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JAPAN INTERNATIONAL COOPERATION AGENCY (JICA)
MINISTRY OF HEALTH, REPUBLIC OF UZBEKISTAN

THE STUDY ON THE RESTRUCTURING OF HEALTH AND MEDICAL SYSTEM IN THE REPUBLIC OF UZBEKISTAN

FINAL REPORT
MAIN REPORT

DECEMBER 2003

SYSTEM SCIENCE CONSULTANTS INC.

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JAPAN INTERNATIONAL COOPERATION AGENCY (JICA)
MINISTRY OF HEALTH, REPUBLIC OF UZBEKISTAN

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FINAL REPORT

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Contents of Final Report

Summary
Main Report (including Appendices)
Supporting Report
Data Book

Foreign exchange rate
USD 1.00=UZS 980 in November 2002 (Main Report Chapter 16 Priority Programs)
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PREFACE

In response to the request of the Government of the Republic of Uzbekistan, the Government of Japan agreed to conduct the Study on the Restructuring of Health and Medical System in the Republic of Uzbekistan, and entrusted the Study to Japan International Cooperation Agency (JICA).

JICA selected and dispatched a study team consisted of 9 members and headed by Mr. Hiroshi Abo, System Science Consultants Inc. six times between November 2002 and November 2003. In addition, JICA set up an advisory committee headed by Mr. Hiroya Ogata, Professor of Graduate School of Medicine, Kyushu University between November 2002 and November 2003, which examined the study from specialist and technical points of view.

The team held discussions with the officials concerned of the Government of Uzbekistan and conducted field surveys at the study area. Upon returning to Japan, the team conducted further studies and prepared this final report.

I hope that this report will contribute to the promotion of this project and to the enhancement of friendly relationship between our two countries.

Finally, I wish to express my sincere appreciation to the officials concerned of the Government of Uzbekistan for their close cooperation extended to the Team.

December, 2003

Kazuhisa Matsuoka
Vice-President
Japan International Cooperation Agency

December, 2003

Mr. Kazuhisa Matsuoka
Vice-President
Japan International Cooperation Agency (JICA)

LETTER OF TRANSMITTAL

Dear Sir,

We have pleasure to submit you the final report entitled "The Study on the Restructuring of Health and Medical System in the Republic of Uzbekistan".

