ADB

Completion Report

Project Number: 36509
Loan Number: 2090
November 2012

Uzbekistan: Woman and Child Health Development Project

Asian Development Bank

CURRENCY EQUIVALENTS

Currency Unit – sum (SUM)

		At Appraisal (23 June 2004)	At Project Completion (31 December 2011)
SUM1.00	=	$0.000981	$0.000557
$1.00	=	SUM1,018.54	SUM1,795

ABBREVIATIONS

ADB	–	Asian Development Bank
CRH	–	central *rayon* hospital
Health-I	–	World Bank-funded Health-I Project (1998–2004)
Health-II	–	World Bank-funded Health-II Project (2004–2011)
HMIS	–	health management information system
JPIB	–	joint project implementation bureau
ICT	–	information and communication technology
MDG	–	Millennium Development Goal
MOF	–	Ministry of Finance
MOH	–	Ministry of Health
O&M	–	operation and maintenance
PHC	–	primary health care
SVP	–	*Selski Vrachebny Punkt*
TA	–	technical assistance
UNFPA	–	United Nations Population Fund
UNICEF	–	United Nations Children's Fund
WCH	–	women's and children's health
WHO	–	World Health Organization

GLOSSARY

makhalla	–	local self-governing community-based organization
oblast	–	province
rayon	–	district
Selski Vrachebny Punkt	–	rural medical point, with at least one medical doctor

NOTES

(i) The fiscal year (FY) of the Government of Uzbekistan and its agencies ends on 31 December.

(ii) In this report, "$" refers to US dollars.

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BASIC DATA

A. Loan Identification

1.	Country	Uzbekistan
2.	Loan Number	2090
3.	Project Title	Woman and Child Health Development Project
4.	Borrower	Republic of Uzbekistan
5.	Executing Agency	Ministry of Health
6.	Amount of Loan	$40 million
7.	Project Completion Report Number	PCR: UZB 1378

B. Loan Data

1.	Appraisal	
	– Date Started	23 June 2004
	– Date Completed	9 July 2004
2.	Loan Negotiations	
	– Date Started	24 August 2004
	– Date Completed	25 August 2004
3.	Date of Board Approval	23 September 2004
4.	Date of Loan Agreement	2 November 2004
5.	Date of Loan Effectiveness	
	– In Loan Agreement	31 January 2005
	– Actual	9 March 2005
	– Number of Extensions	0
6.	Closing Date	
	– In Loan Agreement	30 June 2010
	– Actual	8 May 2012
	– Number of Extensions	2
7.	Terms of Loan	
	– Interest Rate	ADB's LIBOR-based lending facility
	– Maturity (number of years)	25
	– Grace Period (number of years)	5
8.	Disbursements	

a. Dates

Initial Disbursement	Final Disbursement	Time Interval
5 May 2005	8 May 2012	84 months
Effective Date	**Original Closing Date**	**Time Interval**
9 March 2005	30 June 2010	63 months

b. Amount ($)

Cat. No.	Category or Subloan	Original Allocation	Last Revised Allocation	Amount Canceled	Net Amount Available	Amount Disbursed	Undisbursed Balance
01A	Medical Equipment	18,078,000	26,864,333	0	26,864,333	26,826,755	37,578
01B	Training Equipment	2,206,000	2,269,968	0	2,269,968	2,206,415	63,553
01C	HMIS & Office Equipment	1,882,000	1,772,000	0	1,772,000	1,751,132	20,868
01D	Vehicles	70,000	70,000	0	70,000	1,499	68,501
02	Consulting Services & JPIB Staff	1,873,000	1,683,000	0	1,683,000	1,665,282	17,718
03	Training & Fellowships	1,492,000	1,652,158	0	1,652,158	1,050,140	602,018
04	Information/ Education/ Communication Materials	449,000	449,000	0	449,000	415,608	33,392
05	Supplies	3,338,000	2,281,093	0	2,281,093	1,879,167	401,926
06	System Development & Studies	1,600,000	385,448	0	385,448	329,667	55,781
07	Interest and Commitment Charge	5,163,000	2,573,000	0	2,573,000	1,969,581	603,419
08	Unallocated	3,849,000	0	0	0	0	0
	Total	**40,000,000**	**40,000,000**		**40,000,000**	**38,095,246**	**1,904,754**

HMIS = health management information system, JPIB = joint project implementation bureau

9. Local Costs (Financed)
   - Amount ($ million) 2.95
   - Percent of Local Costs 71.12
   - Percent of Total Cost 7.40

C. Project Data

1. Project Cost ($ million)

Cost	Appraisal Estimate	Actual
Foreign Exchange Cost	35.85	35.14
Local Currency Cost	34.15	153.79
Total	**70.00**	**188.93**

2. Financing Plan ($ million)

Cost	Appraisal Estimate	Actual
Implementation Costs		
Borrower Financed	30.00	150.84
ADB Financed	34.84	36.12
Other External Financing	0.00	0.00
Total	**64.84**	**186.96**
IDC Costs		
Borrower Financed	0.00	0.00
ADB Financed	5.16	1.97
Other External Financing	0.00	0.00
Total	**5.16**	**1.97**
Grand Total	**70.00**	**188.93**

ADB = Asian Development Bank, IDC = interest during construction.

3. Cost Breakdown by Project Component ($ million)

Component	Appraisal Estimate	Actual
A. Base Cost		
1. Woman and Child Health Services	33.38	171.26
2. Finance, Information, and Management	3.40	2.14
3. Blood Safety Program	13.58	9.05
4. Project Management	2.16	2.36
5. Taxes and Duties	2.10	2.15
Subtotal (A)	**54.62**	**186.96**
B. Contingencies		
1. Physical Contingency	2.73	
2. Price Contingency	7.48	
Subtotal (B)	**10.21**	
C. Interest and Commitment Charges	**5.16**	**1.97**
Total	**70.00**	**188.93**

4. Project Schedule

Item	Appraisal Estimate	Actual
Date of Contract with Consultants		
A. Woman and Child Health Services		
Start date	January 2007	April 2007
Completion date	December 2009	June 2010
B. Blood Safety Program		
Start date	April 2008	February 2009
Completion date	December 2009	June 2011
Equipment and Supplies		
Dates		
First Procurement	May 2005	June 2005
Last Procurement	December 2009	October 2011
Completion of Equipment Installation	March 2010	December 2011

5. Project Performance Report Ratings

Implementation Period	Ratings	
	Development Objectives	Implementation Progress
From 1 Jan 2005 to 31 Dec 2010	Satisfactory	Satisfactory
From 1 Jan 2011 to 31 Dec 2011[a]	On Track	On Track

[a] Effective 1 January 2011, the project performance report system was replaced by a new project performance rating system that no longer provides separate ratings of development objectives and implementation progress and instead gives an overall project rating.

D. Data on Asian Development Bank Missions

Name of Mission	Date	No. of Persons	No. of Person-Days	Specialization of Members[a]
Project Inception	22 Mar–1 Apr 2005	3	30	a, b, d
Project Review	6–17 Jul 2005	2	22	a, d
Project Review	10–22 Oct 2005	2	24	a, d
Project Review	13–17 Feb 2006	4	16	a, b, d, e
Project Review	2–13 Oct 2006	3	36	a, c, d
Project Review	30 Apr–12 May 2007	3	36	a, c ,d
Midterm Review	29 Oct–13 Nov 2007	3	48	a, b, c, d, f
Project Review[b]	27 Jun–4 Jul 2008	2	16	a, b
Project Review	26 Jun–13Jul 2009	4	36	d, b, c
Project Review	27 May–22 Jun 2010	4	23	d, b, c, e
Project Review	4–10 May 2011	3	21	d, b, e
Project Completion Review	5 July–15 August 2012	3	34	a, b, f

[a] a = project officer, b = project analyst, c = project administration unit head, d = project management officer, e = staff consultant, f = international consultant.

[b] In 2008, after the midterm review, project administration was delegated to Uzbekistan Resident Mission (URM). Once the project was administered by URM, the project was under close review through daily discussions, weekly meetings, quarterly reviews under quarterly portfolio review exercises and project review missions.

I. PROJECT DESCRIPTION

1. The Asian Development Bank (ADB) approved the Woman and Child Health Development Project on 23 September 2004 with a loan of $40 million from its ordinary capital resources, and a technical assistance (TA) grant of $300,000.[1]

2. In the mid-1990s, the Government of Uzbekistan initiated health sector reforms to improve service quality and efficiency, strengthening in particular primary health care (PHC) for rural populations. In 2002, the government endorsed a series of long-term state programs for woman and child health (WCH)[2] and requested ADB assistance to address gaps in WCH services. ADB and the World Bank[3] agreed with the government to develop complementary projects, with the World Bank supporting PHC and health financing, and ADB supporting WCH.

3. The project's intended impact was to improve the health status of women and children in Uzbekistan. While investment in WCH services and strengthening of WCH programs were required, the project rationale was also to support PHC and health financing and management. This broader approach would help disseminate information to the general public and provide improved and earlier access to WCH services at the PHC level, thereby optimizing hospital services. The project focused on two interrelated outcomes: (i) support for health sector reforms, and (ii) increased efficiency of the health care delivery system for WCH. The outputs of the project were (i) strengthened WCH services; (ii) strengthened finance, information, and management; and (iii) improved efficiency of blood service delivery.

II. EVALUATION OF DESIGN AND IMPLEMENTATION

A. Relevance of Design and Formulation

4. The project was relevant at appraisal, and consistent with the government's health sector priorities. It was designed to support long-term national programs promulgated by Presidential Decree UP-2107 (State Program on Reforming the Healthcare System of the Republic of Uzbekistan) in 1998. The decree recognized the need for wide-ranging general health reforms and for the improvement of WCH in particular and included (i) integration of child and maternity services; (ii) improved safe motherhood and health of reproductive-age women; (iii) better primary medical and sanitary assistance for women, pregnant women, and children; (iv) establishment of regional mother and child screening centers for early detection of at-risk pregnancies and pathologies among infants and pregnant women, to prevent the birth of disabled children; (v) creation of medico-genetic centers for the examination of women and children; and (vi) restructuring and increasing the quality of pediatric services. This resulted in the formulation of WCH long-term state programs, which were adopted in 2002.

5. The project was consistent with ADB's country strategy and program for Uzbekistan, which emphasized improving human development, including health, to reduce poverty and achieve the health-related Millennium Development Goals (MDGs).[4] The project was consistent with the ADB Policy for the Health Sector,[5] which had five strategic directions: (i) PHC for

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[1] ADB. 2004. *Report and Recommendation of the President to the Board of Directors: Proposed Loan and Technical Assistance Grant to the Republic of Uzbekistan for the Woman and Child Health Development Project.* Manila.

[2] The WCH initiatives included in particular the integrated management of childhood illnesses, a safe motherhood initiative, promotion of breastfeeding, micronutrient deficiency control, and family planning.

[3] The World Bank, active in the health sector in the country since 1998, has been supporting the government's PHC.

[4] ADB. 2002. *Country Strategy and Program Update (2003-2005): Uzbekistan*. Manila.

[5] ADB. 1999. *Policy for the Health Sector.* Manila

vulnerable groups, (ii) effective interventions, (iii) innovation, (iv) support for health sector reforms, and (v) increase in sector efficiency by improving managerial capacity and collaboration with partner institutions. The project design addressed the needs of health reforms and donor coordination in the sector. Project formulation was fully participatory, involving all project stakeholders and other development partners. With government guidance, ADB prepared the project in close coordination with the World Bank, and project coverage and activities complemented and supported the World Bank's Health-II project.

6. There was a strong technical rationale for (i) integrating maternal, newborn, and child health in PHC; and for (ii) the project components. By working closely with the World Bank and relying on technical inputs and activities of the United Nations and bilateral agencies involved in maternal, newborn, and child health, the project ensured integration of WCH care in PHC, benefitted from complementary activities, and avoided duplication, while supporting the implementation of sector reforms. To strengthen coordination, the government decided to establish a Joint Project Implementation Bureau (JPIB) under the Ministry of Health (MOH), the project's executing agency, for both the ADB and the World Bank-financed health projects.[6]

7. The project remained relevant at completion. The expansion of the project's coverage to the whole country, which was decided at midterm,[7] strengthened the project's relevance, reducing disparities among regions and facilitating the implementation of administrative and technical sector reforms across the country.

B. Project Outputs

8. The performance targets for the project's impact, outcome, and outputs and the summary of achievements are in Appendix 1.

Output 1: Strengthened Women's and Children's Health Services

9. The objective of this output was to strengthen the primary care and first referral network for WCH, with improved quality of services and capacity of medical and paramedical professionals to provide health care meeting international standards. The objective was achieved. The output supported effective interventions in maternal and neonatal care.[8] Newborn and maternal deaths were significantly reduced through improved quality prenatal care integrated in PHC. The output also established an effective referral system—from PHC to specialized services equipped to deal with emergencies—which has proven effective in reducing neonatal and maternal deaths. The infant mortality rate declined from 15.1 per 1,000 live births in 2004 to 10.4 in 2011, and maternal mortality rate declined from 31.4 in 2004 to 23.1 in 2011. Project funds were used to upgrade WCH medical and paramedical skills through the training of health professional and procurement of equipment. Community empowerment was strengthened through health education, with information disseminated to the community and families, particularly through family nurses and midwives.

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[6] The ADB and World Bank projects jointly covered the costs of establishing and operating the JPIB.

[7] The project was designed to initially cover 6 of Uzbekistan's 13 regions, with possible expansion in geographical coverage. ADB approved a reallocation of loan proceeds for expansion of project activities under component 1 to the remaining 7 regions in January 2008, and related minor changes in scope in December 2009 and November 2010.

[8] The United Nations Children's Fund (UNICEF) has highlighted that 79% of infant deaths in Uzbekistan occur during the first 30 days of life as a result of avoidable causes, although 95% of deliveries are attended by health professionals.

10. **Strengthening referral links.** At appraisal, links existed between the different levels of WCH services, but there were no systematic referrals. The objective of improving the referral system was highly relevant, and was achieved by the project. Effective referral links for WCH care services and functions were established, and WCH services at the PHC level—*Selski Vrachebny Punkt* (SVP) (rural medical point, with at least one medical doctor)[9]—were linked with, and supported by (i) the central *rayon* (district) hospitals (CRH), with polyclinic and maternity services; and (ii) provincial prenatal centers, with clearly defined roles and responsibilities.[10] The project also succeeded in changing working approaches and practices and provided the required equipment. Referrals from SVPs to CRHs decreased by 40% in 2010 (compared to 2004), while the proportion of referred patients that were accepted for hospitalization increased from 66.8% in 2007 to 74.3% in 2011.

11. Equipping referral facilities. The project supported WCH health services through a wide range of inputs, including training, capacity building, and provision of medical equipment. PHC facilities were equipped under the World Bank project, and the project therefore focused on equipping WCH referral facilities in 81 districts and six provincial maternity units including obstetric and neonatology departments, diagnosis and laboratory divisions, and perinatal centers. The government financed the reconstruction and renovation of buildings (civil works) and improvement of internal utility services (water supply, sanitation, heating, and waste management) of these facilities to ensure proper installation and operation of modern medical equipment funded by the project. At appraisal, the procurement of equipment was planned in two phases, with three or four provinces to receive equipment initially, with equipment provided to other provinces based on the outcome of the midterm review assessment. At the midterm review, rehabilitation of 88 health facilities in six project provinces was completed. Based on the positive findings of the midterm review, the component's activities were expanded to the remaining seven provinces in January 2008. To maximize the utilization of loan funds, reallocation of loan savings for procurement of additional medical equipment was approved in December 2009. The project implementation schedule was revised and the loan closing date was extended. At project completion, the component's targets were exceeded with 227 maternity facilities modernized with essential equipment and facilities. The summary of project procurement activities is in Appendix 2.

12. **Continuing education.** The project ensured full integration of WCH in the health system by training professional at all levels—including PHC nurses, midwives, and general practitioners and CRH and provincial center specialists (Appendix 3). The project helped update the curriculum for nurses and general practitioners to international standards, and develop a nursing baccalaureate degree. The project also introduced two innovative on-the-job training mechanisms: (i) a team approach for WCH, involving nurses, midwives, and doctors; and (ii) cascading training so initially-trained supervisors then trained lower-level staff. At project completion, 18 training centers were established to train pediatricians, neonatologists, obstetrician-gynecologists and nurses, and were equipped with presentation and educational tools, copy machines, clinical guidelines and consumables. In addition, training courses for nurses on seven directives were developed, 484 trainers prepared, more than 20,000 nurses of

[9] The *Selski Vrachebny Punkt* are staffed with at least one medical doctor, and are the first contact points with health services in rural areas.

