

Annex E: Uzbekistan Country Findings

Background: Uzbekistan faces the same challenges regarding governance as the other countries in Central Asia. It also inherited the Soviet legacy of a health system that was over-regulated and punitive. Reforms not only required the creation of new policies and laws support the process, but also dramatic shifts in roles and responsibilities of government institutions. In addition, a monitoring and evaluation system that could provide data and evidence to guide policy decisions was also needed.

Performance Monitoring Plan Analysis: The Strategic Objective for Uzbekistan is to increase the percentage of outpatient visits for primary care, thereby decreasing the dependence on specialty care. There are 21 indicators of performance for the SO and four IRs. Of these, 17 were met or exceeded, 3 are in suspension, and one was not met. A discussion of the usefulness of these indicators is discussed below.

The SO indicator addresses the percentage of the population covered by the rural PHC reforms. While the percentage has been increasing, annual growth in the percentage of the population covered in the original pilot sites between 06 and 07 was very small at 2.5 percentage points or less. This slow growth in coverage contrasts with the oblasts added in the 2006 where over the first year coverage increased 30 percentage points in Khorezm and 21.5 percentage points in Karakalpakstan. The data also shows that the baseline for PHC coverage is quite high for the 4 oblasts where Zdrav will begin working on PHC reform roll out in 08 (55-68%). In these same 4 oblasts the baseline percentage of PHC outpatient visits is quite low (34.5% in one and less than 28% in the other three). The PMP tables do not provide information about the ideal target ratio of primary to specialty care. Without this context it is difficult to judge the significance of the targets for the growth in primary care visits thus far.

There are two indicators for the Intermediate Result pertaining to Stewardship, and both were met. The first is “Regulations permitting national roll-out of oblast funds pooling and per capital payment system for the rural PHC facilities, and urban PHC and case-based hospital payment system pilots critical to Uzbekistan to enable changes in financing and management of health facilities in the next phase of the reforms.” With such a broad scope, there was a modest target of one for 2007, with 2 being achieved. The second indicator was “number of products created to enhance policy dialogue or policy marketing/participation submitted to government or used for advocacy or public outreach.” The target of 10 was overshoot, with 31 such products being created. As with the indicators for the SO, it is not clear from the Stewardship indicators what the end point would be. It might be more useful to have a list of reform provisions that are vulnerable without further governmental action. The targets could track the number and/or quality of these that are in place. It is not clear whether a Cabinet of Ministers Resolution on oblast pooling and per capita financing has the force of law that will assure enduring change. This change in selection of targets would help USAID to be more focused about the pending legal and policy priorities needed to protect USAID supported

reforms. The list of products is too broad to be useful. It shows a high level of activity, but is not helpful in gauging progress.

The six indicators for Resource Use are appropriate reference points for progress in establishing new systems for financing health care and managing health care utilization. However, three of the indicators, IR 3.2.3 C, E, and F, do not include contextual information regarding the total universe. Therefore, it is not possible to determine what the ideal outcome or end point would be. This contextual information should be added to the notes.

For the Service Delivery IR, the 8 indicators address all the priorities in this area with the exception of EBM, which should be explicitly referenced. One possibility might be the number of medical school disciplines (out of a total of x number of disciplines) that use EBM and CPGs in their curriculum. Three of the indicators for this IR are in suspension awaiting decisions of either the ADB or GoU. Of the other five, one of the two targets for IR 3.2.2 H was not met. IR indicator 3.2.2 H addresses the PHC practices with quality improvement systems. The two targets measure 1) the percentage of PHC practices with QI systems in the whole country and 2) the percentage for the Ferghana pilot only. While the Ferghana pilot target was exceeded (52.7% actual compared to a target of 40%), the percentage for the whole country has lagged for three years (e.g., 12.4% actual compared to a target of 15% for 2007). The presentation of the back-up data for the indicator is quite good as it includes data on the total number of PHC practices, thus providing context for an end point of performance for this indicator. Indicator IR 3.2.2.2 A, “Adherence to select evidence-based CPGs or standards of care improved in FGPs by at least 50%,” is ambiguous as to the intended denominator for the 50%.