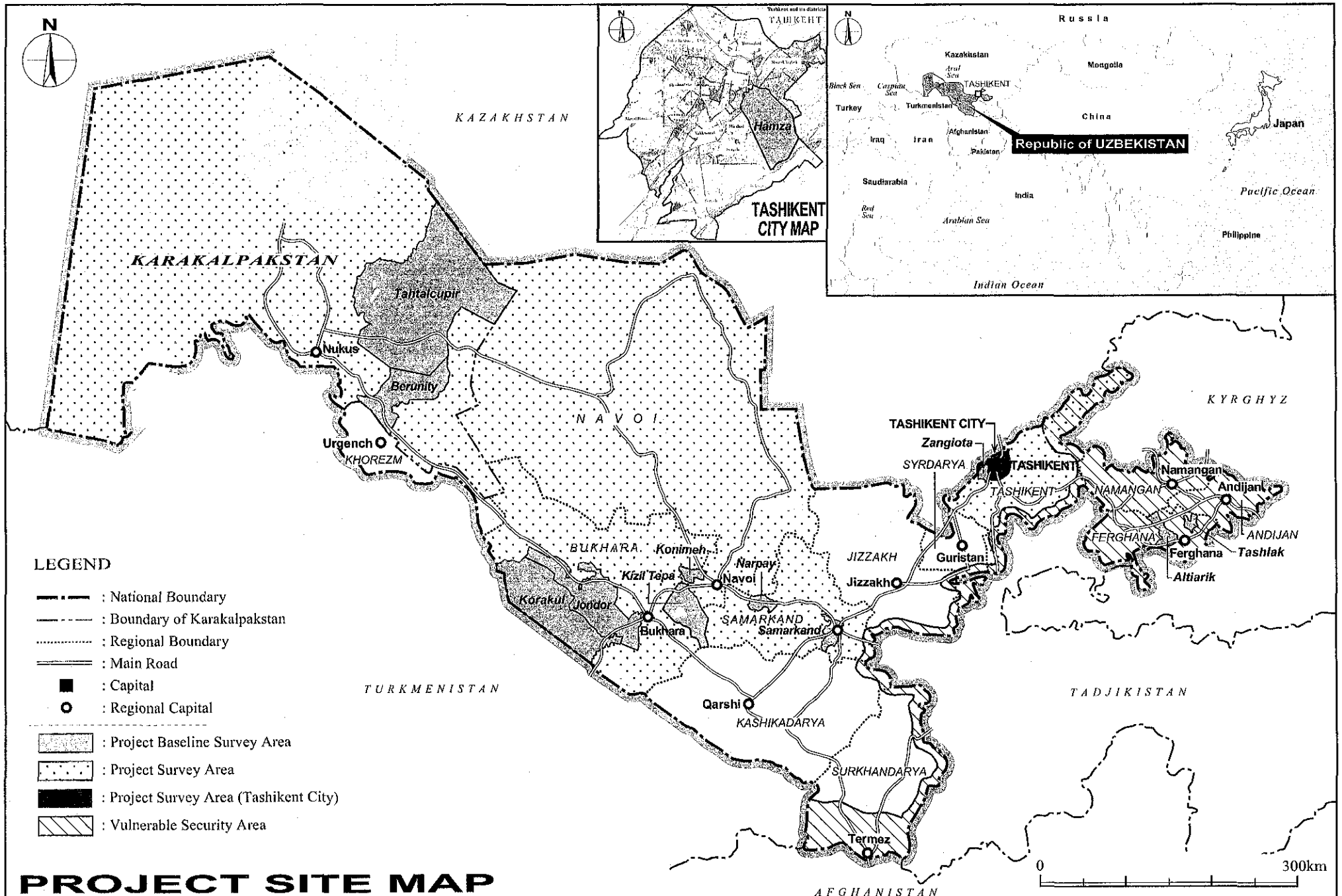
The report includes detailed analysis and recommendations on each health sector, and the results of the Baseline survey conducted in six Oblasts. Reflecting these outputs, a Master Plan was formulated, presenting six priority programs.

The report consists of the Summary Report, Main Report, Supporting Report and Data Book. The Summary Report summarizes the results of all the studies. The Main Report contains results of study conducted over two phases, and the Master Plan including prioritized projects. The Supporting Report includes details of investigation and the Data Book contains the analysis of the results of the Baseline survey.

All members of the Study Team wish to express grateful acknowledgment to the personnel of your Agency, Ministry of Foreign Affairs, Ministry of Health, Labor and Welfare and Embassy of Japan in Uzbekistan for all assistance extended to the Study Team. The Study Team sincerely hopes that the results of the study will contribute to the future improvement of health and medical system in particular and to socioeconomic development of Uzbekistan.

