Board of Directors

FOR OFFICIAL USE ONLY

R110-17
6 November 2017

Proposed Loan
Primary Health Care Improvement Project (Uzbekistan)

1. The Report and Recommendation of the President (RRP: UZB 50190-002) on the proposed loan to Uzbekistan for the Primary Health Care Improvement Project is circulated herewith.

2. This Report and Recommendation should be read with *Country Operations Business Plan: Uzbekistan, 2017–2019*, which was circulated to the Board on 19 December 2016 (DOC.IN.492-16).

3. In the absence of any request for discussion and in the absence of a sufficient number of abstentions or oppositions (which should be communicated to The Secretary by the close of business on 27 November 2017), the recommendation in paragraph 36 of the paper will be deemed to have been approved, to be so recorded in the minutes of a subsequent Board meeting. Any notified abstentions or oppositions will also be recorded in the minutes.

For Inquiries: Megan Counahan, Central and West Asia Department
(Ext. 1467)
Annalisa Carlota, Office of the General Counsel
(Ext. 4267)

Report and Recommendation of the President to the Board of Directors

Project Number: 50190-002
November 2017

Proposed Loan
Republic of Uzbekistan: Primary Health Care Improvement Project

Asian Development Bank

CURRENCY EQUIVALENTS
(as of 9 October 2017)

Currency unit	–	sum (SUM)
SUM1.00	=	$0.0001240
$1.00	=	SUM8060.80

ABBREVIATIONS

ADB	–	Asian Development Bank
CVD	–	cardiovascular disease
DALY	–	disability-adjusted life year
HMIS	–	health management information system
JPIB	–	joint project implementation bureau
MOH	–	Ministry of Health
O&M	–	operation and maintenance
PAM	–	project administration manual
PHC	–	primary health care
SDG	–	Sustainable Development Goal
TIPME	–	Tashkent Institute of Postgraduate Medical Education
UHC	–	universal health coverage
WCH	–	Woman and Child Health
WHO	–	World Health Organization

NOTE

In this report, "$" refers to United States dollars.

Vice-President	W. Zhang, Operations 1
Director General	S. O'Sullivan, Central and West Asia Department (CWRD)
Director	R. Hiraoka, Social Sector Division, CWRD
Team leader	M. Counahan, Health Specialist, CWRD
Team members	A. Carlota, Counsel, Office of the General Counsel F. Djumabaeva, Associate Project Analyst, CWRD E. Izawa, Unit Head, Project Administration, CWRD M.I. Martin, Associate Project Officer, CWRD W. Montealto, Operations Assistant, CWRD D. Mukhammadaliyev, Social Sector Officer, CWRD S. Roth, Senior Social Development Specialist (Social Protection), Sustainable Development and Climate Change Department

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PROJECT AT A GLANCE

1. Basic Data — **Project Number:** 50190-002

Project Name	Primary Health Care Improvement Project	**Department /Division**	CWRD/CWSS
Country	Uzbekistan	**Executing Agency**	Ministry of Health
Borrower	Uzbekistan		

	2. Sector	**Subsector(s)**	**ADB Financing ($ million)**
✓	**Health**	Health system development	45.00
		Total	**45.00**

3. Strategic Agenda	**Subcomponents**	**Climate Change Information**	
Inclusive economic growth (IEG)	Pillar 2: Access to economic opportunities, including jobs, made more inclusive	Climate Change impact on the Project	Low
Environmentally sustainable growth (ESG)	Eco-efficiency		

4. Drivers of Change	**Components**	**Gender Equity and Mainstreaming**	
Governance and capacity development (GCD)	Client relations, network, and partnership development to partnership driver of change Institutional development Organizational development	Gender equity (GEN)	✓
Knowledge solutions (KNS)	Application and use of new knowledge solutions in key operational areas		

5. Poverty and SDG Targeting		**Location Impact**	
Geographic Targeting	No	Rural	High
Household Targeting	No		
SDG Targeting	Yes		
SDG Goals	SDG3, SDG5, SDG10		

6. Risk Categorization: Low

7. Safeguard Categorization **Environment:** C **Involuntary Resettlement:** C **Indigenous Peoples:** C

8. Financing

Modality and Sources	**Amount ($ million)**
ADB	**45.00**
Sovereign Project (Concessional Loan): Ordinary capital resources	45.00
Cofinancing	**0.00**
None	0.00
Counterpart	**13.80**
Government	13.80
Total	**58.80**

Source: Asian Development Bank

I. THE PROPOSAL

1. I submit for your approval the following report and recommendation on a proposed loan to the Republic of Uzbekistan for the Primary Health Care Improvement Project.

2. The proposed project will support the government's health service optimization process, which aims to improve and expand the primary health care (PHC) services delivered in rural areas. The process will bring health services closer to the people and improve early diagnosis, treatment, and chronic care with the goal of achieving healthy life expectancy and productivity. The project will strengthen the rural health sector by providing newly established rural family polyclinics with modern equipment and health workforce development to expand their service delivery. The project will be supported by tools to monitor the government's broader PHC reform efforts and will include the pilot test of a digital health management information system (HMIS) in a rural region.