[10] Presidential Decree No. 3923 (19 September 2007) regarding key directions for further intensification of healthcare reforms and implementation of the State Healthcare Development Program defined the following key tasks for implementation of the reforms: (i) form an up-to-date healthcare organizational structure, ensuring integration of services, methodical administration and quality control of medical services; (ii) make profound improvements in the quality of the health care system for mothers; and (iii) improve the health training and retraining system.

PHC facilities were trained (compared with a target of 12,000), and more than 3,500 WCH care specialists re-trained, surpassing the target of 2,500.

13. **Quality monitoring and improvement.** With technical support from the World Health Organization (WHO) and the United Nations Population Fund (UNFPA), the project promoted an evidence-based approach to WCH care. The evidence-based medical centre of the Tashkent Institute of Advanced Medical Education prepared guidelines and clinical protocols (with indicators) to be used in training and on the job. Supervisory capacity building was also introduced and incorporated into the capacity building program.

14. **Health education.** The project provided technical support to develop educational materials, using family nurses and midwives to disseminate the information. Materials were prepared and distributed in cooperation with the Institute of Health and Medical Statistics, and included nine booklets (total of 88,000 copies), five posters (21,000 copies), and seven brochures (27,000 copies). The project, together with nurses and midwives, developed and published three types of WCH educational materials for dissemination among the population. In addition, 7 video presentations promoting breast feeding and balanced diet were produced and broadcast on TV.

Output 2: Strengthened Finance, Information, and Management

15. With support from the project, a new model of PHC financing and management was expanded to all provinces. New hospital financing mechanisms developed under the World Bank project were tested, and a national health management information system (HMIS) was initiated. Successful WCH initiatives were translated into new MOH policies and strategies and supported decentralization of health system management. This output was achieved, the details are given below.

16. **Implementing financial reforms.** The project helped expand a new management and financing model for PHC services,[11] which required (i) establishment of a legal basis for the reforms, with appropriate government and MOH orders; (ii) information and training of SVP heads and financial officers; and (iii) the financial and technical reform monitoring, using monitoring indicators and field visits by MOH and Ministry of Finance (MOF) representatives.

17. Per capita financing and management reforms for rural PHC developed and tested under the World Bank Health-I project were progressively implemented with support from the project. Per capita financing is now implemented nationwide, covering all 3,200 SVPs. The development of a case-based payment[12] mechanism for hospital financing proved technically too complex to be achieved within the project timeframe. A model was developed under the project based on selected hospitals of Fergana province. It is expected to be tested under the recently approved World Bank Health-III project.

18. **Strengthening management capacity.** The project supported the Tashkent Institute of Advanced Medical Education to develop training for SVP heads and financial managers and to

[11] The model had been piloted in selected provinces under the World Bank Health-I project. PHC services remain free (except for pharmaceuticals for the non-poor). Each SVP receives an annual budget based on the population it covers (described as “per capita financing”). SVPs are also granted greater financial and organizational autonomy (allocation of funds and human resource management).

[12] Case-based payment is linked to the disease diagnosed for each patient. Groups of similar diseases are identified (“disease-related groups”), and the average cost of the treatment is computed for each group. For each patient, hospitals are paid based on the cost of the disease-related groups to which the patient belongs.

organize management training for teachers of the general practitioner training centers. The project organized training courses in health management, including per capita financing for 251 managers (vs. 133 planned). Overall, JPIB coordinated training of 3,000 SVP managers.[13] The project introduced monitoring and evaluation mechanisms for implementation of the reforms, as well as for WCH and blood safety, which will benefit overall sector management capacity.

19. **Health Management Information System.** The project aimed to support the MOH HMIS at SVP, district, and national levels through training, capacity building, and provision of hardware and software. At the SVP level, management and financial data are collected to help provinces and MOH monitor implementation of the reforms and support evidence-based decision-making. Overall, 80 information centers were established (vs. 70 planned). The project equipped district medical information centers with computers connecting them to the MOH corporate network, facilitating real time data collection. A national data processing center was established, and a local network was developed in MOH. The necessary information technology equipment was procured under the project jointly with World Bank Health-II project, and 80 MOH officials were trained to use information and communication technology (ICT) in their daily activities. An ICT training center was established in MOH (hardware, software, and furniture). A donor database was developed under the blood safety component.

20. **Supporting health sector policy reform.** A 2005 government resolution on health sector financing and management[14] was translated into new policies and strategies. The project also helped MOH formulate various orders in support of a new approach in WCH services (establishment of working groups and development of clinical guidelines) and for the establishment of the national blood safety program. Appendix 4 lists the related MOH orders developed with project assistance.

Output 3: Improved Efficiency of Blood Service Delivery

21. The project introduced a national blood safety program, with system restructuring mechanisms, quality assurance, and reorganized blood collection and testing nationwide. The project supported restructuring of the blood transfusion supply system and established six regional blood transfusion centers with modern equipment and facilities; 236 medical facilities received blood storage equipment. In 2000, only 60% of blood samples were screened for infectious diseases before transfusion; this had increased to 100% at project completion. A national donor database was established, accessible to all blood centers. Blood collection became more centralized, using also mobile government-financed vehicles. A strategic plan was developed and implemented for a transition from nonvoluntary, needs-based blood donation to voluntary blood donation. Other ministries (including the ministries of education, emergency and defense), community-based organizations, and nongovernmental organizations helped promote voluntary blood donations with posters, video-clips, a website, and media campaigns. In 2011, 98% of all blood donations were voluntary.

22. MOH prepared new guidelines for the use of blood, introducing significant changes in information, working approaches and practices and giving greater attention to blood safety.[15]

[13] During the midterm review in November 2007, ADB and the World Bank agreed to share the costs of training: project funds covered training of the SVP heads, and World Bank resources covered the training of the SVP financial officers.

[14] Cabinet of Ministers Resolution 217 of 28 September 2005, regarding measures to further reform the financing and management system for public health care facilities.

[15] Old reusable blood collection materials were discarded. The Ministry of Finance allocates recurrent funds for disposable syringes, needles, and plastic bags for blood collection.

The project financed six national conferences, as well as study tours to France and the Netherlands for 26 specialists. In collaboration with WHO and the United States Center for Disease Control and Prevention, 1,870 national, provincial and district specialists were trained in blood safety.

C. Project Costs

23. The total project cost estimated at appraisal was $70.0 million, to be financed with $40.0 million from ADB and $30.0 million from the government. At appraisal, $18.0 million was earmarked for equipping the SVPs in the project area, but the government instead equipped the SVPs with assistance provided through the World Bank health projects. During the midterm review, the government requested that ADB use the resulting savings to expand project coverage and equip district and provincial WCH referral facilities in the seven provinces not originally covered by the project. ADB approved a reallocation of loan proceeds for expansion of project activities in January 2008. In October 2010, the government requested an additional reallocation of the loan proceeds to equip additional maternity facilities and finance laboratory and storage equipment for blood centers. ADB approved the request in November 2010, together with an extension of the loan closing date until 31 December 2011, to allow for the completion of procurement and installation of the equipment. Through reallocation of loan proceeds and extension of the loan closing date, the government was able to maximize the utilization of loan funds. The government significantly increased the allocation of domestic resources for recurrent costs, ensuring project sustainability. The final actual project costs are $188.93 million, of which ADB financed $38.09 million while the government contribution amounted to $150.84 million. Unused loan funds ($1.9 million) were canceled at project closing (Appendix 5).

D. Disbursements

24. Disbursements were delayed at the beginning of the project, due to slow procurement progress. However, disbursements accelerated after 2007 when an agreement and close cooperation with the concerned agencies were reached (Appendix 6).

25. The imprest account was operated and maintained in accordance with ADB's *Loan Disbursement Handbook* (2007, as amended from time to time). In 2009, during the review of withdrawal applications for replenishment of the imprest account, it was noted that the JPIB had used $426,652 in ADB funds during 2008–2009 for the government-financed portion of the project without prior consultation with ADB. In response to advice from ADB, the government fully reimbursed the ADB funds in question by the first quarter of 2010.

E. Project Schedule

26. The project became effective on 9 March 2005, and was scheduled to be implemented over 5 years, with loan closing on 30 June 2010. The loan closing date was extended twice, primarily to accommodate the expansion of project scope nationwide (from six provinces originally). The project was completed on 31 December 2011 and the loan account closed on 8 May 2012. The physical progress was behind schedule during the first 2 years due to delays in contract awards and disbursements, and a delay in rehabilitation of the maternity and blood centers that were to receive new equipment (this was the responsibility of the local governments). However, the physical progress accelerated significantly in 2008–2009; in addition, when physical progress was slow, JPIB and its partners (the United States Agency for International Development, WHO, and UNICEF) shifted attention to training, and developed

guidelines and protocols, and started training activities. All project activities, including those in the seven added provinces, were completed according to the revised timeline, resulting in nationwide coverage (Appendix 7).

F. Implementation Arrangements

27. The MOH was the executing agency for the project; the deputy minister for WCH in MOH was the project coordinator. An interagency project steering committee provided overall guidance. JPIB was established to implement both the project and the World Bank Health-I and Health-II projects. The implementation arrangements facilitated efficient collaboration and coordination of development partners' health reform activities through JPIB. This arrangement allowed complementary and timely support for health system financing and policy reforms; these were mainly supported by the World Bank Health-I project, but were essential for the success of the ADB project. It also facilitated integration of WCH in PHC and eventually permitted the entire country to be covered by the WCH and blood safety components.

G. Conditions and Covenants

28. Of the 34 covenants, 32 were complied with and 2 (related to the implementation of health sector reforms and requiring government orders involving other agencies) were in the process of being complied with at the time of project completion (Appendix 8). These covenants were linked to health sector reforms, and the government is in the process of ensuring the proposed reforms are properly adapted to suit the Uzbekistan context. There were also delays in loan compliance in two cases: (i) timely submission of audit reports, and (ii) allocation of government resources for rehabilitation of health facilities in the project area.

H. Technical Assistance

29. The TA (completed in December 2007) was rated *satisfactory*.[16] It had three components: (i) a study of the causes of child mortality, (ii) health system optimization, and (iii) improved health system monitoring. Although the identification of qualified consultants and coordination of their inputs proved difficult, MOH and JPIB used TA inputs effectively with ADB approval. The TA consultants (i) highlighted the need to focus on neonatal care; (ii) identified the needs of health professionals; (iii) recommended the restructuring of the national blood safety program, to ensure blood safety and quality assurance; and (iv) identified key areas for improving monitoring through the development of HMIS for MOH, and the requirements for a database on blood donors. The TA consultants' inputs proved very valuable ultimately to the project, and most of their recommendations were later implemented.

I. Consultant Recruitment and Procurement

30. The recruitment of project consultants and procurement of goods were delayed due to government procedures relating to contracts for goods and services. At the outset of the project, completion of the contracting process after contract award took 3 months on average; this decreased somewhat in the middle of the project as a result of closer coordination among concerned agencies on procurement.

[16] ADB. 2008. *Technical Assistance Completion Report: Capacity Development for Woman and Child Health Development in Uzbekistan.* Manila.

31. An autonomous agency, Uzmedexport,[17] was responsible for international competitive bidding. It took 6 months for the first bidding documents to be finalized, with the support of an international consultant engaged under the TA. JPIB's need for technical support was assessed at appraisal, but the availability of national procurement expertise was overestimated, and ADB recruited international consultants to support procurement of goods. Suppliers of medical equipment and laboratory reagents were required to submit samples of goods to a special certification agency, and to receive certification within 2 months. The responsibility for payment certification and the recourse for certification delays was unclear, but after extensive consultation the government agreed to cover the certification process fees and the procurement agency agreed to pay suppliers within 2 months. It took 1 year to clarify this matter, but the case served as a reference for similar procurement issues later. The contract packaging was revised for efficiency in operation and maintenance (O&M) and staff training. After expansion of project scope (to new provinces), ADB authorized repeat orders for additional equipment with the same specifications, which further facilitated timely procurement.

J. Performance of Consultants and Suppliers

32. The inputs of the two consulting firms (one for WCH care and another for blood safety) and individual consultants were relevant to the project needs. Most of their recommendations were implemented. The consultants' performance was *satisfactory*.

33. The performance of suppliers was *satisfactory*. One of the project suppliers provided equipment that was not in compliance with specifications (i.e. the use of metric scales and thermometers), but the supplier immediately replaced the equipment in accordance with the specifications.

K. Performance of the Borrower and the Executing Agency

34. The performance of the executing agency was *satisfactory*. The executing agency, MOH, showed strong ownership and leadership in implementing the project and ensuring coordination with other partners. The need for institutional capacity support for government agencies was identified at the start of project implementation. JPIB, which also administered implementation of the World Bank Health-II project, faced initial difficulties (e.g., preparation of bidding documents), but gained sufficient knowledge to support project implementation by the middle of the project. TA resources were allocated to facilitate the project implementation and provide on-the-job training and coaching. JPIB managed staff turnover with strong leadership at the management level, which contributed to the eventual success of the project.

L. Performance of the Asian Development Bank

35. The performance of ADB was *satisfactory*. When issues were identified, ADB actively sought solutions through discussion and collaboration with concerned agencies. Loan reviews were conducted regularly. ADB flexibly responded to the needs of the project by (i) using TA resources to support the project, (ii) approving the government's request to expand project coverage and reallocate loan proceeds, (iii) approving the government's request to make changes in the procurement mode and packaging, and (iii) extending the loan closing date. In 2008, after the midterm review, project administration was transferred to Uzbekistan Resident Mission, which proved effective.

[17] As per sector-specific requirements, MOH used the "Uzmedexport" agency to handle project-related procurement.

III. EVALUATION OF PERFORMANCE

A. Relevance

36. The project is rated *relevant.* At appraisal it was important for the government to reform basic health services to achieve the health MDGs, which were a government priority. Data indicated that infant mortality was particularly affected by neonatal deaths, and the project focused on improving maternal and neonatal care. Integrating WCH with PHC is efficient for the early identification of high-risk pregnancies. The project complemented the World Bank Health-II project, which supported PHC and sector reforms. JPIB as a joint project implementation body facilitated coordination of the development partners.

37. Expanding coverage nationwide provided an equitable distribution of project benefits and significantly increased the likelihood that improvements in WCH and blood safety introduced by the project would be sustained. Having new equipment and newly trained health professionals in all provinces ensures the new guidelines are implemented uniformly, while additional maternity centers with modern medical equipment and improved access to quality WCH services ensures that the lives of more mothers and newborns are saved.

B. Effectiveness in Achieving Outcome

38. The project is rated *effective* in achieving its outcomes. The project objectives of supporting health sector reforms and improving the efficiency of WCH services were achieved. The government's initiatives focused on improving quality and overall effectiveness of health services delivery, while sector reforms were developed and piloted under the World Bank Health-I and Health-II projects, which focused on PHC and financing and management reforms. The project expanded the government WCH reforms nationwide and piloted new finance and services mechanisms as appropriate, complementing the World Bank health projects. The project successfully achieved 6 of 8 performance targets: (i) more equal health care resource allocation across provinces (the difference was reduced from 11.6% to 6.6%); (ii) increase of 75% in the percentage of non-salary recurrent resource allocation for PHC (target of 20%); (iii) increase of 20% in PHC utilization (target of 10%), and reduction of 10% in hospital referrals and admissions (equal to target); (iv) reduction of 45% in the incidence of moderate iron deficiency anemia among pregnant women (target of 22%); (v) contraceptive prevalence among all fertile-aged women was 56.6% in 2011;[18] and (vi) reduction in the incidence of infectious diseases, particularly tuberculosis prevalence decline from 75.9 per 100,000 in 2004 to 52,9 in 2011.[19] The ultimate financial self-sufficiency of the blood centers will depend on the success of the new hospital financing model, which is being tested. Reduction of the incidence of stunting among under-5 children target is a long-term activity (stunting results from long-term malnutrition).

39. In addition to providing equipment and training, the project changed the working approaches and behavior of health professionals. Midwives and obstetrician-gynecologists—including in PHC, family nurses and at district maternity centers and provincial perinatal centers—have been trained and use more effective methods, and use modern equipment.

[18] The target considered contraceptive prevalence among married women only, while the available data is for all fertile-aged women, including single women.

[19] The target on reduction of infectious diseases also included stabilizing the incidence of HIV which was achieved.