Sincerely,

Hiroshi Abo
Team Leader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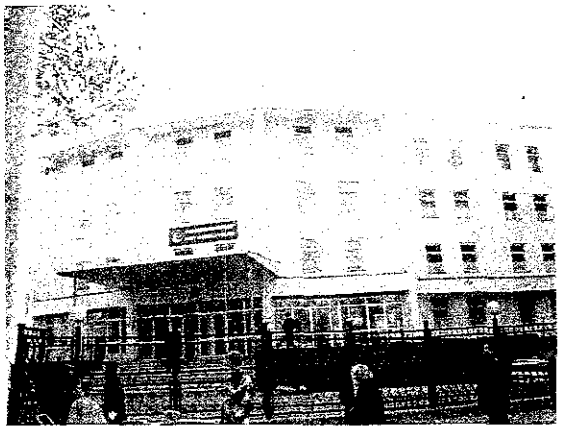
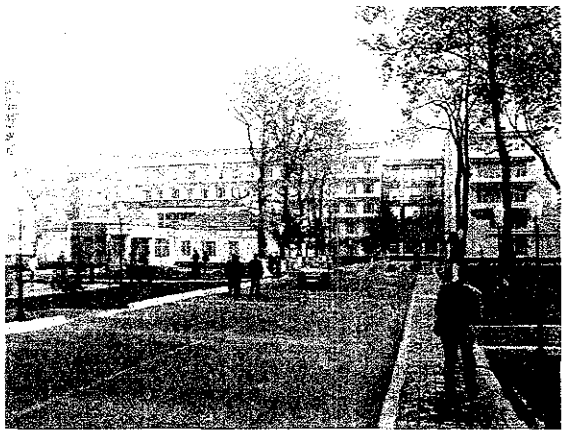
LEGEND
: National Boundary
: Boundary of Karakalpakstan
: Regional Boundary
: Main Road
: Capital
: Regional Capital
: Project Baseline Survey Area
: Project Survey Area
: Project Survey Area (Tashkent City)
: Vulnerable Security Area
0
300km
PROJECT SITE MAP

Photo 1: Medical Facilities

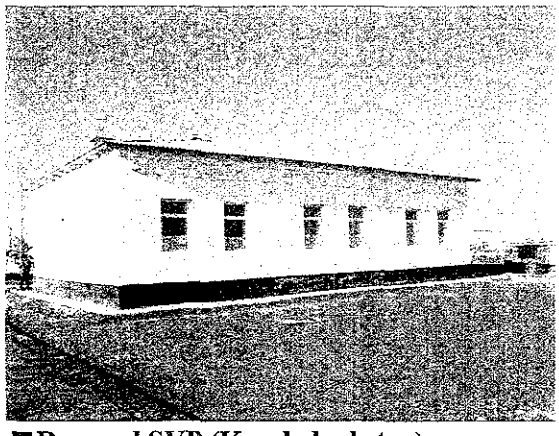


■**Oblast Maternal Hospital (Navoi City)**
Hospitals of oblast level (general and specialized) are usually large buildings and keep hundreds beds, to cover oblast population. Different specialists work to provide tertiary level health care.



■**Republican Emergency Center (Tashkent City)**
This center is recently established as a core of emergency care stating in 1week free of charge in treatment.

■**Rayon Central Hospital (Ferghana Oblast)**
As a secondary facility level, RCH treats inpatient in each specialized department. Most of RCH is complex buildings in adjacent zone. Not only referred patients, but also many patients come directly.



■**Renewal SVP (Karakalpakstan)**
Under the health reform, SVP is established as a PHC facility on community base. Trained GP and nurse are allocated and optimal equipment and essential drug will be supply.

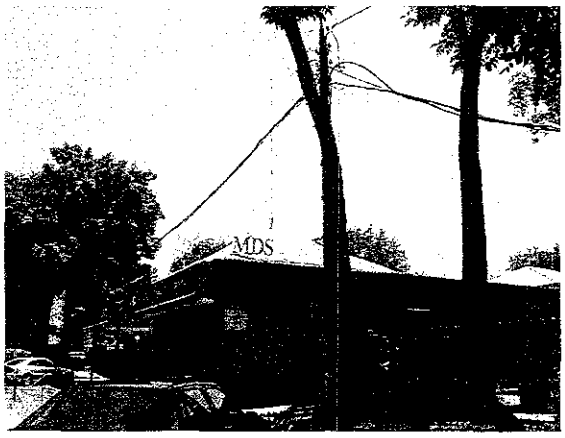
■**X-Ray in Oblast Hospital (Ferghana Oblast)**
Most of the medical equipment is remained since supplied in 1980s, and it becomes superannuated. Medical staff looks after it well, but consumables are limited and diagnosis level is restrained.