II. THE PROJECT

A. Rationale

3. **Country profile**. Uzbekistan is a middle-income country of about 32 million people, almost two-thirds of whom live in rural areas. Uzbekistan's economy has grown 7.6% per year on average during 2012–2016, which has resulted in an increase of per capita gross national income from $420 in 2003 to $2,220 in 2016[1] and a decline in the poverty rate from 14.1% in 2013 to about 12.5% in 2016.[2] Despite sustained high economic growth, rural–urban disparities remain. Rural household income in 2015 was 46.0% of the national average. In 2017, the government adopted a 5-year national development strategy, which sets out five priority areas: (i) governance and public administration; (ii) rule of law and the judicial system; (iii) economic development and liberalization; (iv) social development; and (v) security, tolerance, and foreign policy.[3] The strategy identifies inclusive growth and continued economic diversification as key to its reform objectives.

4. **Health sector policy and performance**. When Uzbekistan declared its independence in 1991, its health system needed significant restructure and reform to meet existing and future health needs. It was centralized, aging, and hospital-dominated; and its workforce could not meet the future needs of the population. It needed to transition to new forms of management, financing, and health care provision.

5. Uzbekistan recognized these challenges and placed high importance on sector reform, starting with PHC reform in 1999. Under the State Health System Reform Program, it improved and modernized health infrastructure, trained staff, and pilot-tested financing and management reforms to promote innovation. Substantial investment in tertiary care resulted in the establishment of multi-profile pediatric and regional hospitals, and the upgrade of district and 10 other specialized hospitals. With the help of the Asian Development Bank (ADB) and the World

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[1] World Bank Open Data. Uzbekistan. Gross National Income per Capita, Atlas Method (current US$) https://data.worldbank.org/country/uzbekistan (accessed 4 September 2017).

[2] World Bank. 2017. The World Bank in Uzbekistan: Country Snapshot. April 2017. http://pubdocs.worldbank.org/en/421341493272766409/Uzbekistan-Snapshot-April-2017.pdf. p. 3.

[3] Government of Uzbekistan. 2017. *The Strategy of Action of the Republic of Uzbekistan in Five Priority Development Areas between 2017 and 2021*. Presidential Decree No. PP-2857. Tashkent (7 February).

Bank, reforms, particularly structural and financing, have continued with the implicit aim of improving accessibility, equity, and quality of care through health system strengthening.[4]

6. The health indicators show significant and continuous improvement since 1991. In 1990–2015, major improvements were seen in the maternal mortality ratio and the under-5 and infant mortality rates. During the period, the maternal mortality ratio fell from 66 to 36 per 100,000 live births; the mortality rate for children under 5 years declined from 48.2 to 15.1 per 1,000 live births; and the infant mortality rate dropped from 35.5 to 11.4 per 1,000 births.[5]

7. However, the health indicators for noncommunicable diseases (chronic ones like cancer and diabetes), especially for cardiovascular disease (CVD), show alarming trends with escalating premature mortality and morbidity rates.[6] CVD, which causes premature death and loss of productive life years, is estimated to cause more than 45% of all annual deaths worldwide[7] and is the leading cause of adult mortality in Uzbekistan.[8] CVD-specific mortality rates for men (238 per 1,000 people) are significantly higher than those for women (133 per 1,000 people) largely because of CVD risk differences.[9] To reduce risks and improve mortality rates, Uzbekistan needs to improve and bring PHC services closer to patients.

8. **Health system financing**. Public spending on health care marginally increased between 2010 and 2014 both in absolute terms and in relative terms (as a proportion of total government expenditure, gross domestic product, and per capita). Total health expenditure as a proportion of total public expenditure increased from 8.67% in 2010 to 10.74% in 2014. Health expenditure per capita increased from $75.74 to $124.11 in real terms, indicating a commitment to strengthen the sector.[10] In 2012, the country spent 5.9% of its gross domestic product on health. In the same year, public financing sources (mostly raised through taxes) accounted for 53.1% of total health spending, with the remainder coming mostly in the form of out-of-pocket expenditure.[11] Uzbekistan funds secondary care on an input basis and is increasingly self-financing through user fees. PHC is funded predominantly through tax-based public financing, and, as laid down by policy, all citizens are entitled to a package of care, including services to cover chronic conditions. The planned social health insurance system and ongoing PHC reforms will help improve financial sustainability of the health system.[12] The private sector plays a small part in Uzbekistan's health system and is unlikely to provide these improved services because of the low rate of revenue return.

9. **Primary health service delivery**. Inequalities and differences in the health status and ability of the population to access health services are seen between people living in urban and

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[4] The national priority areas in health policy included the protection of maternal and child health, the prevention and control of infectious diseases, the protection of the environment, and the strengthening of tertiary care services.

[5] Ministry of Health statistics, 2016.

[6] Global Health Data Exchange. Global Burden of Disease Study 2015. http://ghdx.healthdata.org/gbd-2015/data-input-sources (accessed 5 June 2017).

[7] N. Townsend et al. 2015. Cardiovascular Disease in Europe—Epidemiological Update 2015. *European Heart Journal*. 36 (40). pp. 2696−2705.

[8] CVD is the leading cause of deaths worldwide, but the introduction of risk-based PHC management has halved CVD mortality rates in many countries. Modern diagnostic equipment will help establish risk-based systems in Uzbekistan.