C. Efficiency in Achieving Outcome and Outputs

40. The project is rated *efficient.* Despite delays at the initial stages of project implementation, the project achieved its key outcome targets. Integrating WCH in PHC achieved additional benefits for the health system. The referral system for WCH care and delivering quality care at appropriate levels brought significant cost savings. MOH has developed a comprehensive HMIS. The blood safety program consolidated blood safety testing in a limited number of blood centers and facilitated quality control and cost savings. New guidelines by MOH optimized blood transfusion and the use of blood products, thereby avoiding unnecessary risks while reducing costs.

41. The project used resources efficiently, and project elements (improved equipment, clinical guidelines, and training) were implemented in close collaboration with the World Bank and other partners. WHO, UNICEF, and the United Nations Population Fund supported the development of clinical guidelines and training of health professionals at all levels. Extending project coverage to the whole country ensured maximum project outcome and outputs.

D. Preliminary Assessment of Sustainability

42. The project is rated *likely sustainable*. The system of continuous professional education for health professionals was strengthened under the project. The new nursing curriculum has helped upgrade the professional qualifications of nurses and increased incentive opportunities.[20] Clinical guidelines and protocols were introduced and are now used uniformly by health professionals. The revised curricula and training materials of health professionals are used by graduate and post-graduate students in medical services and institutions nationwide. A health care monitoring and quality control system was introduced at the PHC level. The "partnership deliveries" introduced under the project have been adopted and became standard procedure for both health professionals and the general population. Women can now choose how to deliver, with qualified health professionals present during deliveries. The government now allocates sufficient funding to cover the cost of O&M of blood centers. Reforms will be strengthened and further developed under the ongoing World Bank Health-III project.[21]

E. Impact

43. The project impact is *significant.* The project has resulted in improvements in the health-related MDG indicators (Appendix 1). The project has significantly improved the service-rendering capacity of the PHC, mother and child health protection, blood services, and health departments through developing training and methodological guidelines and conducting training programs. The project also enhanced awareness among the rural population of reproductive and child health protection through educational programs in close cooperation with local social agencies such as the Association of Nurses, *makhallas* (local self-governing community-based organization), and women's committees in local communities.

44. **Safeguards.** The project had no impact on land acquisition and on indigenous people. The project was classified as category B for environmental safeguards. The project supported

[20] Including the preparation of a master's degree in nursing, which is expected to be approved for the 2013–2014 academic year.

[21] However, health system financial sustainability is a global issue. Most people in Uzbekistan are convinced that the government will continue to finance free delivery of essential health care services through general taxation. At the same time, alternative or complementary financing must be explored to reduce the burden on the government budget.

the development of environmental manuals for designing, operating and maintaining health facilities, [22] and medical staff was trained in the implementation of these manuals. All construction works were funded by the government. At the end of the project, an environmental audit report was conducted. The findings showed that the O&M of participating medical facilities complied with government requirements.

45. **Gender.** The project was categorized as having gender equity as a theme: women were the project's immediate beneficiaries, and the project ensured female participation in training, service delivery and WHC activities (Appendix 9).

IV. OVERALL ASSESSMENT AND RECOMMENDATIONS

A. Overall Assessment

46. The project is rated *relevant, effective, efficient,* and *likely sustainable*. The project impact is *significant*. Overall, the project is rated *successful*. Despite initial delays, it achieved more than what was originally planned, covering the whole country instead of six provinces as planned at appraisal. In addition to rehabilitation of health facilities, procurement of modern equipment, and training of health professionals, the project introduced evidence-based medicine and quality assurance mechanisms for WCH care and blood safety, such as clinical guidelines and peer reviews. Referrals for blood transfusions have been modified, reducing the number of transfusions and associated risks. The community has developed a new behavioral approach towards PHC and WCH care. The services provided by family nurses and SVPs, and the new approach to delivery, focusing on the safety and comfort of the mother and child, are widely used.

B. Lessons Learned

47. The project illustrates the importance of (i) strong commitment by the government, (ii*)* close collaboration among development partners, and (iii) prompt response to changing client needs during implementation. The leadership provided by MOH and the project coordinator was a key to the project's achievements. The project was not a stand-alone WCH project, but a part of broader health sector reforms. Strong collaboration among partners[23] and responsiveness to actual needs was an important contributor to the success of the various programs. The knowledge and working practice of health professionals improved from the outset. Because other partners addressed some project activities, it was possible to reallocate resources and expand geographical coverage. This improved project achievement and increased the likelihood of sustainability.

48. The project was somewhat overambitious in setting the timelines for achieving the reforms. The government was fully committed to the reforms, but progress depended on the progress of other projects. In this project, two loan covenants were partly complied with at the project completion due their complexity. If reforms are significant, it is useful to consider a phased approach, so that interim achievements can be captured within the project timeframe.

[22] The manual was adopted through the Ministry of Health Order No. 600, December 2007.
[23] Technical inputs were provided by the World Bank, United States Agency for International Development, WHO, UNICEF, and the United Nations Population Fund.

C. Recommendations

1. Project-related

49. **Covenants.** ADB will monitor the progress of ongoing health sector reforms that were covenanted under the project but have not yet been complied through the dialogue with World Bank and other partners, and under the ongoing World Bank heath projects.

50. **Joint evaluation of primary and women's and children's health care.** MOH may consider organizing a joint evaluation among partners of the results, lessons, and recommendations of the partner-supported health sector projects, including the project.

2. General

51. **Continuous training.** Health professionals require continuous training to maintain their position as specialists. Training should be further institutionalized for the health professionals to continue their practice, even for general practitioners, midwives, and nurses.

PERFORMANCE INDICATORS AND ACHIEVEMENTS

Design Summary	Performance Indicators	
	Targets at appraisal	**Achievements at project completion**
Impact Millennium Development Goals (MDGs): improved health status of women and children	MDG: reduce MMR by 75% in 1990–2015; Project goal: reduce by 20% in 2004–2009 in project sites (64 in 1991; 34 in 2002)	Achieved. MMR nationwide varied as follows: 2004: 31.4; 2005: 30.8; 2006: 24.3; 2007: 23.8; 2008: 21.4; 2009: 30.4; 2010: 21.4; 2011: 23.1.[a] There was a sharp increase in MMR in 2009 due to an epidemic of viral pneumonia in pregnant women. MMR declined from 31.4 in 2004 to 23.1 in 2011, i.e. a 26.4% reduction.
	MDG: reduce IMR by 66% in 1990–2015; project goal: reduce IMR by 25% in 2004–2009 in project sites (38 in 1991; 62 in 2002)	Achieved. IMR also declined from 15.2 per 1,000 live births in 2004 to 11.2 in 2009, 10.9 in 2010, and 10.4 in 2011.[a] IMR declined from 15.2 to 10.4, (a 31.6% decline).
	MDG: reduce U5MR by 66% in 1990–2015; project goal: reduce by 25% in 2004–2009 in project sites (51 in 1991; 73 in 2002)	Achieved. U5MR declined from 21 per 1,000 live births in 2004 to 15.9 in 2009, and 14.8 in 2011.[a]
	Halt or begin to reverse by 2015 the spread of infectious diseases, e.g., TB, HIV/AIDS (Prevalence of HIV/AIDS=<0.01%, TB=109 in 2001).	Achieved. With donors' assistance (the World Bank through the Health-II and Central Asia AIDS Control projects, the Global Fund, DFID, USAID, CDC, World Vision, and JICA) better laboratory equipment and large-scale screening programs, detection of HIV infections improved. The number of people identified with HIV infections increased until 2009, but decreased in 2010. HIV prevalence was estimated at 8.2 per 100,000 in 2005, 32.2 in 2009, 29.3 in 2010, and 24.1 in 2011.[c] Tuberculosis prevalence decline from 75.9 per 100,000 in 2005 to 63.7 in 2009, 61.3 in 2010, and 52.9 in 2011.[a]
Health Sector Reform Goal: improved efficiency of health service delivery.	Improved share for PHC versus non-PHC in government (non-salary recurrent) expenditures by at least 15% by 2009 (<10% in 2002).	Achieved. PHC's share of non-salary, recurrent health expenditures was 45.5% in 2009, 45% in 2010, and 45.2% in 2011 (first 6 months).[d]

Outcome Support health sector reform initiatives	Equalized health care resource allocation across provinces and *rayons* by 2009	Achieved. Resource allocation for PHC facilities varied from 39.8% to 51.4% of MOH budget for PHC in 2007 (a difference of 11.6%), to 42.6% to 49.2% of MOH budget for PHC in 2010 (a difference of 6.6%) across regions. The regional range in per capita expenditures in rural PHC facilities SUM3,619–SUM6,731 in 2007, SUM6,756–SUM14,655 in 2009, SUM9,671–SUM14,148 in 2010, and SUM12,386–SUM25,386 in 2011 (the average in 2011 was SUM15,442 per capita).[b]
	Improved percent non-salary recurrent resource allocation for PHC and WCH to 20% by 2009 (15% in 2000)	Achieved. In PHC facilities, the share of non-salary expenditures in the recurrent budget increased from 5.6% in 2008 to 9.8% in 2011.[b]
	Financial self-sufficiency for blood safety program by 2009	Partly achieved. The state budget covered 81% of the costs of the blood safety program in 2010 (85% of the costs for the first 9 months of 2011).[d] Hospitals are the main consumers of blood and blood components, and self-financing of the blood centers cannot be achieved until a new model of hospital financing is in place.
Improve the efficiency of health care delivery system for woman and child health (WCH)	Increased PHC utilization and access by 10%, and reduced hospital referrals and admissions by 10% by 2009	Achieved. The number of visits per capita per year to PHC facilities was 3.9 in 2004, 4.2 in 2005, 4.4 in 2009, 4.6 in 2010, and 4.7 in 2011 (i.e. 20% increase between 2004 and 2011). Hospitalization for rural populations decreased in parallel: 12.6% were hospitalized in 2006; 11.6% in 2010; and 10% in 2011.[a, b] This may be a result of improved service quality resulting from the use of clinical guidelines in PHC and better equipment at SVP facilities.
	Reduced incidence of moderate iron deficiency anemia among pregnant women to 22% by 2009 (27% in 1996)	Achieved. A 2005 study in three provinces (Republic of Karakalpakstan, Khorezm and Fergana) showed 15.7% of pregnant women had moderate anemia. Data collected in medical records under the World Bank Health-II project, however, suggest a higher rate (45%). Since 2010, multivitamins containing iron and folic acid are distributed to pregnant women in rural areas free of charge, using state funds.
	Increased contraceptive prevalence among married women to 70% by 2009 (56% in 1996, 65% in 2002)	Achieved. Contraceptive prevalence among all fertile-aged women (including unmarried women) was 56.6% in 2009, 52.9 % in 2010, and 56.6% in 2011. No records are currently kept on the use of contraceptives only. Special studies need to be conducted to clarify the rate among married women.
	Reduced incidence of stunting among under-5 children to 25% by 2009 (31%, 1996)	Partly achieved. Stunting affected 3.1% of children in 2011, 2.5% in 2009 and 3.2% in 2010.[a]
	Reduced incidence of infectious diseases by 2009 (e.g. HIV/AIDS incidence stabilized)	Achieved. There were 7.8 new cases of HIV/AIDS per 100,000 population in 2004, reaching 14 in 2009, and then declining to 12.4 in 2011.[c] An increasing incidence is probably linked to better screening and identification, the HIV incidences are now stabilizing.

Outputs Strengthened WCH services	Increased percent pregnant women receiving first antenatal care by a trained health professional within first trimester to 50% by 2009 (39%, 1996)	Achieved. 82.8% of pregnant women received their first antenatal care from a trained health professional in 2009, and 87.7% in 2010.
	Increased percent of pregnant women with anemia, receiving iron supplements by 10% by 2009	Achieved. In 2011, 57% of pregnant women with anemia received iron supplements (source: survey,[e] and SVP report of pregnant women with anemia). Since 2010, multivitamins containing iron and folic acid are distributed to pregnant women in rural areas free of charge, using state funds.
	Increased usage of birth spacing counseling by 20% by 2009	Achieved. According to data from the Department of Maternity and Child Welfare (MOH), better counseling regarding contraception increased the number of women using birth spacing of at least 3 years; birth spacing of less than 2 years declined from 8% in 2009 to 6.8% in 2010.
	Increased percent births attended by skilled health professional or delivering at maternity houses or hospitals by 2009 (94% gave birth in hospitals, 1996)	Achieved. Percentage of deliveries attended by qualified medical staff in maternity units or in-patient facilities was 99.2% in 2009, and 99.5% in 2011.[a]
	Reduced average length of hospital stay for normal delivery to an average of 5 days by 2009 (9 days, 2000)	Achieved. The average length of stay after normal delivery was 5.4 days in 2009, 5.3 days in 2010, and 5.2 days in 2011.[a]
	Increased percent of fully immunized children under-2 years by 2009 (95% by 1996)	Achieved. The immunization rate for children aged less than 2 years was 99.5% for measles, mumps and rubella, 99.4% for poliomyelitis, 99.4% for TP, and 99.3% for hepatitis B. For children under 1 year, immunization reached 99.5% for BCG, 99.5% for poliomyelitis, 99.2% for Hepatitis B; 99.2% for Hemophilus influenza type B; and 99.3% for Hepatitis B.[f]
	Increased percent of newborns receiving hepatitis B vaccination to 20% by 2009 (8%, 2001)	Achieved. 97.8% of newborns received the hepatitis B vaccine in 2009, 98.6% in 2010 and 99.3% in 2011.[f]
	Increased percent under 3-month infants exclusively breastfed to 20% by 2009 (4%, 1996; 9% in 2002)	Achieved. 98.1% of infants under 3 months of age were exclusively breastfed in 2009.[a]
	Decreased hospital referrals from rural doctoral points (SVPs), and hospital admissions by 10% by 2009	Achieved. A 2010 project survey found the number of referrals from SVPs to CRHs decreased by 40% compared with 2004. While 20% of the patients referred to SVPs were referred for hospitalization in 2004, only 12% of them referred for hospitalization in 2010.[e] The absolute number of patients referred from SVPs to CRHs in the winter averaged 2,104 patients in 2011 vs. 2,352

		patients in 2007, showing a decline in the number of referrals from SVPs. In addition, the survey showed that referrals from SVPs were also more appropriate: as a result, while 66.8% of all patients referred from SVPs for hospitalization were hospitalized in 2007, 74.3% of them were hospitalized in 2011, an increase of 7.5%.
Strengthened finance, information, and management	Budgeting process based on capitation in the rural doctoral points (SVPs), and SVPs are permitted to retain savings in every province by 2009	Achieved. In accordance with the schedule approved by the Cabinet of Ministers Resolution No. 217 (September 28, 2005), per capita financing and management reforms are gradually introduced in all regions. Per capita financing is now applied to all SVPs.[b]
	Use of new hospital payment mechanism in pilot regions by 2009	Partly achieved. In the first phase of project implementation (2005–2006), other countries' experiences on new hospital financing mechanisms were studied, and it was decided to develop hospital financing on a case-based payment mechanism: similar payments would be made for similar diseases or DRGs. The preparation of DRG financing requires data and collection of information. Collection forms were prepared and agreed upon, and a methodology to calculate the cost of one treated case was discussed. The result of this phase was the issuance of the MOH Order No. 113 (February 2, 2007) regarding Form No. 066/y-06, designed to collect source data on clinical activities of hospitals, which was to be further processed to obtain the data needed for case-based hospital financing. In the second phase (2007–2010) the statistical information on the clinical activity of Fergana region hospitals was collected and DRGs were developed; financial information on resource expenditures for the treatment was also collected. In parallel, CRH physicians and statisticians in Fergana Province were trained in the use of the 10th revision of the International Classification of Diseases to improve the quality and reliability of data in filling out the experimental No. 066/y-06 form. Further implementation of the hospital financing system is envisaged under the World Bank Health-III project.[b]
	Improved access to timely and appropriate data for decision-making	Achieved. The project has started developing a comprehensive Health and Management Information System, to be used by MOH and by the various levels of care (PHC, hospitals, blood centers) for planning and budgeting.
Improved efficiency of blood service delivery	Blood collection increased to 10,000 per million per year by 2009 (8,000 per million per year, 2002)	Partly achieved. There were 3,691 blood collections per million population per year in 2009, 3,731 in 2010, and 3,773 in 2011. The needs for blood and blood banking have decreased significantly over the last few years. First, health professionals became more aware of the risks of blood-borne infections and new guidelines for blood transfusions were disseminated; second, MOH order No. 42 in 2004 imposed strict requirements for blood donation and blood preparation, reducing the number of donations. Since 2010, as regional blood centers are now equipped with modern diagnostic equipment, an increase in blood donations is being observed, particularly from voluntary unpaid blood donors; there is also a 30% increase in adequate blood storage in the user facilities.[g]