■**Laboratory in SVP (Tashkent Oblast)**
Some of SVPs are supplied minimum equipment, such as microscope, centrifuge and spectrophotometer. SVP is expected to be a primary diagnosis base for epidemiological survey in the future.

Photo 2: Health Environment

■**Tubeculosis Center (Tashkent City)**

As one of specialized reseach institutes, TB center has own referral system. Also has a function to treat inpatients who are detected and referred from other general hospitals.

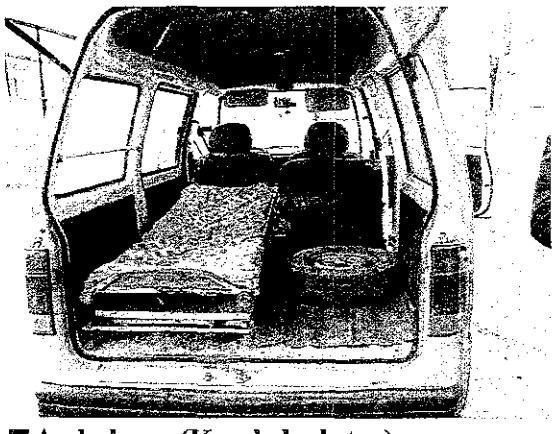


■**Private Clinics: MDS (Tashkent City)**

MDS keeps a highest technology for diagnosis in Tashkent, using CT and MRI. Linking with enterprises, MDS tries to formurate private insurance.

■**Waiting Hall in Policlinics (Tashkent City)**

Policlinic treats outpatient in urban area having a few specialists. Sometimes policlinic stands by neighboring rayon hospital.



■**Ambulance (Karakalpakstan)**

Most of ambulances is pooled in Ambulance Station for urgent "03" call. Also hospitals keep ambulance to refer patient. Carrying equipment is quite simple and poor, due to the purpose is transportation.

■**Waterworks (Tashkent City)**

Tashkent City can supply enough water to resident. there is a great gap between above area and Aral Sea Region, and this causes minus healh impact to Karakalpakstan and Urgench.

■**Toilet in Primary School (Karakalpakstan)**

For environmental health and health promotion, School Health can play an important role. Children can learn sanitation and hygiene and give impact to their family.

Photo 3: Meeting and Discussion

■ **Counterpart Meeting**

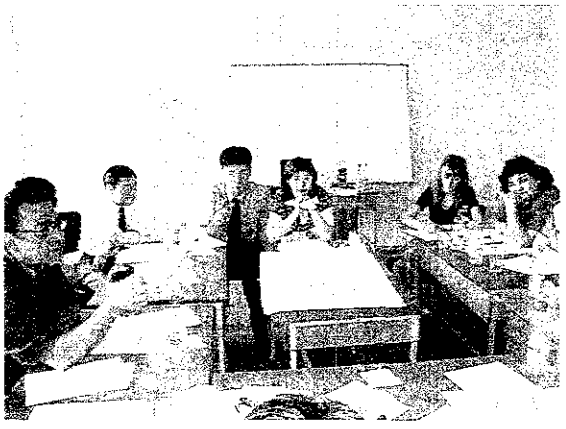
To identify major concerns and issues affecting the health care and medical services in Uzbekistan, counterparts are selected in Ministry of Health.

■ **Steering Committee**

To creat a concensus among related ministries and envision Master Plan together, Steering Committee was hold.

■ **Donor Round Table Meeting**

To share the understanding on general contents of M/P and identify major issues of health sector together, other donors and NGOs gethered for workshop.



■ **Working Group Session**

For effective study and discussion, sector-wise working groups were hold several times acrossing other donors, NGOs, counterparts and specialists.

■ **Focus Group Meeting (Female Group)**

In the field study, to know the community demand and their capacity building, focus droup was gethered in community (mahalla).

■ **Focus Group Meeting (Medical Staff Group)**

To clarify the gap between health service provider and health service demander, focus group was gethered. If both sides meet together, patient hesitate to say conplaint due to unequal relationship in doctor-patient.