[9] Before menopause, women are significantly less vulnerable to heart disease than men. Post-menopause, however, the mortality risk for female and male equalizes. Current equipment cannot detect microvascular heart disease, which accounts for most heart attacks of post-menopausal women. Modern diagnostic equipment will be able to detect it.

[10] World Bank. Health expenditure per capita (http://data.worldbank.org/indicator).

[11] M. Ahmedov et al. 2014. Uzbekistan: Health System Review. *Health Systems in Transition*. 16 (5). pp. 1–137.

[12] Republic of Uzbekistan. 2017. *"On measures for the further development of private healthcare sector"*. Presidential Decree №PP-2863. Tashkent (1 April).

rural areas. The PHC segment still faces problems of service quality and availability in general, but specifically in rural areas. In 2017, a presidential decree outlining a restructured health service delivery system accelerated progress in PHC reform efforts.[13] Before the decree, PHC was provided through rural health points that offered very limited health care and diagnostic services, which led people, particularly those in rural communities, to seek health care from higher-level clinics or hospitals. These health facilities are typically far from their homes, and the cost of the care they provide, both to the government and to the individual, is higher. The service optimization process of the Ministry of Health (MOH) will consolidate PHC services and establish 793 rural family polyclinics. The optimization process aims to (i) increase the availability of a wider spectrum of health services not currently available to rural populations and (ii) prevent people from bypassing PHC facilities for nonemergency care to reduce the overutilization of secondary and tertiary health facilities.

10. **Rural family polyclinics**. Rural family polyclinics will provide improved health services through modern equipment and a well-trained health workforce, and will become a key component of the PHC system. Polyclinics are PHC facilities that provide general and specialist health services, including diagnosis, to people on an outpatient basis. They are independent of hospitals and ideally provide 60%−70% of the population's health needs.

11. Rural family polyclinics will be in every district of the country. Their site was determined by MOH and was based on a population analysis (about one clinic per 10,000 residents) and/or the distance between clinics. In less populated districts, clinics obviously will service fewer people but will be within reach. Decommissioned rural health points will be converted to housing for health staff to attract staff to rural areas and allow longer operating hours. The project will not carry out any civil works because the existing clinics are in sufficiently good order to use the modern diagnostic equipment now, and all the equipment is portable.

12. The project will support government efforts to improve PHC services by providing key equipment and training for the 793 newly established rural family polyclinics.[14] The equipment that will be procured under the project is not currently available in the rural PHC system. The equipment, and training on its use, will increase the chances of overcoming Uzbekistan's key health challenges, particularly those relating to CVD, antenatal care, and disease prevention. Matching an investment in equipment with training to increase the diagnostic and therapeutic skill of PHC staff will contribute to more equitable distribution of the health workforce, increase the quality of diagnosis and reduce the irrational use of drugs, reduce inappropriate hospital admissions, and increase the availability of health services in rural areas. Improving diagnostic and therapeutic interventions significantly strengthens a country's health system.

13. **Value added by ADB assistance**. The project aligns with the United Nations Sustainable Development Goal (SDG) 3 on universal health coverage (UHC)[15] and SDG 5 on universal access to reproductive health.[16] The project will promote SDG 3's clear focus on equity, including equity-focused monitoring and evaluation, to help ensure that targets are being met and that no one is being left behind, and to contribute toward achieving SDG 5. A strong health system is needed to meet these SDGs, and expanding and optimizing the scope of PHC services through

[13] Government of Uzbekistan. 2017. *Measures of Improving the Organization of Activities of Primary Medico-Sanitary Care Institutions in the Republic of Uzbekistan*. Presidential Decree No. PP-2857. Tashkent (1 April).

[14] ADB provided project preparatory technical assistance for the Electronic Healthcare Development Project (TA 9148-UZB, $800,000, approved on 5 August 2016).

[15] WHO defines UHC as all people receiving the health services they need without suffering financial hardship.

[16] SDG 5's indicator 5.6 is to ensure universal access to sexual and reproductive health and reproductive rights.

infrastructure or equipment investments also needs to be linked to a health system improvement framework.[17] The project will apply the UHC monitoring framework of ADB and the World Health Organization (WHO), which will provide an opportunity to monitor the performance of the health system and its reforms and to ensure that the investments will help achieve UHC in Uzbekistan.[18] This framework would not have been incorporated without ADB financing. MOH will be able to use the results provided to refine policies and programs and help reduce inequities in service access, coverage, and health and well-being.

14. **Link to national development strategy and ADB sector priority**. The project aligns closely with Uzbekistan's national goal of improved quality of life and better services and its health strategic plans.[19] It is in line with ADB's country operations business plan, 2016–2018 for Uzbekistan[20] and paves the way for a long-term programmatic approach consistent with ADB's health operations plan.[21]

15. **ADB experience and lessons learned**. The project directly builds on the achievements and lessons learned from ADB's previous support for the health sector. In 2004, ADB approved a sovereign loan of $40 million for the Woman and Child Health (WCH) Development Project, which demonstrated 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 but a part of broader health sector reforms. Strong collaboration among partners and responsiveness to actual needs was an important contributor to the success of the various programs."[22]

16. **Development coordination**. Under previous health projects financed by ADB and the World Bank, MOH established a joint project implementation bureau (JPIB) and development partner coordination mechanisms.[23] Implementation of the project will be closely coordinated with the projects of other development partners—such as the third and fourth health projects of the World Bank, which are also procuring equipment—to ensure that there is no duplication of procurement.[24] In addition, the project team will work closely with WHO and the United Nations Children's Fund (UNICEF) to monitor the PHC reform and adapt the ADB–WHO UHC monitoring framework for Uzbekistan.