The IR for Population and Community Health has 3 indicators that were well chosen, but the targets do not represent stretch goals. The indicator for IR 3.2.1 “Percentage of PHC practices enrolled or assigned population with knowledge about relevant health topics” has the same target of 60% through 2009 with a 2006 baseline of 61%. The targets for IR indicator 3.2.1B part A “number of entities which serve as mechanisms or channels to empower health action by an individual or community” was exceeded by over 100% in 2007. IR indicator 3.2.1 B Part B “Number of interventions which increase the capacity of the entities to serve as mechanisms or channels to empower health action by an individual or community” was exceeded by 80%.

Stewardship: In contrast to its regional counterparts, the Government of Uzbekistan (GoU) was slower to open its doors to health reform. Health reform was launched in 1998 through a Presidential decree on state reform of the health care system in Uzbekistan. Addressing social reforms broadly, this decree included the framework for subsequent health reform legislation. Uzbekistan reform efforts are assisted with loan projects from the World Bank (WB) and the Asian Development Bank (ADB), which provide \$40 million each in loan funding. The WB loan is intended to facilitate the health reform process and the ADB loan focuses on strengthening maternal and child health services. The work of the two banks is harmonized through a Joint Program Implementation Board (JPIB). Tensions between the U.S. and Uzbek governments and

minimal civil society engagement present continued challenges for success in the reform process, however.

ZdravPlus II focused its Stewardship efforts in Uzbekistan on 1) legal and policy change, 2) institutional structure, roles and relationships, 3) policy marketing and public relations, 4) monitoring and evaluation, and 5) donor/project collaboration and coordination. ZdravPlusII's role as a key partner of the JPIB has been to assist the GoU by drafting seminal policy and legal documents and conducting studies on operational issues to improve and support the legal and policy decisions related to reforms. Key achievements have been COM resolution #217 (2005) which accepted oblast pooling and recognized the Oblast Health Department (OHD) as the health purchaser, MOH order #484 (2005) which put forward guidelines for roll-out of rural capitated financing reforms, MOH order #12 (2006) which outlined urban PHC reform model concepts, MOH order #432 (2007), which provided guidelines for budget calculation of reformed PHC facilities. In addition, legal documents for case-based hospital payment system pilots are pending, and policy concept papers have been developed for urban PHC, hospital payment systems, QI, EBM, and CME. These achievements represent important steps in improving efficiency and effectiveness of health care services and are remarkable achievements given the operating environment.

The coordinated efforts of the JPIB and ZdravPlus II have been critical to making progress with governance reforms in Uzbekistan, but the government structure regarding policy decision-making creates challenges and makes the process more labor intensive. There is no health policy unit within the MOH. Instead, a department for each topical area (i.e. MCH) handles policy issues that relate to their topic. Cross-cutting policy changes, such as rural PHC, require the creation of a working group that involves all relevant departments.

The Stewardship function is critical to the progress of ZdravPlus II's work in the other components as little is accomplished in Uzbekistan without prior legal and political authorization, making Resource Use, Service Delivery and Population/Community Health inextricably linked to Stewardship. Continued efforts in Stewardship will certainly be needed to refine the legal and policy structure in order to ensure continued reforms in the other component areas. The Resource Use and Service Delivery components have seen some successes to-date under the legal frameworks created by ZdravPlus II's assistance with governance improvements. The national roll-out of the rural PHC financing and management reforms is largely complete, and this has been ZdravPlus II's primary accomplishment in Uzbekistan especially as it now serves as the model for the pending urban PHC roll-out. Indicators and monitoring systems have been set up to capture both rural and urban finance and management reforms, and quality improvement components are being incorporated into these reforms. However, the development of civil society has suffered under the tenuous situation in Uzbekistan. There is very limited NGO activity, with the GoU revoking the registration of many international and local NGOs. In addition, community organizations are almost always quasi-governmental. This has significantly limited ZdravPlus II's plans for civil society

activities and the Population/Community Health efforts had to be significantly restructured.

Resource Use: ZdravPlus II activities in the component of Resource Use focus on 1) improving the efficiency of PHC, 2) increasing the equity of health financing, and 3) increasing provider responsiveness to the community. These objectives are addressed chiefly through scaling up a rural PHC financing and management model, establishing a similar program for urban PHC on a pilot scale, and developing a case-based payment system for hospitals.