	90% blood screened for infectious disease before transfusion by 2009 (60%, 2000)	Achieved. In 2009, 100% of blood donations were tested for infectious diseases; no cases of blood-transmitted infection through transfusion of blood or blood products were observed.[g]
	Self-sufficiency for liable blood components by 2009 (no shortage)	Partly achieved. According to data obtained in 2011 in the final survey for the project, blood and blood components were available in 89.2% of CRHs.
Activities Strengthen WCH services.	Implementation plan for antenatal care: decree prepared; introduced in at least one province by 2006	Achieved. Issuance of MOH Order No. 425 on antenatal care (5 September 2005).[b]
	Maternal and Child Health Care Order assessed and updated by at least early 2006	Achieved. MOH Orders Nos. 155, 176, 81, 226.[b]
	Needs assessment for contraceptives and inventory of contraceptives, including condoms completed by end of 2005	Achieved. According to the MOH Order, reproductive health centers in the regions carry out annual inventory to check the availability of four types of contraception.[b]
	Needs assessment and inventory of iron supplement tablets for anemia completed by end of 2005	Achieved. Needs assessment for iron supplement preparations for children, female adolescents and fertile-aged females was carried out under the World Bank Health-II project in 2006.[b]
	Inventory of essential pharmaceuticals at primary care level as measured by number of essential drugs stocked completed by early 2006	Achieved. A list of essential drugs was established for emergency care in out-patient and polyclinic facilities and SVPs, approved by MOH Order No. 230 of July 24, 2009.[b]
	Inventory and needs assessment of oxygen tanks for central district hospitals (CRHs) completed by early 2006	Achieved. Oxygen tanks were procured for all maternities in 2009.[b]
	Health facility renovation plan prepared by each province at least by end of 2005	Achieved. Project facilities were renovated according to the provinces' renovation plans.[b]
	Province non-salary recurrent budget needs assessment conducted at least by end of 2005	Achieved. Conducted yearly.[b]
	Environmental plan for CRHs completed at least by end of 2005	Achieved. Repair and reconstruction work for each CRH was carried out with environmental standards requirements in accordance with the Sanitary Regulations and Norms.[b]

	Plan for referral transport use in place by 2006	Achieved. Included in MOH Order No. 378 (30 December 2010) on establishing regional perinatal centers.[b]
	Plan for optimization/consolidation of hospitals providing WCH initiating implementation by early 2006	Achieved. MOH Order No. 155 on provision of services to children and Cabinet of Ministers (COM) Resolution No. 48 (18 March 2008) on reorganization of the structure of RMU.[b]
	Human resource plan endorsed for rationalizing health providers by 2007	Achieved. COM Resolution No. 319 (December 18, 2009) on improvement of the system for professional development and retraining of health professionals.[b]
	Regional blood establishment plan of action in place by 2008	Achieved. MOH Order No. 24 (January 18, 2011) on ensuring the quality and safety of blood components and optimization of the work of blood service institutions.[b]
	Percent *rayons* with non-government organizations registered for community empowerment programs	Achieved. In every district, a branch of the Red Crescent Society works in collaboration with nongovernment organizations and communities *(mahalla)* to promote voluntary blood donations.[b]
	Number of villages mobilized for community involvement	Achieved. Community support and activities for their SVP are ongoing in all regions of the country; most villages have mobilized for community involvement.[b]
	Number of health education campaigns held in the province (at least one per province per year)	Achieved. The annual International Donor's Day is celebrated in all regions of the country.[b]
	Nurses and midwives needs assessment conducted by 2006	Achieved. The effectiveness and needs of the patronage (family) nurses was assessed in 2007 (source: JPIB).
	Plan for provinces continuing medical and nurses/midwives retraining programs institutionalization initiated by 2006	Achieved. A cascade-based CPE mechanism for nurses and midwives was developed: MOH Order No. 379 (31 Aug 2006) on conception of CME for medical staff of PHCF, and MOH Order No. 100 (07 March 2007) on CME of nurses and midwives.
	At least 20% of retraining centers renovated and equipped per year per province, after renovation plan prepared	Achieved. 171 training centers under CRH were renovated and equipped in 2008 (vs. 16 planned).[b]
	At least 20% nurses/midwives trained through the new retraining program per year per province (starting 2006)	Achieved. More than 16,000 nurses were retrained in six modules (vs. 11,717 planned).[b]
	At least 20% obstetricians and gynecologists trained through the new	Achieved. 1,387 obstetricians and gynecologists were trained (vs. 1,102 planned).[b]

	retraining program per year per province (starting 2006)	
	At least 20% pediatricians trained through the new retraining program per year per province (starting 2006)	Achieved. About 44.2% completed—460 pediatricians (out of a planned 1,042) were trained under the project. The rest were trained by other partners (e.g., UNICEF).[b]
	At least 20% hospital/ health managers trained per year per province (starting 2006)	Achieved. 251 health managers (including district hospital managers) were trained in different management courses (133 planned).[b]
	At least 20% supervision visits took place from CRHs to rural doctoral points per year per province (starting 2007)	Achieved. Based on the data of regional Project Implementation Bureaus in 2007 the average number of visits from CRH to SVP was 8.1 per provinces. This indicator was 16 in 2009, and 13.3 in 2010. A survey (based on responses by SVP professionals)[e] found an on average 6 visits of safety motherhood specialists in 2007, increasing to 11 visits on average in 2011.
Strengthen finance, information, and management.	An annual development plan for the project period (5 years) prepared by early 2006	Achieved. The action plan by project components has been prepared annually.[b]
	Rural doctoral points (SVP) facilities with budget allocation based on capitated financing initiated in at least 3 initial provinces by midterm review	Achieved. Reforms on per capita financing and management in rural PHC are scaled up around the whole country. All SVPs are now financed on a per capita basis.[b]
	CRH with hospital payment system initiated in at least one province by the end of 2006	Achieved partly. The piloting of experimental reporting form No. 66 in Fergana region started based on MOH Directive No. 113 (2 February 2007). Statistical information about clinical activity of Fergana province hospitals was collected, and a database on treated patients generated. Financial information about the cost of treatment was also collected.[b]
	Improved health management information system for the financing strategies/systems and use of system data at all levels of the financial system initiated in at least one province by end of 2006	Achieved. Automatization of the MOH office was 100% completed, equipment was delivered and installed, MOH employees were trained in ICT. Across the country, 80 information centers and DPCs of the Ministry of Health (instead of the envisaged 70 information centers) were established to provide information to public health leaders and facilitate online decision making. A MOH local area network was developed. MOH was equipped with an appropriate server, computer and communication equipment, and with necessary software; 80 MOH employees were trained to use modern computer technology (e.g., email, e-document management, e-digital signature, portal of workgroup computing).[b]
	Financial plan for self-supported regional blood establishments prepared by end of 2006	Achieved partly. In September 2007, a local consultant economist was recruited to develop a financing plan for self-sufficiency of regional blood centers. The draft of financial plan submitted to MOH will need to be improved before testing

		new methods and tools, and the technical and financial results of pilot reform will be taken into consideration.[b]
Build blood safety program	National blood safety program established by 2007	Achieved partly. A comprehensive National Blood Safety Program has been developed and is under MOH approbation.[b]
	National policy and legislation developed by 2007	Achieved. Seven national policy related legal documents were adopted.[b]
	National quality system and standards (World Health Organization) created by 2008	Achieved. National quality system and standards were developed and adopted by MOH Order No. 172 (June 2012).[b]
	100% voluntary non-remunerated blood donation by 2009	Achieved. Voluntary. non-remunerated donors accounted for 98% of all donors in the country in 2012.[a]
	6 comprehensive regional blood establishments created (none in 2002)	Achieved. Six Regional Blood Centers were established in Tashkent, Bukhara, Karshi, Nukus, Samarkand and Fergana cities and outfitted with modern equipment.[b]
	Hospital blood banks (patient-oriented functions) established by 2009	Achieved. Hospital blood banks (patient-oriented functions) established, by MOH Order MOH No. 24 (18 Nov 2011).[b]
	Clinical protocols for safe blood use established by 2007	Achieved. Clinical protocols for safe blood use established,[b] by MOH Orders Nos. 78 and 88 (February 2007).
	Hemovigilance system implemented in 2009	Achieved. Hemovigilance system implemented.[b]
	Number of regional blood establishments created and operational per year per region	Achieved. The project established six Regional Blood Centers in Tashkent, Bukhara, Karshi, Nukus, Samarkand, and Fergana.
Improve project management, monitoring, and evaluation for joint project implementation bureau (JPIB) (joint indicators with Health-II)	Evaluation and monitoring surveys and analysis timely	Achieved. An M&E specialist joined JPIB in July 2006. MOH established a working group on M&E for the ADB and World Bank projects. The working group developed a project framework for the projects, identifying the expected joint results. To ensure regular information on the projects' M&E indicators, MOH issued an order that defines the mechanism of data collection and compilation of the projects' M&E indicators, specifying the health facilities responsible for providing the relevant information. Routine data collection and regular monitoring of projects' M&E indicators has been maintained. In 2007–2008, baseline surveys were conducted regarding: evaluation of continuous education; safe motherhood; financial reforms; and satisfaction of consumers with medical services rendered in WCH facilities. In 2009, the pilot projects were evaluated in Fergana province with respect to (i) establishment of a NICU in the perinatal

		center, (ii) financing of hospital services, and (iii) establishment of regional blood centers. In September–November 2011 a final survey was conducted to evaluate the project impact on obstetric facilities, management and information systems in health care facilities, blood centers rationalization and regionalization, and establishment of NICU in perinatal centers (pilot project).[b]
	Project outputs are produced on time and on budget	Achieved. Despite initial delays, all project outputs were implemented within the loan budget, by the end of the project (taking into account extension of the loan closing date). Loan savings were reallocated and permitted additional coverage of facilities (WCH and blood centers).
	JPIB shows improved capacity and shows proactive approach to solving issues and achieving positive outcomes	Achieved. After an initial period of learning and capacity building, project implementation accelerated and was completed satisfactorily.
	Average time for bidding process	The bidding process was initially delayed but improved with the engagement of TA consultants for procurement and project management. ICB preparation and registration took on average 488 days; NCB, 353 days; shopping, 250 days.[b]
	Investments per region	Total investment was $229,177,212.08, distributed as follows among provinces:[b] Andijan: $7,028,367.49; Bukhara: $15,981,967.46; Tashkent city: $124,825.33; Djizzak: $3,587,612.81; Kashkadarya: $22,705,332.92; Navoi: $46,016,898.46; Namangan: $2,721,630.26; Republic of Karakalpakstan $28,140,675.09; Samarkand: $9,945,951.15; Surkhandarya: $12,003,384.04; Syrdarya: $4,418,773.29; Tashkent: $20,599,724.09; Fergana: $37,977,395.73; Khorezm: $17,924,673.96
	Equipment distributed per region	The cost of medical equipment procured was $31,196,935.28, distributed among provinces as follows: Andijan: $2,033,475.50; Bukhara: $2,462,650.30; Tashkent city: $3,037,795.09; Djizzak: $1,286,956.12; Kashkadarya: $2,756,682.36; Navoi: $857,834.41;

		Namangan: $1,404,018.72; Republic of Karakalpakstan $2,477,123.79; Samarkand: $3,111,053.24; Surkhandarya: $1,815,220.42; Syrdarya: $1,178,190.02; Tashkent: $3,813,074.36; Fergana: $3,533,576.92; Khorezm: $1,429,284.01
	Timely submission of annual work programs and budgets	Quarterly report on project implementation progress are submitted to ADB according to the set reporting deadlines.
	Establishment of Region Project Implementation Bureau in project regions and staff recruited	Provincial PIB established and fully equipped in all project regions.
Inputs		
(i) Consulting services	$1.9 million	$1.66 million
(ii) Training and fellowships	$1.5 million	$1.05 million
(iii) Systems development and research studies	$1.6 million	$0.33 million
(iv) Educational (IEC) materials	$0.5 million	$0.42 million
(v) Medical, training, and HMIS equipment; vehicles	$22.2 million	$30.78 million (vehicles: $0 for ADB financing)
(vi) Reagents and medical consumables	$3.3 million	$1.88 million
(vii) Construction works	$31.0 million	$36.12 million (use of contingencies)
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Total ADB financing	$40.0 million	$38.09 million
Government financing	$30.0 million	$150.84 million (huge increase in covering recurrent costs)
Total project costs	$70.0 million	$188.93 million

ADB = Asian Development Bank, BCG = an antituberculosis vaccine, CDC = United States Center for Disease Control and Prevention, COM = The Cabinet of Ministers of Uzbekistan, CPE = continuous professional education, CRH = central *rayon* (district) hospital, DFID = Department for International Development of the United Kindom, DPC = data processing center, DRG = disease related group, Global Fund = The Global Fund to Fight AIDS, Tuberculosis and Malaria, ICB = international competitive bidding, HMIS = health management information system, IMR = infant mortality rate, JICA = Japan International Cooperation Agency, JPIB = joint project implementation bureau, M&E = monitoring and evaluation, MDG = Millennium Development Goals, MMR = maternal mortality rate, MOH = Ministry of Health, NICU = neonatal intensive care unit, OH = province (*oblast*) hospital, PHC = primary health care, PIB = project implementation

bureau, RMU = *rayon* medical unit, SSES = sanitary and epidemiologic institution, SVP = *Selski Vrachebny Punkt* (rural medical point), TA = technical assistance, TB = tuberculosis, U5MR = under-5 mortality rate, UNICEF = United Nations Children's Fund, USAID = United States Agency for International Development, WCH = woman and child health, WHO = World Health Organization

[a] Source: Institute of Health and Medical Statistics
[b] Source: JPIB
[c] Source: Republican AIDS Control Center
[d] Source: Ministry of Health
[e] Source: World Bank Health-II project
[f] Source: Republican State Sanitary Epidemiological Center
[g] Source: Research Institute of Hematology and Blood Transfusion

SUMMARY OF PROJECT PROCUREMENT ACTIVITIES AND CONTRACTS

Table A2: COMPARISON OF PLANNED AND ACTUAL PROCUREMENT

		At Appraisal			Actual		
	Activities	Number of Contracts	Procurement Mode	Estimated Value ($'000)	Number of Contracts	Procurement Mode	Amount ($'000)
1.	Equipment and Vehicles			22,458			
a.	Vehicles for Project Implementation Bureau	2	LCB/DP	70	1	IS	2
b.	Medical equipment and supplies			18,077			25,739
	Hospitals: CRH, OH (Ward, NICU, Lab, DC, BCU)	6	ICB	8,016	22 2 1	ICB LIB NCB	20,072
	Phase II: SVP and/or CRH, OH	2	ICB	6,600			
	Blood Transfusion Centers Large BTCs	1	ICB	1,149	8 4	ICB LIB	4,667
	Blood Transfusion Centers: Small BTCs	2	ICB	1,527			
	Blood Transfusion Centers: BTCs in transition	1	ICB	785			
c.	Training equipment for Training center	3	ICB	2,206	4 4 2	LIB IS NCB	3,015
d.	HMIS, office equipment, office supplies			2,105			
	EBM center, JPIB, OPIB furniture	1	LCB	12	2	IS	14
	HMIS, office equipment	2	ICB	1,870	3 2	ICB LIB	1,000
	HMIS office supplies	1	LCB	145		NCB	
	JPIB/OPIB office supplies	5	LCB	78	multiple	NCB	82
2.	Supplies and Reagents (CRH, OH, BTCs)	6	ICB	3,115			3,511
3.	IEC Materials	2	IS/LCB	449	multiple	NCB	514
	TOTAL			**26,022**			**32,876**

BCU = blood collection unit; BTC = blood transfusion center; CRH = central district hospital; DC = diagnostic center; DP = direct purchase; EBM evidence-based medicine; HMIS = health management information system; ICB = international competitive bidding; IEC = information, education, and communication; IS = international shopping; JPIB = joint project implementation bureau; Lab = laboratory; LCB = local competitive bidding; LIB = limited international bidding; NCB = national competitive bidding; NICU = neonatal intensive care unit; OH = province *(oblast)* hospital; OPIB = province project implementation bureau; SVP = *Selski Vrachebny Punkt* (rural medical point)

Source: Asian Development Bank estimates.