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[17] A health system needs staff, funds, information, supplies, transport, communications, and overall guidance and direction to function. Strengthening health systems means addressing key constraints in each of these areas.

[18] ADB. 2016. *Monitoring Universal Health Coverage in the Western Pacific: Framework, Indicators, and Dashboard*. Manila. https://www.adb.org/publications/monitoring-universal-health-coverage-western-pacific.

[19] Laws and presidential decrees generally set the overall priorities and directions for health reforms. Follow-up decrees by the Cabinet of Ministers and MOH provide more detailed guidance and implementation plans.

[20] ADB. 2015. *Country Operations Business Plan: Uzbekistan, 2016–2018*. Manila.

[21] ADB. 2015. *Health in Asia and the Pacific: A Focused Approach to Address the Health Needs of ADB Developing Member Countries—Operational Plan for Health, 2015–2020*. Manila.

[22] ADB. 2012. *Completion Report: Woman and Child Health Development Project in Uzbekistan*. Manila (para. 47).

[23] Government of Uzbekistan. 2015. *About Measures for Enhancement of the Mechanism of Implementation of Investment Projects with Participation of the International Financial Institutions*. Resolution of the Cabinet of Ministers of Uzbekistan No. 334. Tashkent (23 November).

[24] World Bank. Health System Improvement Project. http://projects.worldbank.org/P113349/health-system-improvement-project?lang=en&tab=overview. Preparation is underway for a fourth health project in Uzbekistan, estimated at $92 million.

B. Impact and Outcome

17. The project is aligned with the following impact: level of hospitalization, incidence, and disability of populations in service areas reduced (footnotes 3 and 13). The project will have the following outcome: availability[25] of PHC services in rural areas expanded.[26]

C. Outputs

18. **Output 1: Health services in family polyclinics in rural areas strengthened**. This output will provide equipment to each of the newly established family polyclinics. Each polyclinic will receive the same set of equipment, which has been selected based on a needs assessment and health indications. The set of equipment will include (i) a digital diagnostic ultrasound unit for antenatal care or noninvasive examination of internal organs or vessels; (ii) a 12-lead electrocardiograph for noninvasive routine examination of the heart, which can identify underlying heart conditions; (iii) an ophthalmoscope for eye examinations and an otoscope for ear examinations; (iv) surgical instruments for minor surgical procedures for conditions that can be treated quickly and easily using only local anesthetic; (v) gynecology and midwifery instruments to improve birth outcomes, cancer screening, and reproductive health; (vi) a dental chair and basic dental equipment (vii) a home-visit bag and equipment for nurses to provide home patient care; (viii) a weighing scale with height measurement for physical assessment; and (ix) a computer and printer to facilitate service data reporting. The project will make sure that all procured equipment will be registered with and maintained by MOH's National Maintenance Center, which opened in 2017.

19. **Output 2: Capacity of polyclinic staff enhanced**. This output will provide training to about 2,700 health technology operators, doctors, and nurses at family polyclinics to ensure their competence in using the equipment and to improve their diagnostic and therapeutic skills. This in turn will help improve the quality of care, and public trust in and use of PHC services; and ultimately reduce morbidity and mortality. Under this output, Uzbekistan's medical training institutions will be provided with the necessary training and equipment to institutionalize the skills of their health staff.

20. **Output 3: PHC monitoring tools institutionalized**. This output will provide monitoring tools to monitor and strengthen the performance of the country's health system. The project will pilot-test a digital HMIS, which will incorporate clinic management, in the rural region of Sirdaryo, one of the country's 12 regions. The HMIS developed during the pilot could be readily incorporated in all regions in the future. MOH began a similar HMIS pilot in 24 urban PHC facilities in May 2017. Except for the pilot rural region, monitoring in all other regions will use current paper-based data collection and reporting mechanisms. Monitoring will help ensure that the investments contribute to the achievement of UHC. The monitoring tools will incorporate the same core health and service indicators, whether digital or paper, so they can be directly compared.

D. Summary Cost Estimates and Financing Plan

21. The project is estimated to cost $58.8 million (Table 1). Detailed cost estimates by expenditure category and by financier are included in the project administration manual (PAM).[27]

[25] WHO defines this as the availability of good health services within reasonable reach of those who need them, and where other aspects of service organization and delivery allow people to obtain the services when needed. It is separate from affordability, accessibility, and acceptability.
[26] The design and monitoring framework is in Appendix 1.
[27] Project Administration Manual (accessible from the list of linked documents in Appendix 2).

ADB will finance the expenditures in relation to consulting services, equipment, furniture, monitoring project management, and training.