In earlier contracts, ZdravPlus II supported the development of a per capita financing system for rural PHC centers (SVPs), with pooled contributions at the oblast level to increase equity across rayons (districts). Also for the first time, this model provided the SVPs with some limited flexibility in spending excess funds (i.e, those not consumed by service delivery). The scope of changes in financing and management required establishment of the SVP as an independent legal entity. Once this complex development process was completed, expansion of the model greatly accelerated under the current contract, reaching 2867 SVPs in 2007, with complete national coverage expected in 2008. This is a remarkable achievement in the reform of a system that has long been characterized by perverse incentives to waste resources.

This large-scale expansion reflects ZdravPlus II's long-standing and highly effective cooperation with GoU and major donors in Uzbekistan. The \$30 million World Bank Health I Project supported expansion of the rural PHC health financing model until 2004. Under the subsequent Health II Project, accelerated scale up of the financing model took place in spite of reductions in ZdravPlus II funding levels. Officials from the World Bank described cooperation with ZdravPlus II as critical to the Health II loan health financing component, particularly the project's role in convincing the Ministry of Finance to support reform of rural PHC financing by providing a documented, functioning model for replication under the World Bank loan. USAID's modest, but sustained, investment in ZdravPlus II has had a development impact in orders of magnitude greater than the project's budget.

Further, bank officials credit ZdravPlus II technical assistance with more than achieving an effective health financing reform model for replication. They describe ZdravPlus II's role in the successful implementation of their loan projects as vital. While these large projects could certainly finance a broad range of technical assistance (TA), the mechanisms to do so are cumbersome and provide TA of variable quality and effectiveness. In particular, these mechanisms cannot duplicate ZdravPlus II's comparative advantage of an established country presence, excellent working relations with government and academic counterparts, and cultural competence. In addition, they rate the technical competence of ZdravPlus II staff as excellent. One official summarized this impression: "You can't divorce Bank accomplishments from ZdravPlus II."

Country and regional Bank officials also observed that the difficult and complex reforms in health financing and other areas supported by ZdravPlus II provide models for other

sectors. The underlying principles of basing policy on evidence apply broadly to other sectors, such as agriculture and education. For example, ZdravPlus II's support for accreditation approaches in health may influence approaches in the education sector.

The impact of ZdravPlus II's work in health financing also demonstrates its effectiveness in influencing major strategic decision-making, despite its small budget and its focus on concrete implementation issues. Bank officials observed that ZdravPlus II organized a pivotal conference on regional experiences in health financing, with presentations from advanced programs in Kazakhstan and Kyrgyzstan. This conference addressed tax issues as well as health issues, and attracted attendance by Ministry of Finance. These officials credit the conference with progressive changes in MOF policy.

Facility staff acknowledge that allocations to non-salary expenditures remain low. In the rural and urban facilities visited, managers described substantial constraints on their financial autonomy, even under the new system. In particular, staffing flexibility appears to be limited. The most prominent source of savings mentioned was from utilities. Guidelines for the use of excess funds further restrict the manager's options—25% for staff incentives, 75% for “material and technical” improvements. A challenge that remains to be addressed is developing the ability of facility directors to take a more active role in managing the budget under their control.

Service Delivery: In accordance with GoU priorities, ZdravPlus II's focus is on the development of a cadre of general practitioners (GPs). This category of physician did not exist in the Soviet era, adversely affecting the efficiency of health care and impeding the access of patients to needed services. The project's focus in this area includes developing basic GP training and continuing medical education, introducing evidence-based medical practice, and developing modern approaches to quality assurance (QA) in health care. Quantitative targets for QA activities in 2007 were exceeded in the initial implementation area (Ferghana), but expansion fell slightly short of national targets.

ZdravPlus II has coordinated the development of rural GPs posted in SVPs with its support for reform in resource use and management, creating many potential synergies.

The large scale training of GPs has been accomplished through a 10 month course designed to retrain specialized physicians to provide primary care. World Bank projects have financed training costs, but Bank officials and counterparts in the ministry and in training institutions all agreed that ZdravPlus II's technical role in GP training has been central to the program. ZdravPlus II contributions include a focus on the quality of training, institutionalizing both pre-service and in-service GP training beyond the Bank project, introducing critical content areas (especially the principles of evidence-based medicine and of modern quality improvement), and supporting efforts to measure the quality of care provided under the GP program.