SUMMARY OF TRAINING PROGRAMS

Description	Description of Topics	Target Participants	Actual Participants	Planned To be Trained	Actual trained	Sources of Financing and actual trained
Component 1: Decentralized WCH Delivery Services						
Family Nurse Training						
Master TOT training-Tashkent	7 modules	Senior nurses from Tashkent	Senior nurses from Tashkent Policlinics	10	24	Project
		Senior nurses from Provinces		65		
TOT Training-provinces	7 modules	Senior nurses from provinces	Senior nurses from provinces	65	48	Project
	7 modules	Senior nurses from districts	Senior nurses from districts	330	450	Project
Training-districts	7 modules	SVP nurses	SVP nurses	9,750	20,000	Nurse association
Institutionalization		College lecturers		840	546	Nurse Association
			Medical Institute teachers		182	Project
WHO Neonatal Care and Breastfeeding & NICU course for Neonatologist & Neonatal Nurses						
TOT-Tashkent	TOT-Province	Neonatologists, neonatal nurses	Neonatologists, neonatal nurses	12	16	Project 75 specialists trained EU/UNICEF
Training-province	Training-province	CRH neonatologists	CRH neonatologists	258	149	Project
Follow-up training		CRH neonatologists		258		Starting 2008 WHO Neonatal care program integrated into the Effective Perinatal Care course
Institutionalization		Medical Institute lecturers		840		
Follow up mentoring		Medical Institute lecturers		840		
	Using of neonatal equipment		CRH neonatologists, nurses		549	Project
NICU Specialist Course for Neonatologists for Province level						
Training-Tashkent	Training-Tashkent	NICU specialists	NICU specialists	12	53	Project UNICEF
Hospital IMCI for Pediatricians & Pediatric Nurses						
TOT-Tashkent	TOT-Tashkent	Pediatricians and/or nurses	Pediatricians	24	24	Project 48 pediatricians trained EU/UNICEF
Training-provinces	Training- provinces	CRH pediatricians, pediatric nurses	Pediatricians, teachers of Medical Institutes	1,042	463 579	Project EU/UNICEF

Description	Description of Topics	Target Participants	Actual Participants	Planned To be Trained	Actual trained	Sources of Financing and actual trained
Follow-up training		CRH pediatricians, pediatric nurses	Pediatricians	1,042	463	Follow-up activities by EU/UNICEF
Delivery Course: normal & complicated for Obgyns & Midwives						
TOT-Tashkent	TOT-Tashkent	Obgyns and midwives	Obgyns, neonatologists and midwives	24	45	EU/UNICEF
Training- Provinces	Training- provinces	CRH obgyns & midwives	Perinatal Centers, CRHs Obgyns, neonatologists & midwives	1,349	255	GIZ, UNFPA and UNICEF; remaining 1,094 midwives trained EU/UNICEF
ollow-up training		CRH obgyns and midwives		1,349		
Training-provinces		Remote SVP obgyns and midwives	not applicable	93		
Institutionalization		Medical Institute lecturers		100		EU/UNICEF Project
Follow up mentoring		Medical Institute lecturers		100		
	Intensive therapy and anesthesia course		anesthesiologists and resuscitators of perinatal centers and CRHs	166		Project
Prenatal course- normal and complicated for Obgyns & Midwives						
TOT-Tashkent		Obgyns & Midwives	Obgyns	24	24	Project
Training-provinces		Clin Diag Center Obgyns and midwives women's consultation centers	SVPs, GPs and obgyns	612	216	396 midwives trained Health-II
Training-provinces		Remote SVP obgyns and midwives		93		Health-II
Follow-up training		Remote SVP obgyns and midwives		93		Health-II
Training-provinces		SVP midwives and obgyns		93		Health-II
Institutionalization		Medical Institute lecturers		100	18	Project 82 midwives trained Health-II
Follow up mentoring		Medical Institute lecturers		100		Health-II
Reproductive Health & IUD courses for Obgyns & Midwives						

Description	Description of Topics	Target Participants	Actual Participants	Planned To be Trained	Actual trained	Sources of Financing and actual trained
TOT-Tashkent	TOT-Tashkent	Obgyns & Midwives	Medical Institutes teachers, regional reproductive centers specialists	12	79	Project
Training-provinces		CRH obgyns		770		UNFPA Project
Follow-up training		CRH obgyns		770		
Training-provinces		CRH midwives		579		
Training-provinces		Clinical Diagnostic (Polyclinic) Center obgyns and midwives		612		
Follow-up training		Clinical Diagnostic (Polyclinic) Center obgyns and midwives		612		
Training-provinces		SVP obgyns		164		Health-II
Training-provinces		SVP midwives		93		UNFPA
Patronage training abroad					1	Project
Participation at International Congress of Anesthesiologists					1	Project
Introductory study tour on preparation of Nurse baccalaureates					12	Project
Total for Component 1				**23,135**	**23,754**	
Component 2: Finance, Information and Management						
Orientation workshops on rural PHC F&M reforms	Orientation workshops on rural PHC F&M reforms	CRH and OH managers	Province, district and primary level health managers, economic professional	150	545	USAID
	Orientation seminars on dissemination of per capita financing				700	USAID
	Technical workshops on per capita budgeting of PHC facilities				623	USAID
Orientation workshops on F&M reforms of hospital services	Orientation workshops on F&M reforms of hospital services	Health managers and hospital head doctors and economic professional	Health managers and hospital head doctors and economic professional	150	139	USAID

Description	Description of Topics	Target Participants	Actual Participants	Planned To be Trained	Actual trained	Sources of Financing and actual trained
Workshop on implementation of geographic allocation formula of health resources		CRH and OH managers, economic and finance professional		150		
National workshop on international/regional and local experience in community initiatives on financing to meet health needs		CRH and OH managers		150		
	National seminar on reforming rural/urban PHC facilities		Health economists and representatives from financing institutions		89	Project
Workshop on linking small grant/seed money programs to community initiatives		CRH and OH managers		150		
Study tours to Fergana province (Health-I original pilot region)	Study tours to Fergana province (Health-I original pilot region)	Province and/or district managers	Province/district managers	150	102	Project
	Study tour to Kyrgyzstan and Kazakhstan		CRH and OH managers		11	USAID
Training on basic management	Training on basic management	PHC Facility head doctors	PHC Facility head doctors	75	2,927	Project
		PHC Facility finance (practice) managers	PHC Facility finance (practice) managers	75	130	TIAME
		Economic professional at CRH	Economic professional at CRH, health managers	75	249	Project
			Trainers of GP training centers	0	33	USAID
		Province/district health managers and hospital managers	Health and finance managers	75	61	USAID
	Accounting at PHC facilities		PHC facility finance (practice) managers		37	USAID
	Business plan development for PHCF		Health and finance managers		24	USAID
	Planning of expenditures at PHC facilities		Health and finance managers		24	USAID

Description	Description of Topics	Target Participants	Actual Participants	Planned To be Trained	Actual trained	Sources of Financing and actual trained
Training on population database startup	Training on population database startup	CCs professional and PHC health professional	CCs professional and PHC health professional	1,950	71	USAID
Computer training on development of hospital financing reforms	Computer training on development of hospital financing reforms	CRH professional	CRH professional	1,950	56	USAID
	Fundamental IT for MOH office automatization		MOH office staff		80	Project
Training to improve purchasing skills		Republican and province professional		100		
Follow-up training on improving purchasing skills		Republican and province professional		100		
Training on developing accreditation guidelines for operation under new health financing (provider payment) system	Training on developing accreditation guidelines for operation under new health financing (provider payment) system	Republican and province CRH and/or OH professional	Republican and province CRH/OH professional	75	29	USAID
Human resource planning	TOT on human resource management	CRH and OH managers	Province/district health managers and hospital managers	150	60	Project
	Training on HR management	CRH and OH managers	HR staff of health facilities		880	Project
Follow-up training on human resource planning		CRH and OH managers		120		
	Flagships courses on health system				4	Project
Total for Component 2				**5,645**	**6,874**	
Component 3: Blood Safety Program						
Overseas Ref Center Visit-Slovenia (Jordan)	Overseas Ref center visit Groningen (Netherlands), Paris (France)	Policymakers, blood transfusion leaders	Policymakers, blood transfusion leaders	10	21	Project
Internal Reference Center Visit	Visit to Republican Blood Transfusion Center for familiarization with work of donor, procurement, laboratory and	Policymakers, blood transfusion leaders, heads of regional blood centers, laboratory specialists	Policymakers, blood transfusion leaders, lab specialists from regions	30	30	Project

Description	Description of Topics	Target Participants	Actual Participants	Planned To be Trained	Actual trained	Sources of Financing and actual trained
	distribution departments					
Workshops						
Managerial Structure	Included in CDC seminar on Principles of safe blood transfusion	field specialists	field specialists from regional blood centers Tashkent, Fergana, Bukhara, Samarqand, Nukus	10	60	Project WHO CDC
Legal affairs	Included in CDC seminar on Principles of safe blood transfusion	field specialists	field specialists from regional blood centers Tashkent, Fergana, Bukhara, Samarqand, Nukus	10	40	Project WHO CDC
Financing/Insurance	Included in CDC seminar on principles of safe blood transfusion	field specialists	field specialists from regional blood centers Tashkent, Fergana, Bukhara, Samarqand, Nukus	10	60	Project WHO CDC
Facilities and equipment	Included in CDC seminar on principles of safe blood transfusion	field specialists	field specialists from regional blood centers Tashkent, Fergana, Bukhara, Samarqand, Nukus	10	60	Project WHO CDC
Professional and Education	Included in CDC seminar on principles of safe blood transfusion	field specialists	field specialists from regional blood centers Tashkent, Fergana, Bukhara, Samarqand, Nukus	10	40	Project WHO CDC
Quality System	Quality system and technology of safe blood components production	field specialists	field specialist from regional blood centers in Nukus, Samarqand and Fergana	10	122	Project
Data Management (and IT)	Safe blood donation and data management	field specialists	field specialist from regional blood centers in Nukus, Samarqand and Fergana	10	166	Project
Laboratory Controls	Included in seminar on Principles of safe blood transfusion	field specialists	field specialist from regional blood centers in Nukus, Samarqand and Fergana	10	17	Project WHO CDC
Workshops for Education on Current Good Laboratory Practices with WHO	Workshops for education on current good laboratory practices with WHO	field specialists	field specialists	30	40	Project

Description	Description of Topics	Target Participants	Actual Participants	Planned To be Trained	Actual trained	Sources of Financing and actual trained
Hemovigilance (Clinical use)	Hemovigilance (Clinical use)	field specialists	field specialists	30	539	Project
Logistics	Included in seminar on Principles of safe blood transfusion	field specialists	field specialist from regional blood centers in Nukus, Samarqand and Fergana	30	30	Project
Research and Development		field specialists		10		
Total for Component 3				**220**	**1,225**	
Component 4: Project Management						
Project Management		Project Manager, Chief Accountant and/or Financial Manager, Component coordinators		2	2	Project
Financial Management and/or Accounting		Chief Accountant and/or Financial Manager		1	2	Project
Procurement		Chief Procurement Specialist, Procurement Officer-assistant		1	4	Project
Disbursement		Chief Accountant and/or Financial Manager		1	2	Project
Regional PIU Meetings		Project Manager, Chief Accountant and/or Financial Manager, Component coordinators		2		
Total for Component 4				**7**	**10**	
Total for Project				**29,007**	**31,863**	

CC = computer center, CDC = United States Center for Disease Control and Prevention, Clin Diag = clinical diagnostics, CRH = central *rayon* (district) hospital, EU = European Union, F&M = finance and management, Health-I = World Bank-funded Health-I Project, Health-II = World Bank-funded Health-II Project, IT = information technology, MOH = Ministry of Health, NICU = neonatal intensive care unit, Obgyn = obstetrician-gynecologists, OH = province hospital, PHC = primary health care, PIB = project implementation bureau, SVP = *Selski Vrachebny Punkt* (rural medical point), TIAME = Tashkent Institute of Advanced Medical Education, TOT = training of trainers, UNFPA = United Nations Population Fund, UNICEF = The United Nations Children's Fund, USAID = The United States Agency for International Development, WCH = woman and child health, WHO = World Health Organization.
Source: JPIB

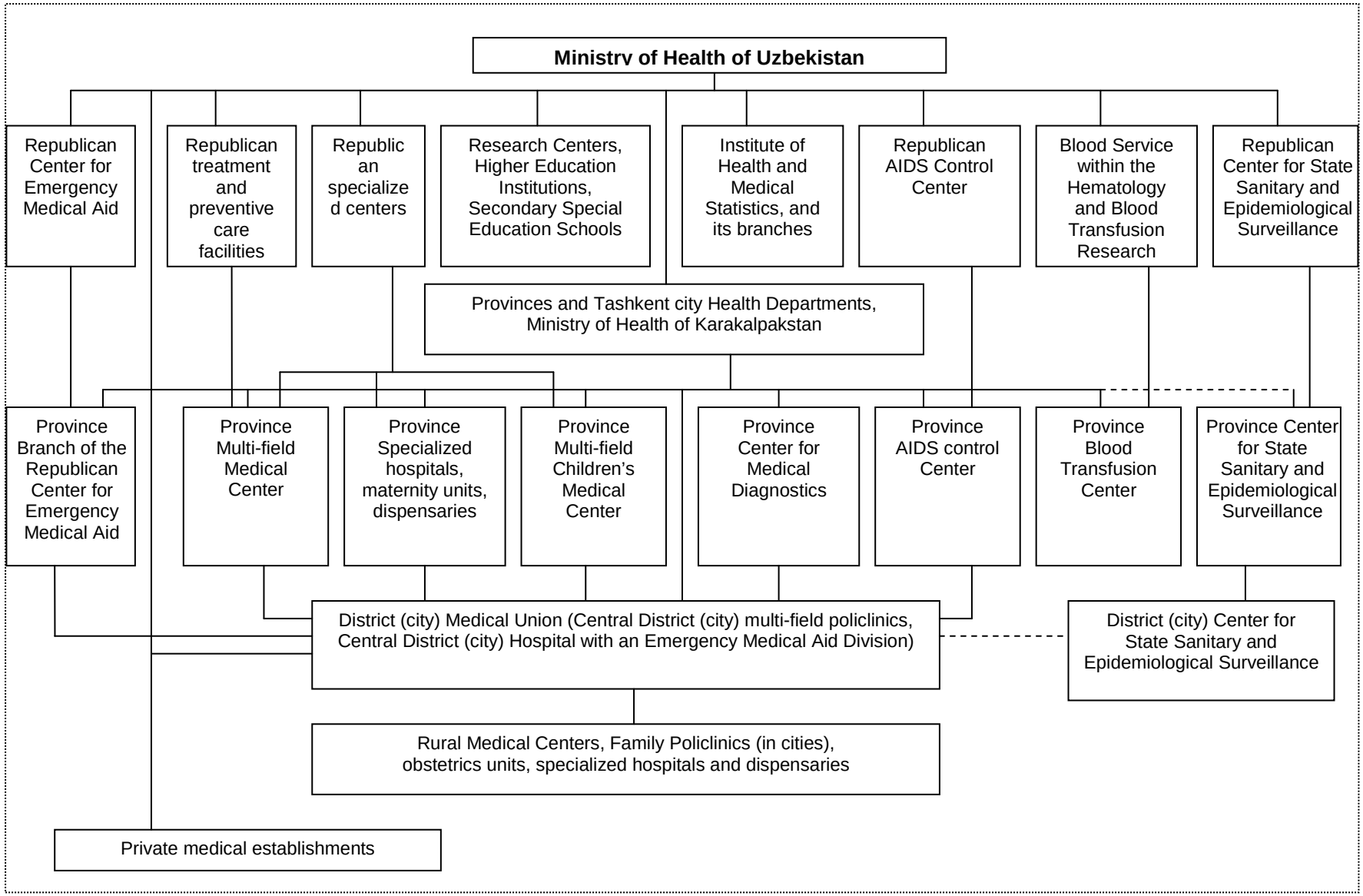
PROJECT-RELATED GOVERNMENT AND MINISTER'S ORDERS