Table 1: Project Investment Plan
($ million)

Item		Amount[a]
A.	**Base Cost**[b]	
	1. Health services in family polyclinics in rural areas strengthened	53.74
	2. Capacity of polyclinic staff enhanced	0.92
	3. Primary health care monitoring tools institutionalized	1.45
	Subtotal (A)	**56.11**
B.	**Contingencies**[c]	2.69
C.	**Financial Charges During Implementation**[d]	0.00
	Total (A+B+C)	58.80

[a] Includes taxes, duties of $13,360,000 and in-kind contribution of $440,000 (PIU office, utilities and some training). Taxes and duties do not represent an excessive share of the project cost. The government will finance taxes and duties by exemption.
[b] In mid-2017 prices as of 21 August 2017.
[c] Physical contingencies computed at 3.08%. Price contingencies computed at 1.5% on foreign exchange costs.
[d] Includes interest charges.
Source: Asian Development Bank and Ministries of Health and Finance.

22. The Government of Uzbekistan has requested a concessional loan of $45,000,000 from ADB's ordinary capital resources to help finance the project. The loan will have a 25-year term, including a grace period of 5 years; an interest rate of 2% per year during the grace period and thereafter; and such other terms and conditions set forth in the draft loan agreement. The summary financing plan is in Table 2.

Table 2: Summary Financing Plan

Source	Amount ($ million)	Share of Total (%)
Asian Development Bank		
Ordinary capital resources (concessional loan)	45.0	76.5
Government	13.8	23.5
Total	**58.8**	**100.0**

Source: Asian Development Bank and Ministry of Finance.

E. Implementation Arrangements

23. The project will be implemented over 4 years. The executing agency will be MOH. Some of its subordinate institutions, such as UzMedInfo and the Tashkent Institute of Postgraduate Medical Education (TIPME), will participate in the implementation of some project aspects.

24. UzMedInfo is an independent economic entity created by MOH. Its charter explicitly mandates it to introduce information and communication technologies for MOH.[28] UzMedInfo is currently implementing an HMIS in 24 urban polyclinics. MOH will engage UzMedInfo as a consultant for the project via single-source selection to expand and incorporate clinic management, based on the existing infrastructure and platform, into the existing HMIS tools to monitor project and PHC reforms.[29] UzMedInfo will not procure equipment for output 3.

[28] Government of Uzbekistan 2007. Order of the Ministry of Health, No. 17. Tashkent (January 2007).
[29] Eligibility procedures are in para. 1.13 (b)–(c) and single-source selection criteria are in para. 2.30 of the ADB Guidelines on the Use of Consultants (2013, as amended from time to time).

25. TIPME is the republican-level institute providing continuous medical education for doctors and other health professionals, and has two other campuses in Andijan and Samarkand. TIPME will lead and coordinate the training.

26. The number of procurement packages was rationalized during project preparation and the request for proposal for procurement under output 1 will be launched before Board approval to maximize project readiness. The implementation arrangements are summarized in Table 3 and described in detail in the PAM (footnote 27).

Table 3: Implementation Arrangements

Aspects	**Arrangements**		
Implementation period	April 2018–April 2021		
Estimated completion date	31 October 2020		
Estimated loan closing date	30 April 2021		
Management			
(i) Oversight body	The MOH will chair the steering committee, which will comprise the PIU project manager and representatives from MOF, MOH, funding agencies, and development partners (WHO and UNICEF). The steering committee will meet at least twice a year.		
(ii) Executing agency	MOH		
(iii) Implementation unit	PIU under MOH		
Procurement	International competitive bidding	5 contracts	$40.17 million
	Shopping	3 contracts	$0.18 million
Consulting services	Individual consultant selection (national PIU staff)	22 contracts	$0.40 million
	Individual consultant selection	5 contract	$0.47 million
	Least-cost selection	1 contract	$0.03 million
	Single-source selection	1 contract	$0.63 million
a. retroactive financing and advance contracting	MOH has requested advance contracting[a] to (i) recruit PIU staff; (ii) recruit an international procurement expert; (iii) procure equipment (output 1); and (iv) procure PIU vehicle, office equipment, and furniture. Retroactive financing is required to establish the PIU, including staff, and mobilize the international procurement expert. It will not amount to more than 20% of the total ADB loan amount.[b]		
Disbursement	The loan proceeds will be disbursed following ADB's *Loan Disbursement Handbook* (2017, as amended from time to time) and detailed arrangements agreed between the government and ADB.[c]		

ADB = Asian Development Bank, MOF= Ministry of Finance, MOH = Ministry of Health, PIU = project implementation unit, WHO = World Health Organization, UNICEF = United Nations Children's Fund.

[a] ADB has advised the government that approval of advance contracting will not commit ADB to subsequently approve financing for the project.

[b] ADB. 2005. C*ost Sharing and Eligibility of Expenditures for Asian Development Bank Financing: A New Approach*. Manila (R-193-05).

[c] The loan proceeds will finance the cost of items produced and procured in ADB member countries, excluding local taxes and duties, ineligible items, and imports financed under other sources.

Source: Asian Development Bank estimates.