As it has with the World Bank Projects, ZdravPlus II has provided essential technical support to a \$40 million Asia Development Bank Woman and Child Health Development Project that started in 2005, focused on maternal and newborn health. The ministry's

Joint Program Implementation Board (JPIB) credits earlier ZdravPlus II work in MCH as the basis of the design of this project, which plans to extend this model to a national level. Beyond the overall design and testing of the model, ZdravPlus II also supports implementation by providing technical reviews, technical assistance on equipment specifications, advice on updating regulations, design of training, conducting IMCI training, and development of a QI training course for managers (to be given to 260 managers.)

JPIB officials cited specific results from quality monitoring based on Zdrav's assistance, and outlined plans to establish QI teams in all facilities supported by the project.

Population/Community Health: The Population/Community Health component in Uzbekistan supports health promotion and works to market the reforms to both the public and providers. There was little emphasis on and knowledge of prevention during Soviet times, and counseling patients to take responsibility for their own health was minimal. The ZdravPlus II project activities in this component aim to educate and empower the population to take more responsibility of their own health and to exercise their rights under the health care reforms. They also work to help the government better understand the concept of health promotion and build their skills in this area. Initially, ZdravPlus II had planned numerous community mobilization activities such as training of health providers on reform efforts, small grants programs for NGOs, and SVP community boards, but due to the climate regarding community action, this work has been scaled back and refocused through different channels. Currently, much of the health promotion work is taking place through the Patronage Nurse Training Program that is being implemented nationally by the ADB project. With ZdravPlus II support, the nurses were trained in Adult Learning Techniques and Interpersonal Communication Skills. They have now transitioned to the Basic Nurse Assessment Skills piece, learning one new 3-day module of health information every 6 months. The topics covered include IMCI, safe motherhood, family planning, TB, anemia, HIV/AIDS, and STIs. The nurses will also receive a bag with specific supplies included, which will help facilitate their role in the community.

ZdravPlus II is also promoting the Mahalla Health Initiative Groups (MHIGs) which are currently operational in 6 rayons of Ferghana Oblast. There are plans to expand this approach to the rest of the Oblast, but there are challenges to organizing the community members. Under the current climate, ZdravPlus II has had to suspend a variety of plans: to organize town hall meetings to educate the public on the reforms and their rights, to hold open houses at the facilities for community members to learn about the services offered at the SVPs, and to develop manuals on health to be used at schools.

Health promotion activities are included in the Patronage Nurse program, but otherwise are limited to pamphlets and DVD soap operas. These efforts are informational only, and it is unlikely that they will result in significant behavior change. There is also little data regarding community members' knowledge of health reforms and their rights.

Conclusions: Despite the restrictive political environment in Uzbekistan, the ZdravPlus II team has made impressive progress in health reform. The cooperation with the World Bank and Asian Development Bank presents a united front to the Uzbek government, and counterparts respond to their collective efforts. While working with the Uzbek government does require tenacity and persistence, the Uzbek government clearly values the technical inputs of the ZdravPlus II, as was evidenced when they intervened to ensure ZdravPlus II could continue working in-country. There has been a great deal of effort to lay the political road map for reform, and by the end of the project the rollout of both rural and urban PHC should be complete. However, additional inputs are needed to further refine the skills and responsibilities of those working within the new system; for example, promoting expansion and creativity within EBM and allowing for more ownership and autonomy of facility financial management. ZdravPlus II is well-positioned to address these topics, provided that current funding levels and political relationships are maintained.

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Background: Uzbekistan is led by a dictatorship and faces the same challenges regarding governance as the other countries in Central Asia. It also inherited the Soviet legacy of a health system that was over-regulated and punitive. In contrast to its regional counterparts, the Government of Uzbekistan (GoU) was slower to open its doors to health reform. Reforms not only require new policies and laws to support the process, but also dramatic restructuring of the roles and responsibilities of government institutions. In addition, a monitoring and evaluation system that could provide data and evidence to guide policy decisions is needed.