Regulatory documents and educational and methodic guidelines related to health financing and management system improvement		
Item	**Date**	**Subject**
COM Resolution No. 217	28 September 2005	Measures on further reforming the financing and management system of public health care facilities of the Republic of Uzbekistan
MOH Order No. 484	4 October 2005	In pursuance of the COM order on measures on further reforming the financing and management system of public health care facilities of the Republic of Uzbekistan
MOH Order No. 477	25 May 2005	Establishment of working group on development of urban PHC model
MOH Order No. 660	14 July 14 2005	Establishment of working group on development of a legal framework for conversion of inpatient health facilities to case-based financing
MOH Order No. 498	10 October 2005	On training and professional development system for PHC financial managers and health-related financial and economic specialists
MOH Order No. 12	13 February 2006	Conception and plan of phased transfer to PHC urban model, which includes per capita financing and management reforms
MOH Order No. 526	24 November 2006	Approval of rural PHC facilities assessment indicators and the form for monitoring of F&M reforms, to track the progress of expansion and functioning of the new system of PHC facilities management and financing
MOH Order No. 36	12 January 2007	Establishment of working group on urban model
MOH No. 113	2 February 2007	Discharged patient statistics card form (Form No. 066/y-06) for collection of hospital activity initial information for further electronic processing and elaborating data, necessary for hospital financing according to a treatment case
MOH Order No. 432	10 October 2007	Approval of methodic guideline on rural PHC facility budget determination on the basis of one inhabitant standard expenditure and establishment of expert group for reform support in PHC facilities.
MOH Order No. 1381	30 November 2007	Establishment of working group to study and evaluate the PHC activity of urban pilot facilities
MOH Order No. 57	25 January 2008	Establishment of working group to study and evaluate the PHC activity of Tashkent city urban pilot facilities
MOH Order No. 747	6 June 2009	Organization of professional development short-term courses on health facilities management for the chiefs of PHC facilities
MOH Order No. 102	31 March 2010	Approval of address list for allocation of server and computer equipment, delivered in the framework of implementation of the Health-II and Women and Child Health Development projects, and approval of ICT educational programs in the framework of projects
MOH Resolution No. 879	9 July 2010	Organization of professional development short-term courses on ICT and information security for the heads and staff of the Ministry of Health
Item	**Date**	**Subject**
MOH Resolution No. 1693	11 December 2010	Conducting workshops on ICD-10 coding for Fergana Province pilot RMUs.
MOH Order No. 54	22 February 2011	Approval of human resources guidelines for specialist methodic guidance and professional development educational programs on human resources and health medical facilities

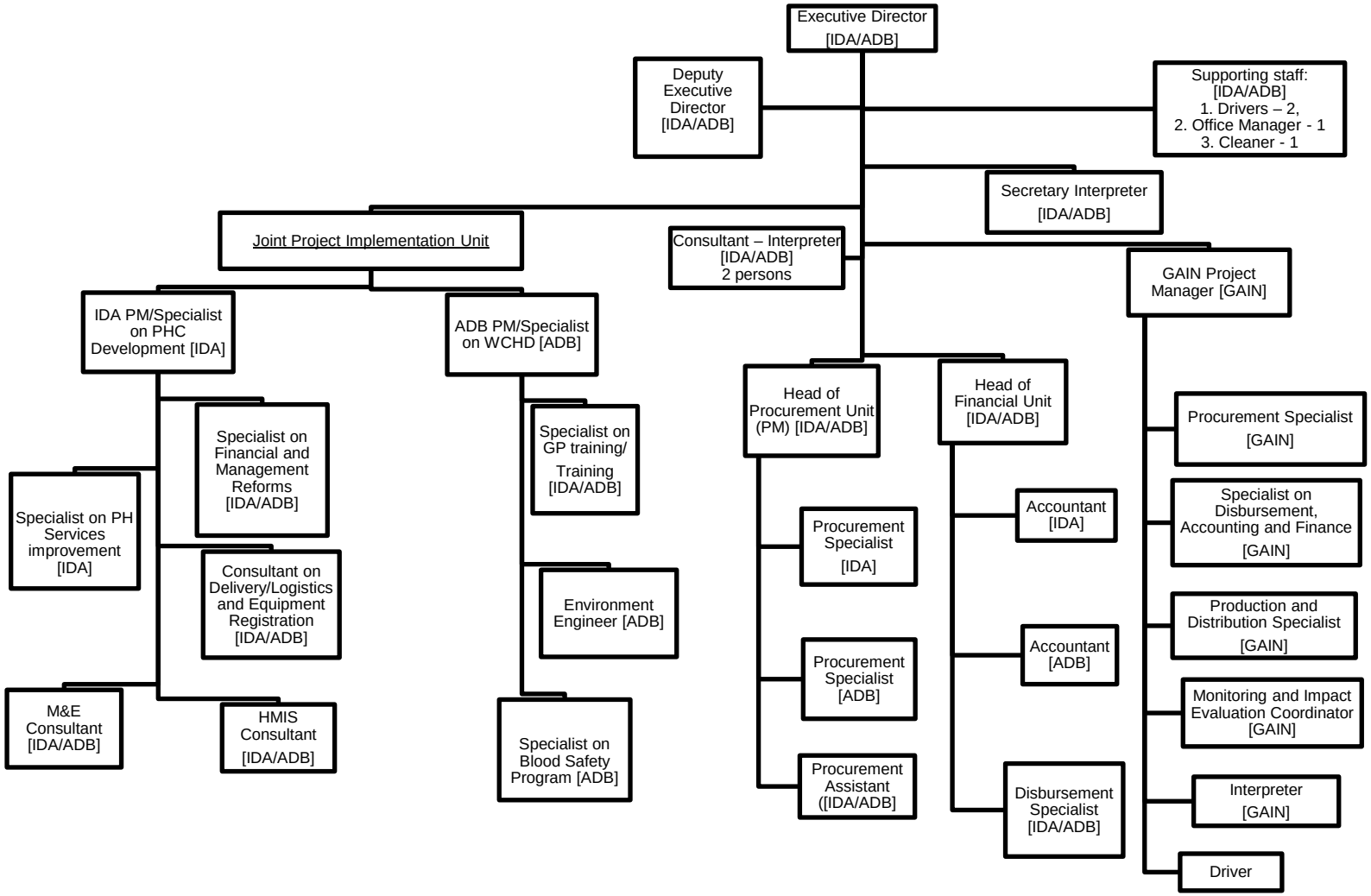
Item	Date	Subject
		management for provincial, urban and district medical facility human resource specialists
MOH Resolution No. 1621	24 November 2011	Organization of professional development short-term courses on actual issues on finance planning in the activity of medical facilities for the specialists of financial accounting services of provincial, urban and district medical facilities
Explanatory Letter		Order of PHC facilities budget planning and financing in accordance with the MOH Order No. 217 of September 2008
MOH Explanatory Letter		Application of SVP staffing standards
Explanatory Letter		Individual issues on health facilities activity organization in accordance with the President's Resolution No. PO700 dated 2 October 2008 and COM Resolution No. 48 dated 18 March 2008
Provision		Regarding chief accountant and chief economist of health regulatory bodies with regard to the duties of PHC facilities budget planning according to per capita principle
Staff normative		Rural doctoral points (SVPs), functioning as separate legal entity, approved by MOH as agreed with Ministry of Finance and Ministry of Labor in December 2009
Temporary staff normative		Urban pilot PCH facilities, functioning as separate legal entity within the framework of the Health-II and Women and Child Health Development projects, as agreed with Ministry of Labor and Ministry of Finance in June 2006
Concept		Main directions of District Health in-patient facilities (RMU) conversion to case-based financing on the basis of disease related groups
Educational methodic guidelines for heads and financial managers of primary health care		The following were developed: (i) methodic guidelines on PHC budget determination on the basis of expenditure normative for one inhabitant; (ii) methodic guideline on development of Business-plan and estimating of PHC facilities expenditures; (iii) basics of management in PHC facilities; (iv) labor legislation; (v) staff office work for the managers of PHC facilities; (vi) human resources service in PHC facilities of Uzbekistan Healthcare system; (vii) reference book for human resources specialists; and (viii) accountancy in medical establishments, funded by the state budget of the Republic of Uzbekistan.
NORMATIVE AND LEGAL DOCUMENTS REGULATING BLOOD SERVICES ACTIVITIES		
Item	**Date**	**Subject**
MOH Order No. 251	6 June 2006	Endorsement of legal documents on blood services in the Republic of Uzbekistan for setting single documentation forms in blood service facilities
MOH Order No. 88	22 February 2007	Endorsement of indications for the use of blood and its components in medical and preventive treatment facilities.
MOH Order No. 162	12 April 2007	On streamlining of blood service facilities activity to provide safety of donor blood and its components, regarding centralization of laboratory research on blood-transmissible

Item	Date	Subject
		infections
MOH Order No. 180	27 April 2007	Establishment of a Ministry of Health Transfusion Committee on the clinical use of blood, which regulates the use of blood in health facilities
MOH Order No. 24	18 January 2011	Improvement of the work of blood service facilities (provision of quality and safety of blood component production, and optimization of blood service facility activity)
MOH Order No. 102	30 March 2011	Screening of blood-transmissible infections: research among people aged 18 to 45 years, creation of database of donors and persons medically restricted from donor service
MOH Order No. 395 dated	7 September 2007	On establishing of the Single Donor Center under the Research Institute of Hematology and Blood Transfusion
MOH Order No. 72	15 June 2012	On improving the quality of medical care and diagnostic services with the standards of quality in blood service
MOH Order No.206	12 June 2012	On reforming and improving the activity of blood service facilities, adherence to the standards of production, and ensuring blood components safety
COM Minutes No.07-6-15	1 February 2008	Action Plan on development of voluntary blood donorship among in the country
COM Resolution No.1	1 January 2009	On measures to improve the institutional structure activity of the AIDS control centers with approval of National Action Plan on prevention of the spread of HIV infection in the Republic of Uzbekistan for 2009-2011
President Decree No. UP-3923	19 September 2007	On main focus areas for further deepening of healthcare reforms and implementation of State Healthcare Development Program
President Resolution No.PP-700	2 October 2007	On measures to improve organization of activity of the country medical establishments

COM = The Cabinet of Ministers of Uzbekistan, F&M = finance and management, ICD = international classification of diseases, ICT = information and communication technology, MOH = Ministry of Health, PHC = primary health care, RMU = *rayon* medical unit, SVP = *Selski Vrachebny Punkt* (rural medical point)
Source: JPIB


Ministry of Health of Uzbekistan
Republican Center for Emergency Medical Aid
Republican treatment and preventive care facilities
Republic an specialize d centers
Research Centers, Higher Education Institutions, Secondary Special Education Schools
Institute of Health and Medical Statistics, and its branches
Republican AIDS Control Center
Blood Service within the Hematology and Blood Transfusion Research
Republican Center for State Sanitary and Epidemiological Surveillance
Provinces and Tashkent city Health Departments, Ministry of Health of Karakalpakstan
Province Branch of the Republican Center for Emergency Medical Aid
Province Multi-field Medical Center
Province Specialized hospitals, maternity units, dispensaries
Province Multi-field Children's Medical Center
Province Center for Medical Diagnostics
Province AIDS control Center
Province Blood Transfusion Center
Province Center for State Sanitary and Epidemiological Surveillance
District (city) Medical Union (Central District (city) multi-field policlinics, Central District (city) Hospital with an Emergency Medical Aid Division)
District (city) Center for State Sanitary and Epidemiological Surveillance
Rural Medical Centers, Family Policlinics (in cities), obstetrics units, specialized hospitals and dispensaries
Private medical establishments

Joint Project Implementation Bureau Institutional Structure



ADB = Asian Development Bank, GAIN = Global Alliance for Improved Nutrition, GP = general practitioner, HMIS = health management information system, IDA = International Development Association of World Bank, M&E = monitoring and evaluation, PHC = primary health care, WCHD = Woman and Child Health Development Project.

APPRAISAL AND ACTUAL PROJECT COSTS

Table A5.1: Appraisal Cost Estimates

($'000)

Item	Total Project Cost			Asian Development Bank Financing			Government Financing		
	Foreign Exchange	Local Currency	Total Cost	Foreign Exchange	Local Currency	Total Cost	Foreign Exchange	Local Currency	Total Cost
A. Investment Cost									
1. Civil Works	0	7.71	7.71	0	0	0	0	7.71	7.71
2. Equipment and Furniture									
a. Vehicles	0	1.31	1.31	0	0.07	0.07	0	1.24	1.24
b. Medical Equipment	18.08	0	18.08	18.08	0	18.08	0	0	0
c. Training equipment	1.73	0.48	2.21	1.73	0.48	2.21	0	0	0
d. Health Management Information System and office equipment	1.85	0.03	1.88	1.85	0.03	1.88	0	0	0
3. Consulting Services									
a. International consultants	1.34	0	1.34	1.34	0	1.34	0	0	0
b. Domestic consultants	0	0.53	0.53	0	0.53	0.53	0	0	0
4. Training and Fellowships									
a. International training	0.16	0	0.16	0.16	0	0.16	0	0	0
b. In0country training	0	2.84	2.84	0	1.34	1.34	0	1.50	1.50
5. Information, Education and Communication Materials	0	0.55	0.55	0	0.45	0.45	0	0.10	0.10
6. Supplies, Reagents and Consumables	3.00	0.42	3.42	3.00	0.33	3.33	0	0.09	0.09
7. System Development and Studies	1.35	0.25	1.60	1.35	0.25	1.60	0	0	0
Subtotal (A)	**27.51**	**14.12**	**41.63**	**27.51**	**3.48**	**30.99**	**0**	**10.64**	**10.64**
B. Recurrent Cost	0	10.89	10.89	0	0	0	0	10.89	10.89
C. Taxes and Duties	0	2.10	2.10	0	0	0	0	2.10	2.10
Subtotal (B)+(C)	**0**	**12.99**	**12.99**	**0**	**0**	**0**	**0**	**12.99**	**12.99**
Total Base Cost	**27.51**	**27.11**	**54.62**	**27.51**	**3.48**	**30.99**	**0**	**23.63**	**23.63**
D. Contingencies									
Physical Contingencies	1.38	1.36	2.74	1.38	0.17	1.55	0	1.19	1.19
Price Contingencies	1.80	5.68	7.48	1.80	0.50	2.30	0	5.18	5.18
Subtotal (D)	**3.18**	**7.04**	**10.22**	**3.18**	**0.67**	**3.85**	**0**	**6.37**	**6.37**
E. Interest and Commitment Charge	**5.16**	**0**	**5.16**	**5.16**	**0**	**5.16**	**0**	**0**	**0**
Total	**35.85**	**34.15**	**70.00**	**35.85**	**4.15**	**40.00**	**0**	**30.00**	**30.00**

Source: Asian Development Bank estimates.

Table A5.2: Actual Cost

($'000)

Item	Total Project Cost			Asian Development Bank Financing			Government Financing		
	Foreign Exchange	Local Currency	Total Cost	Foreign Exchange	Local Currency	Total Cost	Foreign Exchange	Local Currency	Total Cost
A. Investment Cost									
1. Civil Works	0	1.98	1.98	0	0	0	0	1.98	1.98
2. Equipment and Furniture									
a. Vehicles	0	0.03	0.03	0	0	0	0	0.03	0.03
b. Medical Equipment	26.83	0	26.83	26.83	0	26.83	0	0	0
c. Training equipment	1.90	0.30	2.20	1.90	0.30	2.20	0	0	0
d. Health Management Information System and office equipment	1.48	0.27	1.75	1.48	0.27	1.75	0	0	0
3. Consulting Services									
a. International consultants	0.99	0	0.99	0.99	0	0.99	0	0	0
b. Domestic consultants	0	0.67	0.67	0	0.67	0.67	0	0	0
4. Training and Fellowships									
a. International training	0.13	0	0.13	0.13	0	0.13	0	0	0
b. In0country training	0	1.88	1.88	0	0.92	0.92	0	0.96	0.96
5. Information, Education and Communication Materials	0	0.51	0.51	0	0.42	0.42	0	0.09	0.09
6. Supplies, Reagents and Consumables	1.75	0.16	1.91	1.75	0.13	1.88	0	0.03	0.03
7. System Development and Studies	0.09	0.24	0.33	0.09	0.24	0.33	0	0	0
Subtotal (A)	**33.17**	**6.04**	**39.21**	**33.17**	**2.95**	**36.12**	**0**	**3.09**	**3.09**
B. Recurrent Cost	0	145.60	145.60	0	0	0	0	145.60	145.60
C. Taxes and Duties	0	2.15	2.15	0	0	0	0	2.15	2.15
Subtotal (B)+(C)	**0**	**147.75**	**147.75**	**0**	**0**	**0**	**0**	**147.75**	**147.75**
Total Base Cost	**33.17**	**153.79**	**186.96**	**33.17**	**2.95**	**36.12**	**0**	**150.84**	**150.84**
D. Contingencies									
Physical Contingencies	0	0	0	0	0	0	0	0	0
Price Contingencies	0	0	0	0	0	0	0	0	0
Subtotal (D)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
E. Interest and Commitment Charge	**1.97**	**0**	**1.97**	**1.97**	**0**	**1.97**	**0**	**0**	**0**
Total	**35.14**	**153.79**	**188.93**	**35.14**	**2.95**	**38.09**	**0**	**150.84**	**150.84**

Source: Asian Development Bank.