III. DUE DILIGENCE

A. Technical

27. During project preparation, the ADB extensively reviewed the rationale for and technical specifications of the medical equipment requested by MOH. The assessment and health indicator data suggest a solid, evidence-based rationale for the proposed equipment. The electrocardiograph, for example, will help identify underlying heart conditions, which is the leading cause of adult mortality. MOH will be able to maintain the equipment, which is suitable for local conditions. Providing the equipment together with the training will provide an opportunity for the

PHC system to overcome key health challenges relating to CVD, antenatal care, and disease prevention; and strengthen the country's health system.

B. Economic and Financial

28. **Economic**. The project will assist the government in creating strategic and long-term changes to achieve healthy life expectancy and productivity in the country. The project will directly benefit the rural population, particularly poor and vulnerable groups, including women and girls and the medical staff of 793 rural polyclinics. To reflect the true value of the US Dollars (USD), economic benefits and costs are expressed in terms of Purchase Power Parity (PPP) at 2017 base rate, operation and maintenance (O&M) costs were assumed at 3% of the total equipment cost, and the number of disability-adjusted life years (DALY) was improved by 10%.[30] These improvements are reflected in the economic rate of return of 16.8% and a net present value of 69.6 million, which indicate that the project is economically viable.

29. **Financial**. Financial analysis confirmed that the government has the adequate budgetary resources to fulfill its financial obligations under the project.[31] The total annual project cost as a proportion of the government's total annual expenditure ranges from 0.02% in 2018 to 0.12% in 2019, before decreasing to 0.01% in 2021. As a proportion of the government's total health expenditure, the total annual project cost ranges from 0.26 to 0.06% over the same period. The total project cost is significantly less than 1.0% of total government health expenditure. The financial sustainability analysis indicated the government has sufficient capacity to cover annual O&M costs and debt service requirements beyond the implementation period. Spending on O&M is key to maximizing the life of the equipment being purchased under the loan, and the risk of ensuring adequate financing for O&M needs to be monitored closely. The government has a demonstrated track record of maintaining the medical equipment which was provided under ADB's previous health project and have recently established a National Maintenance Center. They have committed to providing post-warranty maintenance through this center and the budget allocation for it is outlined in ministerial orders. Except for the ultrasound machine, all equipment is considered robust and will require limited O&M over its life.

C. Governance

30. The financial management risk is *moderate* mainly because the government has only recently introduced an internal audit system and new measures for financial control and accounting. MOH has extensive experience in the administration of external development partner and donor funded projects. The head of the JPIB staff has 10 years of experience with development partner and donor funded projects. The JPIB continues to coordinate World Bank projects and will be the model for the structure and operations of the PIU for this project. MOH and staff from the States Investment Committee all have experience in complying with ADB standards for financial management and procurement. ADB's Anticorruption Policy (1998, as amended to date) was explained to and discussed with the government and MOH. The specific policy requirements and supplementary measures are described in the PAM (footnote 27).

[30] The DALY measures the overall disease burden, which is expressed as the number of years lost from poor health, disability, or early death. One DALY is considered as one lost year of healthy life. The sum of these DALYs across the population can be thought of as a measurement of the gap between the current health status and an ideal situation where the entire population lives to an advanced age, free of disease and disability.

[31] Financial Analysis (accessible from the list of linked documents in Appendix 2).

D. Poverty, Social, and Gender

31. Uzbekistan faces complex public health challenges, including socioeconomic inequities, escalating health care costs, and a changing disease profile. Overall, 13.7% of the population lives below the national poverty line. Health improvements have multiplicative effects in reducing poverty, improving learning and productivity, and accelerating economic growth. In addition, inclusive growth, sustainable economic development, and national and regional health aims are important policy objectives that cannot be achieved without a healthy population, a strong health system, and reliable PHC services across the country.[32]

32. The project has been classified *gender equity as a theme* because it will directly improve access of women and girls to better health services.[33] Gender is a significant variable for understanding the impact of disease and poor health. Women and girls have other health needs than men and boys. Men and women also have different disease vulnerabilities and may have different levels of access to or understanding of information on disease prevention and treatment. ADB's country gender assessment for Uzbekistan identified some of the numerous complex gender issues related to health. The paucity of sex-disaggregated data makes it difficult to analyze gender-differentiated patterns of access to health care and social protection measures, and acts as a critical impediment for targeted and gender-sensitive social policies and health services for the poor.[34]

E. Safeguards

33. In compliance with ADB's Safeguard Policy Statement (2009), the project's safeguard classification is *category C* for the environment, involuntary resettlement, and indigenous peoples.[35] Environmental impacts during project implementation are expected to be minimal or nonexistent. Minimal health care waste may be generated by some of the equipment, but all rural family polyclinics already have health care waste facilities, policies, and protocols in place, as well as sterilization equipment and policies and procedures to manage it. Since the project will not carry out any civil works, no involuntary resettlement is envisaged. The project will not have an impact on indigenous peoples as defined in the Safeguard Policy Statement.

F. Summary of Risk Assessment and Risk Management Plan

34. The project's risk assessment did not identify risks that were rated *high*. Substantial risks and mitigating measures are summarized in Table 4 and described in detail in the risk assessment and risk management plan.[36]

Table 4: Summary of Substantial Risks and Mitigating Measures

Risks	Mitigation Measures
3.1 Incomplete financial reporting and monitoring. Financial reporting of income and expenditure is not produced automatically and cannot be easily verified for completeness and accuracy by MOH management.	Under new internal audit procedures and recently revised accounting standards, the government has put in place specific financial reporting steps to ensure accurate accounting. With the adoption of an upgraded accounting software, the degree of automation will be increased.