Health reform was launched in 1998 through a Presidential decree on state reform of the health care system in Uzbekistan. Addressing social reforms broadly, this decree included the framework for subsequent health reform legislation. Uzbekistan reform efforts are assisted with loan projects from the World Bank (WB) and the Asian Development Bank (ADB), which provide \$40 million each in loan funding. The WB loan is intended to facilitate the health reform process and the ADB loan focuses on strengthening maternal and child health services. The work of the two banks is harmonized through a Joint Program Implementation Board (JPIB). Tensions between [levels of?] governments and minimal civil society engagement present continued challenges for success in the reform process, however.

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system for hospitals. All five quantitative indicators for this area for 2007 have been met or exceeded (take out since PMP will be discussed at the beginning?).

In earlier contracts, ZdravPlus II supported the development of a per capita financing system for rural PHC centers (SVPs), with pooled contributions at the oblast level to increase equity across rayons (districts). Also for the first time, this model provides the SVPs with some limited flexibility in spending excess funds (i.e., those not consumed by service delivery). The scope of changes in financing and management required establishment of the SVP as an independent legal entity. Once this complex development process was completed, expansion of the model greatly accelerated under the current contract, reaching 2867 SVPs in 2007, with complete national coverage expected in 2008. This is a remarkable achievement in the reform of a system that has long been characterized by perverse incentives to waste resources.

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Country and regional Bank officials also observed that the difficult and complex reforms in health financing and other areas supported by ZdravPlus II provide models for other sectors. The underlying principles of basing policy on evidence apply broadly to other sectors, such as agriculture and education. For example, ZdravPlus II's support for accreditation approaches in health may influence approaches in the education sector.

The impact of ZdravPlus II's work in health financing also demonstrates its effectiveness in influencing major strategic decision-making, despite its small budget and its focus on concrete implementation issues. Bank officials observed that ZdravPlus II organized a

pivotal conference on regional experiences in health financing, with presentations from advanced programs in Kazakhstan and Kyrgyzstan. This conference addressed tax issues as well as health issues, and attracted attendance by Ministry of Finance. These officials credit the conference with progressive changes in MOF policy.

ZdravPlus II's support for per capita financing involves **only public funds ? (not clear what other funds would be available)**, and staff acknowledge that allocations to non-salary expenditures remain low. In the rural and urban facilities visited, managers described substantial constraints on their financial autonomy, even under the new system. In particular, staffing flexibility appears to be limited. The most prominent source of savings mentioned was from utilities. Guidelines for the use of excess funds further restrict the manager's options—25% for staff incentives, 75% for “material and technical” improvements. A challenge that remains to be addressed is developing the ability of facility directors to take a more active role in managing the budget under their control.

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ZdravPlus II has coordinated the development of rural GPs posted in SVPs with its support for reform in resource use and management, creating many potential synergies.

The large scale training of GPs has been accomplished through a 10 month course designed to retrain specialized physicians to provide primary care. World Bank projects have financed training costs, but Bank officials and counterparts in the ministry and in training institutions all agreed that ZdravPlus II's technical role in GP training has been central to the program. ZdravPlus II contributions include a focus on the quality of training, **institutionalizing both pre-service and in-service GP training beyond the Bank project [have they incorporated EBM into the medical school curriculum? See PMP section and maybe change]**, introducing critical content areas (especially the principles of evidence-based medicine and of modern quality improvement), and supporting efforts to measure the quality of care provided under the GP program.

As it has with the World Bank Projects, ZdravPlus II has provided essential technical support to a \$70 million Asia Development Bank Woman and Child Health Development Project that started in 2005, focused on maternal and newborn health. The ministry's Joint Program Implementation Board (JPIB) credits earlier ZdravPlus II work in MCH as the basis of the design of this project, which plans to extend this model to a national level. Beyond the overall design and testing of the model, ZdravPlus II also supports

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Health promotion activities are included in the Patronage Nurse program, but otherwise are limited to pamphlets and DVD soap operas. These efforts are informational only, and it is unlikely that they will result in significant behavior change. However, it has not been possible to collect baseline data about community members' knowledge of health reforms and their rights.

Add Conclusion