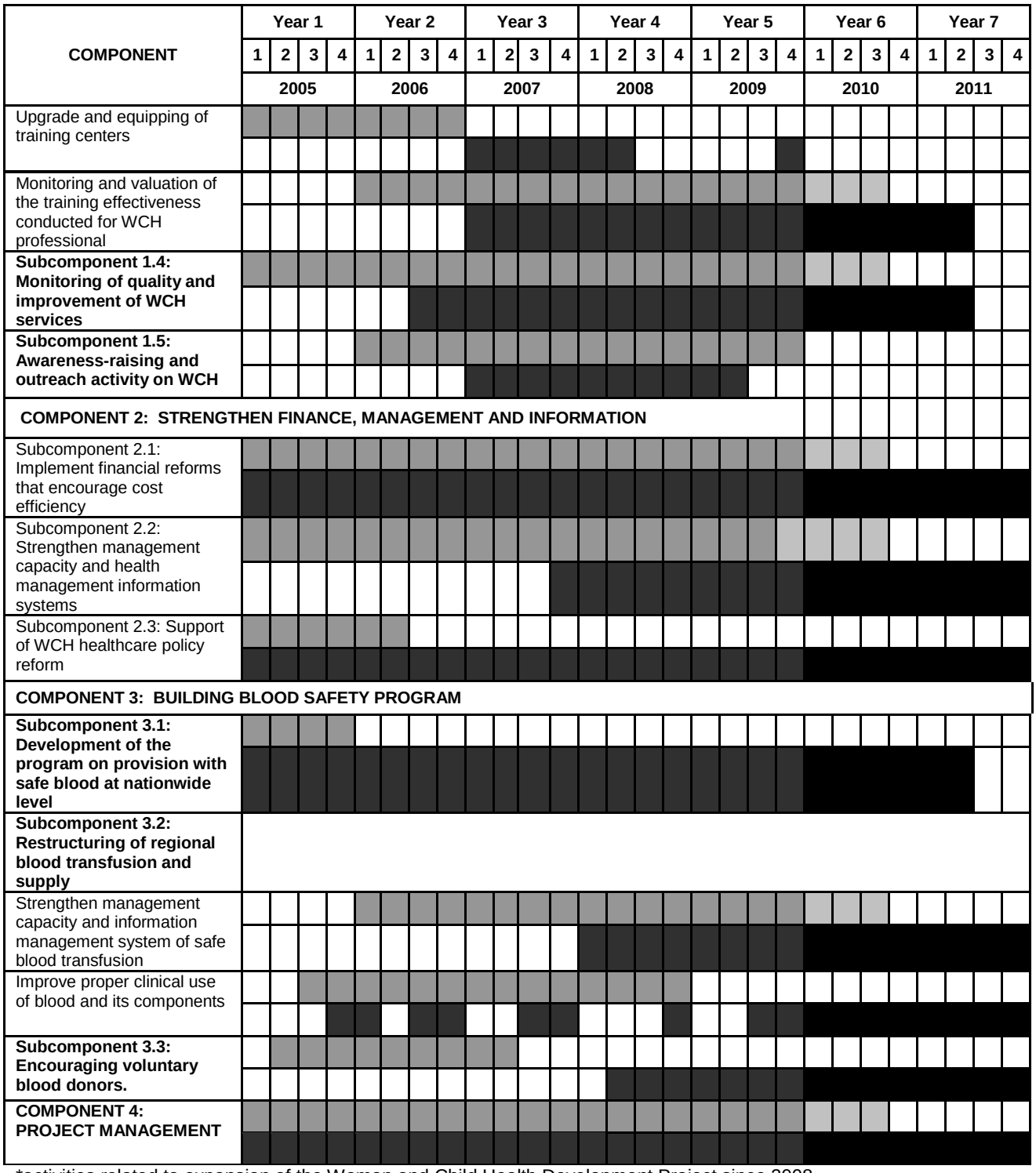
DISBURSEMENTS
$ million

Year	Quarter	Quarterly Actual Disbursement	Cumulative Actual Disbursement	Percentage of Original Loan
2004	IV	0	0	0
2005	I	0	0	0
	II	0.522	0.522	0.05
	III	0	0.522	0.05
	IV	0.030	0.552	(0.62)
2006	I	(0.300)	0.252	(0.62)
	II	0.069	0.321	(0.45)
	III	0.076	0.397	(0.26)
	IV	0.434	0.831	0.08
2007	I	0.042	0.873	0.18
	II	0.469	1.342	1.36
	III	0.027	1.369	1.42
	IV	1.370	2.739	4.85
2008	I	0.223	2.962	5.41
	II	5.305	8.267	18.67
	III	0.691	8.958	20.40
	IV	1.521	10.479	24.20
2009	I	1.211	11.690	27.23
	II	2.052	13.742	32.18
	III	1.915	15.657	37.15
	IV	2.634	18.291	43.73
2010	I	2.049	20.340	48.85
	II	4.453	24.793	60.00
	III	3.837	28.630	70.00
	IV	2.299	30.929	75.32
2011	I	1.849	32.778	80.00
	II	1.420	34.198	83.75
	III	2.393	36.591	90.30
	IV	0.438	37.029	91.78
2012	I	1.104	38.133	95.32
	II	(0.037)	38.096	95.23
	Total	**38.095**	**38.095**	**95.23**

( ) = negative
Source: Asian Development Bank, 2012.

PROJECT IMPLEMENTATION SCHEDULE

COMPONENT	Year 1				Year 2				Year 3				Year 4				Year 5				Year 6				Year 7			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
	2005				2006				2007				2008				2009				2010				2011			
COMPONENT 1: STRENGTHENING OF WCH SERVICES																												
Subcomponent 1.2: Equipment need to ensure WCH functions are met																												
Construction and repair of CRH buildings, province hospitals and training centers																												
Outfit CRH and province hospitals with essential equipment for WCH services, neonatal care, laboratory tests, diagnostics																												
Construction and repair of CRH buildings, province hospitals in additional 7 regions *																												
Outfit CRH and province hospitals with essential equipment for WCH services, neonatal care, laboratory tests, diagnostics in additional 7 regions *																												
Outfit 37 maternities equipment for WCH services through repeat orders																												
Conduct training on equipment usage and maintenance																												
Subcomponent 1.3: Continuous education for WCH activities																												
Development of training program for nurses																												
In-country training for nurses																												
Train overseas on nursing services																												
Upgrade and equip training centers																												
Monitor and evaluate the effectiveness of conducted trainings for nurses																												
Provide continuous education for WCH functions																												
Development of training program on WCH																												
WCH preparatory works in the country (trainings)																												



*activities related to expansion of the Woman and Child Health Development Project since 2008

Legend Planned Actual

CRH = central *rayon* (district) hospital; WCH = woman and child health
Source: JPIB Report, 2012

STATUS OF COMPLIANCE WITH LOAN COVENANTS

No.	Covenants	Reference in Loan Agreement	Status of Compliance
Particular Covenants			
1.	(a) The Borrower shall cause the Project to be carried out with due diligence and efficiency and in conformity with sound administrative, financial, engineering, social, environmental and health care practices; (b) In the carrying out of the Project and operation of the Project facilities, the Borrower shall perform, or cause to be performed, all obligations set forth in Schedule 6 to this Loan Agreement.	Section 4.01 Article IV	**Complied with.** **Complied with.**
2.	The Borrower shall make available, promptly as needed, the funds, facilities, services, land and other resources which are required, in addition to the proceeds from the Loan, for the carrying out of the Project and for the operation and maintenance of the Project facilities.	Section 4.02 Article IV	**Complied with.** The Borrower made available the funds needed for the implementation of all Project components.
3.	(a) In the carrying out of the Project, the Borrower shall cause competent and qualified consultants and contractors, acceptable to the Borrower and ADB, to be employed to an extent and upon terms and conditions satisfactory to the Borrower and ADB; (b) The Borrower shall cause the Project to be carried out in accordance with plans, design standards, specifications, work schedules and construction methods acceptable to ADB. The Borrower shall furnish, or cause to be furnished, to ADB, promptly after their preparation, such plans, design standards, specifications and work schedules, and any material modifications subsequently made therein, in such detail as ADB shall reasonably request.	Section 4.03 Article IV	**Complied with.** **Complied with.**
4.	The Borrower shall ensure that the activities of its departments and agencies with respect to the carrying out of the Project and operation of the Project facilities are conducted and coordinated	Section 4.04 Article IV	**Complied with.** JPIB established good working relations with the relevant departments of MOH and other government

No.	Covenants	Reference in Loan Agreement	Status of Compliance
	in accordance with sound administrative policies and procedures.		agencies involved in the project.
5.	The Borrower shall (i) maintain, or cause to be maintained, separate accounts for the Project; (ii) have such accounts and related financial statements audited annually, in accordance with appropriate auditing standards consistently applied, by independent auditors whose qualifications, experience and terms of reference are acceptable to ADB; (iii) furnish to ADB, as soon as available but in any event not later than six months after the end of each related fiscal year, certified copies of such audited accounts and financial statements and the report of the auditors relating thereto (including the auditors' opinion on the use of Loan proceeds and compliance with the covenants of this Loan Agreement as well as on the use of the procedures for imprest account/statement of expenditures), all in the English language; and (iv) furnish to ADB such other information concerning such accounts and financial statements and the audit thereof as ADB shall from time to time reasonably request. The Borrower shall enable ADB, upon ADB's request, to discuss the Borrower's financial statements for the Project and its financial affairs related to the Project from time to time with the Borrower's auditors, and shall authorize and require any representative of such auditors to participate in any such discussions requested by ADB, provided that any such discussion shall be conducted only in the presence of an authorized officer of the Borrower unless the Borrower shall otherwise agree.	Section 4.05 Article IV	**Complied with.** **Complied with.**
6.	The Borrower shall enable ADB's representatives to inspect the Project, the goods financed out of the proceeds of the Loan, and any relevant records and documents.	Section 4.06 Article IV	**Complied with.** MOH enabled ADB representatives to inspect goods and review performance of consultants during the loan review missions.

No.	Covenants	Reference in Loan Agreement	Status of Compliance
7.	The Borrower shall ensure that the Project facilities are operated, maintained and repaired accordance with sound administrative, financial, engineering, environmental, health care and maintenance and operational practices.	Section 4.07 Article IV	**Complied with.**
Sector			
8.	As the Project Executing Agency, MOH shall have overall responsibility for the carrying out of the Project. The Deputy Minister of MOH in charge of maternal and child health shall be appointed as the Project Coordinator within one month after the Effective Date to oversee implementation of the Project.	Schedule 6, para. 1	**Complied with.** On 14 April 2005, the deputy minister in charge of woman and child health care was appointed as project coordinator.
9.	The interagency PSC established by the Borrower shall provide overall guidance for the Project and oversee the parallel implementation of the Project and Health II Project (WB). PSC shall be chaired by a Deputy Prime Minister and shall comprise representatives of COM, MOH, MOF, Ministry of Economy, Ministry of Labor and Social Protection at the deputy minister level, other institutions concerned and the representatives of ADB and WB. The project coordinator shall act as the secretary of the PSC. PSC shall meet quarterly to review implementation progress, major issues and determine corrective measures. Representatives from the international aid community shall be invited to attend the PSC meetings as observers.	Schedule 6, para. 2	**Complied with.** Interagency PSC was established and conducted regular meetings.
10.	(a) The JPIB established within MOH shall be responsible for joint implementation of the Project and Health II (WB) project. JPIB shall liaise with PSC, ADB and other coordinating bodies. The Borrower shall ensure that JPIB is staffed with adequate and qualified staff at all times throughout project implementation. JPIB shall be headed by a full-time Director who shall report to the Project Coordinator. The Bureau Director shall have the authority to undertake financial	Schedule 6, para. 3	**Complied with.** JPIB established within MOH and staffed with qualified specialists.

No.	Covenants	Reference in Loan Agreement	Status of Compliance
	transactions required for the Project, sign contracts and endorse financial statements. JPIB shall meet with the Project Coordinator as often as needed but not less than once a month. (b) The JPIB shall have the following units: (i) an administrative unit for joint administration of the Project and Health II (WB) project, (ii) a technical unit for the project and (iii) a technical unit for the Health II project. The JPIB shall be funded jointly through the Project and Health II project. The administrative unit shall be responsible for procurement, disbursement, accounting, financial management, monitoring and evaluation, office management and related administrative tasks. The technical unit shall be responsible for coordination of project implementation activities with respect to medical practices, public health, blood banking, finance, management information and training and shall be headed by a Deputy Bureau Director. In addition to the counterpart staff (and staff in charge of the Health II project), about 10 additional full-time shall be hired for implementation of the project on an individual basis in accordance with transparent and competitive recruitment procedures acceptable to ADB.		**Complied with.** The JPIB structure was approved and comprised of (i) executive director; (ii) Administrative Unit; (iii) Financial Unit; and (iv) Procurement Unit.
11.	The Borrower shall establish the OPIBs within 1 month after the effective date in each of the Project provinces and shall appoint an OPIB manager and a technical component coordinator for each of such OPIBs. The OPIBs shall oversee project activities including civil works, delivery and installation of equipment, training and related follow-up activities at local levels. The staff of OPIBs shall be employed and financed through the counterpart funds and shall be housed in the offices of the respective Province Health departments. The OPIB staff shall report to the Bureau Director and to the head of the respective Province Health Department. One full-time environmental engineer shall be hired under the Project specifically for the OPIBs to monitor quality of civil works and to ensure proper placement and use of the	Schedule 6, para. 4	**Complied with.** OPIB in each province was established and was fully operational starting 4 February 2005. The staff of the OPIBs worked under the provincial healthcare departments and was financed by the government. A full-time environmental engineer was hired on 11 January 2006.

No.	Covenants	Reference in Loan Agreement	Status of Compliance
	procured equipment in the project provinces. The Borrower shall ensure that monthly or quarterly meetings are organized between JPIB and OPIBs and that OPIBs' activities are closely coordinated.		
12.	To assure coordination of Project implementation activities, the Borrower shall organize a number of working groups with respect to (i) continuing medical education for WCH care medical and para medical staff, (ii) nursing program, (iii)blood banking, (iv) finance and management, (v) HMIS, (vi) civil works and environmental management, (vii) WCH policy reform and (viii) restructuring health care delivery system. The working groups shall comprise representatives from MOH, relevant government agencies and institutes and other donors, where appropriate. The working groups shall coordinate activities, prepare issues paper, prepare implementation plans and follow-up on concerns raised. The working groups shall report to the Project Coordinator and shall meet at least once a quarter, or as frequently as required. The JPIB and all consultants shall consult closely with the working groups.	Schedule 6, para. 5	**Complied with.** All working groups have been established and there is continuing coordination work between the JPIB and working group members. MOH order No. 52 dated 11 February 2006 approved the composition of eight expert (working) groups of the Ministry of Health. These working groups participate in document preparation, review and approval.
13.	The Borrower shall continue to implement the health care system reform measures, adopted by Presidential Decree UP-2107 of 10 Nov 1998, in a timely manner to optimize the impact of the measures promoted under the Project.	Schedule 6, para. 6	**Complied with.** Key health reforms were implemented in parallel with WB health projects.
14.	(a) The Borrower shall take necessary measures within 6 months after the Effective Date to ensure that (i) the reforms for financing and managing the rural PHC system are replicated at the national level, including pooling of the funds allocated for rural PHC services at the province level; (ii) the reforms for hospital management with respect to secondary level services are carried out in the Project Provinces, including pooling of the hospital funds at the province level, and the hospital case-based payment mechanism is adopted in	Schedule 6 para. 7	**Partly complied with.** To expand PHC financial and management reforms in rural area the Cabinet of Ministers approved the Resolution No. 217 dated 28 September 2005 “About the measures on further reforming the health facilities financing and management system of the Republic of Uzbekistan”. The Resolution confirms the schedule of

No.	Covenants	Reference in Loan Agreement	Status of Compliance
	such hospitals; and (iii) SVPs and CRHs in the Project Provinces achieve increased autonomy in their respective management and financing.		gradual expansion of rural PHC facilities financing including the accumulation of funds at provincial level. The COM Resolution No. 217 dated 28 September 2005 determined that SVP is a legal facility and has rights to make decisions independently on *SVP* financing and operating activities and staff schedule. President Resolution No.PP-700 dated 2 October 2007 "On measures to improve organization of activity of the Republic's medical establishments" determined the establishing of finance and accounting service in health facilities and granting them a legal entity status. The project supported implementation of the financing management activities in hospitals at district level, such as: (i) development of main directions of transferring from in-patient district (urban) health facilities to case-based financing system; (ii) approval of MOH Order No. 113 dated 2 February 2 2007 on "Statistical sheet of the patient discharged from the hospital" (Form No. 066/y-06 - patient discharge statistical card) including software for data collection on hospitals' operation; (iii) collection of statistical data on clinical activity of Fergana province hospitals which was a basis for the database on treated patients and treatment cost; (iv) training of physicians and statisticians of CRH of Fergana province on the use of 10th International Classification of Diseases (ICD-10) to improve the quality and reliability of data