[32] Summary Poverty Reduction and Social Strategy (accessible from the list of linked documents in Appendix 2).
[33] Gender Action Plan (accessible from the list of linked documents in Appendix 2).
[34] ADB. 2014. *Uzbekistan: Country Gender Assessment*. Manila.
[35] ADB. Safeguard Categories. https://www.adb.org/site/safeguards/safeguard-categories.
[36] Risk Assessment and Risk Management Plan (accessible from the list of linked documents in Appendix 2).

Risks	Mitigation Measures
Immature internal audit system. The government put in place a resolution for the financial control and restructure of the accounting and internal audit in budget organizations on 1 September 2017.	The government has recently created an internal audit and financial control services in the Ministry of Health's structure. The new subdivisions will manage the prevention and detection of illegal consumption and theft of budget funds.[a] The project will hire internal auditors to strengthen financial controls, including developing an internal audit manual and adopting annual work plans.
Unreliable electric supply. Rural areas experience interruptions in their electric supply, which might affect the use and maintenance of the project equipment.	The government and the Ministry of Health have assured the Asian Development Bank that measures are being taken to improve the situation and that power supply equipment will be provided to the affected facilities before or in line with the supply of project equipment.
Weak maintenance logistics and/or allocated financing. The large amount of equipment spread over 793 facilities requires substantial efforts and resources for preventive and standard maintenance. Lack of maintenance logistics and/or allocated financing for maintenance (post-warranty) may lead to premature deterioration of equipment.	The government and the Ministry of Health have assured the Asian Development Bank that measures are being taken to improve the situation with regard to maintenance logistics and allocated financing. They are expanding a maintenance authority to cover nationwide maintenance of medical equipment. Capacity-building measures are part of the project (user training through suppliers).

[a] Government of Uzbekistan 2017. *"On further improvement of the mechanism of financing educational and medical institutions and the system of the state financial control"* Presidential decree No. RP-3231. Tashkent (21 August). Source. Asian Development Bank.

IV. ASSURANCES

35. The government and MOH have assured ADB that implementation of the project shall conform to all applicable ADB policies, including those concerning anticorruption measures, safeguards, gender, procurement, consulting services, and disbursement as described in detail in the PAM and loan documents. The government and MOH have agreed with ADB on certain covenants for the project, which are set forth in the draft loan agreement.

V. RECOMMENDATION

36. I am satisfied that the proposed loan would comply with the Articles of Agreement of the Asian Development Bank (ADB) and recommend that the Board approve the loan of $45,000,000 to the Republic of Uzbekistan for the Primary Health Care Improvement Project, from ADB's ordinary capital resources, in concessional terms, with an interest charge at the rate of 2% per year during the grace period and thereafter; for a term of 25 years, including a grace period of 5 years; and such other terms and conditions as are substantially in accordance with those set forth in the draft loan agreement presented to the Board.

Takehiko Nakao
President

2 November 2017

DESIGN AND MONITORING FRAMEWORK

Impact the Project is Aligned with
Level of hospitalization, incidence, and disability of populations in service areas reduced[a]

Results Chain	Performance Indicators with Targets and Baselines	Data Sources and Reporting Mechanisms	Risks
Outcome Availability of PHC services in rural areas expanded[b]	**By 2022** a. Readiness[c] to provide electrocardiograph met by 70% of rural family polyclinics[d] (2017 baseline: not applicable) b. Readiness to provide improved antenatal and reproductive health services through ultrasound for women met by 70% of rural family polyclinics (2017 baseline: not applicable) c. At least 50% of women and men reported increased confidence in consulting rural polyclinics	a–b. WHO facility service and readiness assessment[e] c. Health-seeking behavior survey before and after the project	The government is unable to provide reliable power supply to the rural clinics.
Outputs 1. Health services in family polyclinics in rural areas strengthened	**By 2021** 1a. Standard set of functional equipment installed at 75% of rural family polyclinics[f] (2017 baseline: not applicable) 1b. 100% of supplied equipment registered and integrated with the National Maintenance Center (2017 baseline: not applicable) 1c. At least 50% of the value of the equipment used to diagnose or treat women's health concerns (2017 baseline: not applicable)	1a–c. UzMedInfo equipment inventory list and project procurement plan 1b–c National Maintenance Center (registration database)	The government is unable to expand the maintenance authority to provide nationwide maintenance of the medical equipment.
2. Capacity of polyclinic staff enhanced	2a. 70% of the polyclinic health technology operators certified to use standard set of equipment[g] (2017 baseline: not applicable) 2b. Triennial performance assessment of health technology operations incorporated in the licensing standards for polyclinics (2017 baseline: not applicable).	2a. MOH and PIU reporting 2b. Copy of MOH's licensing standards for polyclinics	Polyclinics experience a high rate of staff turnover.

