public health, and control of communicable disease; (d) building capacity in the Ministry of Health to better monitor and evaluate the reforms, and better manage the restructuring process.	Improved maternal and child health outcomes; numbers of infectious diseases successfully treated Increases in SVP utilization; referral decreasing; admissions decreasing; beds and facilities consolidating and/or decreasing Functioning training programs for GPs and Universal Nurses, public health experts, health policy experts, and financial managers successfully established and in place Measurable shift in allocations from inpatient to outpatient care; improved allocative efficiency in urban pilot centers; improved technical efficiency for hospital (secondary level) services in hospital pilot regions HIV testing and access to MTCT prevention programs in place; coverage of groups at risk; TB DOTS treatment program nationally; increased community involvement in primary care programs Well-functioning monitoring and evaluation process in place, utilizing both facility surveys and household surveys on periodic basis		Health care revenues remain at least constant (real, not nominal) over the life of the project Continuity o of the Government's health care reform strategy and stability in institutional arrangements Coordination between health reform and wider fiscal and macro-economic policies is maintained or improved Continued decentralization and simplification of management of local services Improved coordination among the range of actors involved in public health finance, policy, and delivery Institutional and technical capacity for reforms continues to strengthen

Output from each Component:	Output Indicators:	Project reports:	(from Outputs to Objective)
Primary Health Care Development	1) Improved quality of maternal and child care, as measured by such indicators as i) percentage of women who receive prenatal services; ii) % completion of immunization schedule; and ii) percentage of newborns who receive Hepatitis B vaccination; 2) improved availability of key essential drugs and supplies at the SVP level; 3) % completion of SVP construction/reconstruction per year/per oblast; 4) % SVPs that meet standards and are equipped; 5) % SVPs with telephone or other telecommunication modality; 6) % SVPs with at least one GP working; 7) % of patients in fertile age group practicing family planning; 8) % of children under 5 classified as undernourished; 9) % of patients overweight (risk factor for diabetes, hypertension and heart disease); 10) 10 pilot family practice groups established in urban polyclinics; 11) 3 additional clinical training centers for retraining SVP doctors established by mid-2005; 12) 600 SVP doctors being re-trained per year from September 2005; 13) Number of trainers being trained increased to 30 per year by September 2004; 14) Drop-out rate of trainers following completion of training as trainers; 15) Clinical skills laboratories established and equipped at all Medical Institutes training General Practitioners by September 2005 16) Proportion of primary care facilities ("SVPs") staffed by a general practitioner who has either passed through the 10-month training or newly- graduated (need to avoid including the 3-month course graduates from government scheme)		Construction and rehabilitation of facilities competed at high quality and timely Physician and nurse training and legal status changes are implemented timely Flexibility in supply chain regulations framework Stability in institutional and staffing arrangements Strategies to mitigate possible local political resistance towards provider restructuring effective
Finance and Management Reforms	1) Percentage of patients referred from SVP to hospital level; 2) Improved share of expenditures for: i) recurrent costs relative to fixed assets, and ii) cost-effective primary care services		Experience of pilots effectively replicated on national level Sustainable government commitment of rationalization

Output from each Component:	Output Indicators:	Project reports:	(from Outputs to Objective)
	relative to secondary/tertiary care services; 3) Introduction of a nation-wide provider payment system based on capitated financing for rural PHC facilities; 4) Conversion of at least half of rural PHC facilities in Uzbekistan as independent legal entities with sufficient financial and management autonomy; 5) Improved health information system (HIS) for the financing strategies/systems and use of HIS data at all levels of the financial system; 6) Introduction of hospital payment system in 3 regions.		Decision makers use data and analysis to address underlying financial flow imbalances and misallocation of resources in the face of conflicting stakeholder pressures
Improving Public Health Services	1) Strengthening and improvement of a Public Health Strategy (end of Year 1); 2) Development of integrated public health training plan (end of Year 1); 3) Strengthening and improvement of School of Public Health (end of 2nd year); 4) Approval of plan to scale-up DOTS implementation nationally (end of Year 1); 5) Number of trained public health experts (at least 50); 6) 100% pregnant women have access to HIV testing and have access to MTCT prevention; 7) Increase in coverage of groups at risk by 10%; 8) Number of community-based grant projects implemented		The Government is open and transparent about issues related to public health and policy and growth of infectious diseases Willingness/political commitment to revamp approach to traditional SES/public health approach
Project Management, Monitoring and Evaluation	1) Evaluation and monitoring surveys and analysis timely; 2) Project outputs are produced on time and on budget; 3) CPIB shows improved capacity and shows proactive approach to solve issues and achieve positive outcomes; 4) Average time for bidding process; 5) Disbursements per Region; 6) Investments per Region; 7) Equipment distributed per region; 8) Counterpart financing (% allocated); 9) Main targets by Region;	Primary and secondary data sources, such as CPIB Project Management and Financial Reports Oblast PIB management and financial reports Facility surveys Bank supervision mission Semi-annual reports	

Output from each Component:	Output Indicators:	Project reports:	(from Outputs to Objective)
	10) Total disbursements by category: 11) Timely submission of annual work programs and budgets; 12) Establishment of PIBs in new project districts and staff hired		

Project Components / Sub-components:	Inputs: (budget for each component)	Project reports:	(from Components to Outputs)
Primary Health Care Development	$98.104 million		
Finance and Management Reforms	$5.40 million		
Improving Public Health Services	$7.509 million		
Project Management, Monitoring and Evaluation	$2.896 million		
Unallocated	$4.178 million		


UZBEKISTAN
KAZAKHSTAN
KAZAKHSTAN
KYRGYZ REPUBLIC
TURKMENISTAN
TAJIKISTAN
AFGHANISTAN
PAKISTAN
Aral Sea
2001 level of Aral Sea
1990 level of Aral Sea
1960 level of Aral Sea
Ustyurt Plateau
KARAKALPAKSTAN
Kyzyl Kum
Lowland
Turan
NOVOI
KHOREZM
BUKHARA
DZHIZAK
SAMARKAND
KASHKADARYA
SURKHANDARYA
SYRDARYA
TASHKENT
NAMANGAN
ANDIZHAN
FERGANA
Amu Darya
Syr Darya
Zeravshan
Nukus
Muynak
Urgench
Uchkuduk
Muruntau
Gagarin
Dzhizak
Navoi
Bukhara
Samarkand
Qarshi
Denau
Termiz
Guliston
TASHKENT
Namangan
Andizhan
Kokand
Fergana
Adelunga Toghi (4301 m)
To Atyrau
To Qyzylorda
To Qyzylorda
To Bishkek
To Kashi
To Khorugh
To Mary
To Kabul
0 50 100 150 200 Kilometers
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55°E
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70°E
45°N
40°N
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UZBEKISTAN
SELECTED CITIES AND TOWNS
OBLAST (VILOYATI) CAPITALS
NATIONAL CAPITAL
RIVERS
MAIN ROADS
RAILROADS
OBLAST (VILOYATI) BOUNDARIES
INTERNATIONAL BOUNDARIES
MARCH 2009
IBRD 33508R