No.	Covenants	Reference in Loan Agreement	Status of Compliance
	(b) The Borrower shall also ensure that the planned treasury mechanisms of the Government do not conflict with the financial and managerial independence of the health care delivery services, with respect to pooling of resources referred to under (i) and (ii) hereabove.		in filling the experimental 066/y-06 form. **Complied with.** To avoid conflict between the government treasury system and the financial and managerial independence of the health care delivery services, the following was undertaken: (i) starting from 2007 MOH jointly with MOF issue the guidance documents on explanation of PHC facilities financing mechanism in treasury conditions regularly; (ii) in 2008, MOH jointly with MOF conducted the series of seminars on explanation of PHC facilities financing mechanism in treasury conditions of countrywide treasury-based budget execution; (iii) in 2009, the system of centralized procurement of medicaments and medical goods for PHC facilities at national level was introduced; (iv) in 2010, the consolidated procurement of medicaments and medical goods for PHC facilities at provincial level was introduced; and (v) in 2011, the Treasury Training Center trained the specialists of PHC facilities on financial planning and state procurement.
15.	The Borrower shall undertake the reform measures with respect to the education system for nurse and midwives. In particular, the Borrower shall prepare and adopt a comprehensive education and training plan, including proposed revision of the current curriculum within 2 years after the effective date.	Schedule 6, para. 8	**Complied with.** MOH Order No. 100 dated 7 March 2007 provided for new provisions on advanced training and retraining of nurses and pharmacists considering the implementation of

No.	Covenants	Reference in Loan Agreement	Status of Compliance
			continuous medical education system, and approved the nomenclature of positions and specialties of paramedical professional. MOH has approved 60 training programs for postgraduate training of paramedical professional.
16.	The Borrower shall, within 1 year after the Effective Date, cause MOH to develop and carry out on a pilot basis an organizational framework and implementation plan for an improve WCH care delivery system, acceptable to ADB and ensure that (i) WCH wards, facilities and services in the districts are supported with the CRH management structure, and (ii) effective referral links for services and functions for WCH care are created within and between various facilities at community, SVP, CRH and province levels.	Schedule 6, para. 9	**Complied late.** The President Decree No. 3923 (dated 19 September 2007) issued key directions for further intensification of reforms and implementation of the State Healthcare Development Program. The decree defined key tasks for further healthcare reforms: forming an up-to-date healthcare organizational structure, ensuring a single organization, and methodical administration and medical services quality control; profound quality improvement of the future mothers health protection system; and improvement of the health manpower training and retraining system. The government accepted the proposals of the working group on establishing provincial multi-field children hospitals, district and/or city medical units on the basis of CRH/CCH.
17.	The Borrower shall cause MOH to prepare an optimization plan to rationalize services and staff for WCH within 1 year after the Effective date.	Schedule 6, para. 10	**Complied with.** Prior to the preparation of an optimization plan for WCH, the executing agency conducted a needs assessment of its medical professional. The MOH Order (dated 31 August 2006) approved measures to optimize the healthcare facilities network and

No.	Covenants	Reference in Loan Agreement	Status of Compliance
			capacity for 2006–2009.
18.	The Borrower shall cause MOH to revise, within 6 months after the Effective date, the Ministerial Order 100, 19th of March 2001, on Antenatal Care, to adopt international standards of care and practices in WCH, which shall then be implemented in the Project provinces.	Schedule 6, para. 11	**Complied with.** MOH Order dated 5 September 2005 introduced the modern technologies in antenatal care.
19.	The Borrower shall cause MOH to review, within 1 year after the effective date and update annually the maternal and child health care regulations, including Ministerial Order 500 of 13 November 2003 to incorporate the best practices emanating from evidence-based medical practices, international practices and lessons learned under the Project.	Schedule 6, para. 12	**Complied with.** MOH Order No.155 dated 10 April 2007 "On rendering in-patient services to children of Uzbekistan" replaced MOH Order No. 538 of 1992. The order approved the adapted WHO Clinical Guidelines on management of childhood diseases.
20.	The Borrower shall within 1 year after the Effective Date, cause MOH to (i) develop an essential drug list for PHC and WCH in accordance with recommendations and guidelines of the WHO and (ii) prepare and adopt a plan of action for the continued availability of such drugs in SVPs and CRHs.	Schedule 6, para. 13	**Complied with.** MOH order No.535 dated 6 December 2004 approved the list of drugs for pre-hospital emergency care in SVPs. Issues regarding improved provision of primary healthcare facilities with essential drugs and corresponding consumables, according to the approved list, were included in World Bank's Health-II project implementation.
21.	The Borrower shall: (i) prepare, adopt and implement a national program on blood safety which includes measures to encourage regular, voluntary and non-remunerated blood donations, and (ii) establish an inter-sectoral national committee comprising representatives of MOH, Institute of Hematology, relevant municipalities,	Schedule 6, para. 14	**Partly complied with.** The draft Program is under the government approval. A program on voluntary donor development is being implemented. **Complied with.** The Transfusiology Committee was established in 2007.

No.	Covenants	Reference in Loan Agreement	Status of Compliance
	centers for disease control and prevention, relevant training institutes, provinces and health facilities to oversee the implementation of such program and to provide guidance on developing related services. The committee shall meet at least once every quarter, or as frequently as necessary.		
22.	The Borrower shall ensure that the JPIB has overall responsibility for data collection, analysis and reporting to ADB, among others. A monitoring and evaluation unit (MEU) shall be established within JPIB to monitor the service delivery and health impact, and report thereon. MEU shall compile a benchmark database on basic economic and social conditions in order to provide socio-economic profile of the beneficiaries during the first year of Project implementation and a comparison made between the benchmark and Project completion situations. The database shall be analyzed to provide an assessment of the Project's impact on different social groups, including women and lower income households. The MEU shall also monitor the progress and performance of various sector reforms implemented under the Project.	Schedule 6, para. 22	**Complied with.** Monitoring and evaluation (M&E) specialist was recruited. M&E Working Group for WB and ADB projects was organized under the MOH. The final survey was conducted in 2010.
23.	The Borrower and ADB shall jointly review, with the participation of JPIB, the Project's progress at least twice a year. In addition, they shall undertake a joint midterm review with IDA in the third year of the Project implementation period to (i) review the Project's scope, design, implementation arrangements, (ii) progress in the health reform measures, development strategies and policy measures, (iii) identify any changes or new developments in the sector issues and resource management and allocation, and assess their impact on future Project implementation and sustainability, (iv) review physical progress made and disbursements in relation to the implementation schedule, including progress in achieving the measurable objectives of the Project, (v) review status	Schedule 6 para. 23	**Complied with.**

No.	Covenants	Reference in Loan Agreement	Status of Compliance
	of compliance with the covenants of the Loan Agreement, (vii) identify problems and constraints, if any, and (viii) formulate appropriate recommendations for corrective action.		
	Social		
24.	The Borrower shall ensure that the rehabilitation work undertaken under the Project does not entail any land acquisition, involuntary resettlement or negative environmental impact. In the event of unforeseen land acquisition or involuntary resettlement, the Borrower shall immediately inform ADB and prepare necessary planning documents in compliance with ADB's policy on involuntary resettlement.	Schedule 6, para. 24	**Complied with.**
	Safeguards		
25.	The Borrower shall also ensure that (i) Project facilities are designed, constructed, operated and maintained in accordance with the environment management plans (EMPs) and the environmental rules and regulations of the Borrower and ADB, and (ii) the remedial measures specified in the EMPs are implemented in a timely manner.	Schedule 6, para. 20 (a)	**Complied with.** The implementation was overseen by the environmental engineer and MOH staff.
26.	The Borrower shall within 6 months after the Effective Date cause the project provinces to (i) prepare in consultation with municipalities, related agencies and MOH development plans, including the cost for upgrading of health facilities for each of such provinces under the Project, and	Schedule 6, para. 20 (b)	**Complied with.** During project implementation each pilot region has developed the plan for civil works for WCH facilities, blood services, and CRH laboratories with capital and recurrent expenses.

No.	Covenants	Reference in Loan Agreement	Status of Compliance
	(ii) establish design and supervision committees for civil works at the province level with terms of reference and composition acceptable to ADB.		**Complied with.** By the decision of the Governmental Commission on Health Generation, WCH and Improvement of Family Health Culture, the provincial government authorities were entrusted to control construction and rehabilitation works of health facilities under the project.
	Financials		
27.	Without any prejudice to the provisions of Section 4.02 of the LA, the Borrower shall ensure that the counterpart funds required for the first year of Project implementation are allocated in a timely manner.	Schedule 6 para. 15	**Complied with.** During the project implementation, 2005-2011, the Borrower allocated total of $150.84 million of counterpart funds, including (i) civil works; (ii) goods and services such as vehicles, local trainings, IEC materials, supplies, reagents and consumables; and (iii) recurrent expenses of health facilities.
28.	The Borrower shall prepare development plans annually, throughout the Project implementation period, which shall specify (i) the number of facilities to be constructed or renovated each year, and (ii) related capital and recurrent costs.	Schedule 6 para. 16	**Complied with.**
29.	In addition to the Loan proceeds, the Borrower shall provide financial support to the Project provinces for renovation of SVPs, CRHs and other medical facilities in a timely manner.	Schedule 6 para. 17	**Complied with.**
30.	The Borrower shall ensure that the relevant Project province governments complete the civil works with respect to upgrading physical infrastructure of health facilities in a timely manner prior to procurement of the necessary equipment under the Project.	Schedule 6 para. 18	**Complied with.**

No.	Covenants	Reference in Loan Agreement	Status of Compliance
31.	If by the time of the mid-term review, resources needed for SVP equipment procurement in the Project Provinces are not available through the Health-II Project or other donor funded projects, the Borrower shall provide through budgetary allocation and in a timely manner, the necessary resources required for procurement of such equipment.	Schedule 6 para. 19	**Complied with.**
32.	For the purpose of complying with the requirements of this Loan Agreement with respect to annual submission of audited financial statements, proceeds of the Loan may be used to finance expenditure for private sector auditors and translation of auditors' reports into English, provided that (i) such auditors have qualifications, expertise and terms of reference acceptable to ADB, and (ii) the recruitment process is acceptable to ADB.	Schedule 6 para. 21	**Complied with.**
	Others		
33.	Established, Staffed, and Operating PMU/PIU.	Schedule 6 para. 3 (a)	**Complied with.** The Joint Project Implementation Bureau was established for the ADB and World Bank projects.
34.	After the conclusion of negotiations but before the signing of the contract, ADB shall be furnished with the contract as negotiated for approval. Promptly after the contract is signed, ADB shall be furnished with 3 copies of the signed contract. If any substantial amendment of the contract is proposed after its execution, the proposed changes shall be submitted to ADB for approval.	Schedule 6 para. 3 (e)	**Complied with.**

CRH = central *rayon* (district) hospital; COM = The Cabinet of Ministers of Uzbekistan; CPE = continuous professional education; HMIS = health management information system; ICD = international classification of diseases; IEC = information, education, and communication; JPIB = joint projects implementation bureau; LA = Loan Agreement; MOH = Ministry of Health; NICU = neonatal intensive care unit; OH = province hospital; OPIB/PIB = *oblast* (province) project implementation bureau; PHC = primary health care; PMU/PIU = project management unit; PSC = Project Steering Committee; SVP = rural doctoral points; U5MR = under-5 mortality rate; WB = World Bank; WCH = woman and child health; WHO = World Health Organization
Source: JPIB Report, 2012.

PROPOSED GENDER ELEMENTS

1. The project was categorized as having gender equity as a theme. Gender equality was incorporated into the overall project design as the project aimed to: (i) integrate primary health care into the medical care system; (ii) update policies related to women and children to international standards, and consolidate and strengthen referrals for woman and child health (WCH) services; (iii) optimize human resource development, and (iv) build the institutional capacity for retraining doctors and nurses across the country.

2. The project design and monitoring framework (DMF) included several gender indicators for the project impact, including the following: (i) reduction of maternal mortality rates (MMR) by 20%; (ii) reduction of infant mortality rates (IMR) by 25%; (iii) reduction of incidence of moderate iron deficiency anemia among pregnant women to 22%; (iv) increase in contraceptive prevalence among married women to 70%; (v) increase in the percent of pregnant women receiving their first antenatal care by a trained health professional within the first trimester to 50%; (vi) increase in the percent of pregnant women with anemia receiving iron supplements by 10%; (vii) increase in the use of birth spacing counseling by 20%; and (viii) training of 20% (per year, per province) of nurses/midwives; obstetricians and gynecologists; pediatricians; and hospital and health managers through the new retraining program. The project also aimed to reduce the burden of disease for women, and to increase women's social contribution to their families and communities.

3. The project achieved the following results: (i) MMR declined from 31.4 in 2004 to 23.1 in 2011, i.e. a 26.4% reduction; (ii) IMR declined from 15.2 per 1,000 live births in 2004 to 11.2 in 2009, 10.9 in 2010, and 10.4 in 2011; (iii) a 2005 study in the Republic of Karakalpakstan and Khorezm and Fergana provinces showed 15.7% of pregnant women had moderate anemia (since 2010, multivitamins containing iron and folic acid have been distributed to pregnant women in rural areas free of charge, using state funds); (iv) contraceptive prevalence among all fertile-aged women (including unmarried women) was 56.6% in 2009, 52.9% in 2010, and 56.6% in 2011; (v) 82.8% of pregnant women received their first antenatal care from a trained health professional in 2009, and 87.7% in 2010; (vi) in 2011, 57% of pregnant women with anemia received iron supplements; (vii) better contraception counseling increased the number of women spacing births for at least 3 years; (viii) birth spacing of less than 2 years declined from 8% in 2009 to 6.8% in 2010; and (ix) more than 16,000 nurses (instead of 11,717 planned) were retrained in six modules, 1,387 obstetricians and gynecologists (instead of 1102 planned) were trained, about 44.2% of pediatricians were trained, and 251 health managers (including district hospital managers) were trained in different management courses (instead of 133 planned).

4. At the community level new ideas on WCH were introduced. In the maternity centers, "partnership deliveries" (where relatives can be present) is a major change that was quickly adopted by both health professionals and the general population. Maternity and perinatal centers became "mother and baby friendly". Newborns are no longer separated from their mothers except when necessary for their survival. The delivery rooms are set up to make the mother feel as close to home as possible in a pleasant environment.

5. The training of nurses and midwifes and retraining of WCH specialists were an essential component to ensure knowledge transfer as well as changes in the attitude and practice of healthcare professionals. The project ensured full integration of WCH in the health system by

training professional at all levels. The ultimate goal was to reach gender equality in the training, recruitment, and promotion of health workers.

6. Training courses for nurses on seven subjects have been developed, 484 trainers prepared, more than 20,000 PHC facility nurses have been trained and more than 3,500 WCH care specialists have been re-trained, surpassing the targets of 12,000 patronage nurses and 2,500 medical doctors. In addition the necessary equipment (servers, computers, uninterruptible power supply, printers, and software) was procured under the project jointly with World Bank Health-II project, and 70 Ministry of Health staff were trained to use information and communication technology in their daily activities.

7. Specific attention to gender issues in several project activities led to an increase in women's access to health services and many practical benefits that are likely to bring about significant improvements in women's health status. Reduced distance to health facilities and better services mean that more women were able to be treated in hospitals.

8. New facilities and equipment and upgraded facilities greatly strengthened the capacity of the hospitals to better respond to the needs of women and children, who make up a very high proportion of patients. The project resulted in better facilities for mothers and expectant women.

9. The project's considerable investment in training medical staff is also likely to have a positive impact on the delivery of improved health services to women and children. Women make up a large percentage of health workers and benefited from training relative to their employment levels. Provinces exceeded the gender target of 50% participation by women in training as a whole. The selection criteria for training gave priority to women.

10. **Conclusion and recommendations.** The most significant achievements of the project are: (i) strengthened health care services in maternity facilities for women and children; (ii) established referral system for patients of WCH-related facilities; (iii) standardized provision of obstetric and pediatric care in WCH-related facilities; (iv) medical care monitoring and quality control system for continuous professional education for medical staff, especially women; and (v) new undergraduate and postgraduate education training programs for pediatrics and neonatology. Overall the project also successfully promoted participation by women in training, service delivery and WHC activities. As a result, more women and children benefited from better services. However, the project could have focused more on regular collection of sex-disaggregated data, and the role of women in the sector in general.