Results Chain	Performance Indicators with Targets and Baselines	Data Sources and Reporting Mechanisms	Risks
	2c. 90% of women technical and professional staff of polyclinics (or 1000 women) participate in the training on the use of the equipment (2017 baseline: not applicable)		
3. PHC monitoring tools institutionalized	3a. PHC monitoring framework with indicators approved by MOH and implemented (2017 baseline: not applicable)	3a. MOH facility reporting database	Data reported through the routine health information system are inaccurate and not up to date.
	3b. At least 80% of polyclinics provided annual, sex-disaggregated data for the indicator framework (2017 baseline: 0%)	3b–c. MOH website for the data	
	3c. Data visualization tool displaying sex-disaggregated data developed and updated annually[h] (2017 baseline: not applicable)		

Key Activities with Milestones

1. Health services in family polyclinics in rural areas strengthened

1.1 Advertise individual international procurement expert recruitment notice (Q4 2017)
1.2 Advertise invitation for bids for medical and IT equipment using ICB (Q4 2017)
1.3 Award contract and mobilize international procurement expert (Q4 2017)
1.4 Advertise international and national consultants' recruitment notice (Q1 2018)
1.5 Award contract and mobilize international and national consultants (Q1 2018)
1.6 Issue tender documents for equipment (Q1 2018)
1.7 Award and register goods or equipment contracts (Q3 2018)
1.8 Install and commission equipment in the family polyclinics (Q4 2018)
1.9 Register and integrate installed equipment with the National Maintenance Center (Q4 2018)

2. Capacity of polyclinic staff enhanced

2.1 Design, approve, and roll out training package (Q1 2019)
2.2 Incorporate performance assessment of health technology operators into the MOH's licensing standards for polyclinics (Q3 2019)

3. PHC monitoring tools institutionalized

3.1 Advertise individual international consultant notice (Q1 2018)
3.2 Award contract and mobilize international consultant (Q1 2018)
3.3 Engage service provider (Q2 2018)
3.4 Adapt ADB–WHO UHC monitoring tools as agreed by the interministerial working group (Q2 2018)
3.5 Develop and approve monitoring framework with a core sex-disaggregated indicator set (Q3 2018)
3.6 Advertise IT equipment for HMIS development (Q4 2018)
3.7 Design and develop decision-support and accountability visualization tool (Q1 2019)
3.8 Issue hardware tender documents (Q1 2019)
3.9 Award hardware contracts (Q3 2019)
3.10 Orient primary health care managers on the PHC monitoring tools (Q3 2019)
3.11 Supply and install HMIS hardware (Q4 2019)

Project Management Activities

Establish PIU and open advance fund account (Q4 2017)
Conduct the baseline survey and develop the monitoring and evaluation framework (Q1 2018)
Recruit individual consultants (Q1 2018)
Prepare quarterly progress reports and submit to ADB and/or the government (every quarter)

Participate in ADB missions (average twice a year) Conduct the annual audit and submit the audit reports to ADB (every year) Submit project completion report, wind up the project, and close accounts (2021)
Inputs ADB: $45.0 million (concessional OCR loan) Government: $13.8 million
Assumptions for Partner Financing Not applicable

ADB = Asian Development Bank, HMIS = health management information system, ICB = international competitive bidding, IT = information technology, MOH = Ministry of Health, OCR = ordinary capital resources, PHC = primary health care, PIU = project implementation unit, Q = quarter, UHC = universal health care, WHO = World Health Organization.

[a] Government of Uzbekistan. 2017. *The Strategy of Action of the Republic of Uzbekistan in Five Priority Development Areas between 2017 and 2021*. Presidential Decree No. PP-2857. Tashkent (7 February); Government of Uzbekistan. 2017. *Measures of Improving the Organization of Activities of Primary Medico-Sanitary Care Institutions in the Republic of Uzbekistan*. Presidential Decree No. PP-2857. Tashkent (1 April).

[b] WHO defines availability as the availability of good health services within reasonable reach of those who need them, and where other aspects of service organization and delivery allow people to obtain the services when needed. It is separate from affordability, accessibility, and acceptability.

[c] In this context, readiness means that a polyclinic has (i) a functional electrocardiograph and ultrasound machines, (ii) a health technology operator trained over the past 2 years to operate and read results from an electrocardiograph, (iii) a health technology operator trained over the past 2 years to operate ultrasound machines, and (iv) power supply from regular and alternative power sources (natural gas generator).

[d] A polyclinic provides general and specialist examinations and treatments on an outpatient basis at the PHC level and is independent of a hospital.

[e] Numerator: number of targeted polyclinics with readiness to provide electrocardiograph and ultrasound examination. Denominator: number of targeted polyclinics.

[f] The standard set of functional equipment is based on the project procurement plan.

[g] MOH certifies polyclinic health technology operators after they achieve 80% in a standardized post-training competency assessment tool.

[h] This refers to the development and annual updating of a tool to visualize data for indicators in the PHC monitoring framework.

Source: Asian Development Bank.

LIST OF LINKED DOCUMENTS

http://www.adb.org/Documents/RRPs/?id=50190-002-3

1. Loan Agreement
2. Sector Assessment (Summary): Health
3. Project Administration Manual
4. Contribution to the ADB Results Framework
5. Development Coordination
6. Financial Analysis
7. Economic Analysis
8. Country Economic Indicators
9. Summary Poverty Reduction and Social Strategy
10. Risk Assessment and Risk Management Plan
11. Gender Action Plan