EXECUTIVE SUMMARY

1. INTRODUCTION

1.1 Background of the Study

Since independence in 1991, Uzbekistan has labored to implement democratic institutions and reforms. With the collapse of the previous socialistic structure, obtaining sufficient health care funding has become extremely difficult with repercussions in terms of maintaining an adequate level of medical services. As a result, the Government of Uzbekistan formulated a "National Program of Health Care Reform (1998~2005)" delineating policy for improving the country's health sector.

Under these circumstances, the Government of Uzbekistan requested that the Government of Japan assist in preparing a Master Plan (M/P) for nationwide improvement in the health care and medical services field. In response to the request, "the Study on the Restructuring of Health and Medical System in Republic of Uzbekistan" was carried out from October 2002 to October 2003.

1.2 Outline of the Study

The objectives of the Study are; (1) to prepare a Master Plan for nationwide improvement of health care and medical services in Uzbekistan, aiming to present a framework for the effective implementation of the "National Program of Health Care Reform; (2) to conduct technology transfer of survey methodology to the Uzbekistan counterpart personnel through the Study.

The Study covers the whole area of the Republic of Uzbekistan, and the specific areas of baseline survey are comprised of six (regions) Oblasts of Tashkent (including Tashkent City), Bukhara, Samarkand, Navoi, Ferghana and Republic of Karakalpakstan. The Study was carried out in two phases: Phase I Study from October 2002 to March 2003, and Phase II Study from April 2003 to October 2003.

1.3 Study Methodology

1.3.1 Baseline Survey

The baseline survey was carried out aiming at (i) detailed identification of conditions

prevailing throughout Uzbekistan in general and on a region-wise basis in particular, (ii) supplementary collection of data, and (iii) application of the same to formulating a future framework for improving health care and medical services under the Master Plan.
Importantly, it covered the following aspects to fully grasp the present situation of the supply side but also the demand side such as patient, household and community.

1) Health Financing
2) Medical Facilities
3) Referral System
4) Health Information System
5) Health Service Providers
6) Situation of Human Resources Allocation
7) Health and Medical Services Demand Side (Community) Survey
   - Household Survey
   - Sociological and Medical Anthropological Survey
   - Beneficiaries

1.3.2 Coordination and Participatory Approach

Several meetings and workshops were held involving Uzbekistan side, international organizations, NGOs and JICA Study Team. In addition, 12 Working Groups were organized for analysis of the fact findings, and identification of the best practice and constraints in the existing health situation in Uzbekistan. At the final stage, those Working Groups formulated improvement programs.

2. SITUATIONS OF HEALTH SECTOR

1) Ministry of Health has a close relation with rural governments and is making an effort in health care improvement; however, a system and an influence of the former Soviet period still remain in some parts and inefficiency is observed.
2) Effective and rational use of medical finances is rarely attained and health financing is under threat from various issues such as unstable financial resources. Also, there is not enough capability in administration personnel.
3) Ministry of Health has been arranging to simplify the referral system; however, the medical facilities are redundant in number and sometimes too large in scale, not meeting the demand of the patient and actual health situations.
4) Emergency medical care system is well prepared at Republican level, but standard of

treatment and guidance at pre-hospitalization and each level of medical facilities are not appropriately adopted.

5) The activity of specialized medical facility is expected not only to perform advanced medical services but also to give education for medical professionals, and to carry out necessary research. However, there are some cases that do not function well.
6) There is a problem in the blood test system and its quality. Securing safety in blood is indispensable from the viewpoint of preventing HIV infections.
7) Strengthening of PHC (SVP) level medical services has been introduced by World Bank Project; however, Rayon and Oblast level medical facilities do not always function sufficiently.
8) The existing equipment is not always sufficient to provide adequate medical services. The management of operation and maintenance for equipment in medical facilities is weak.
9) Admission of students to medical institutes, nursing schools and colleges is carried out without analysis of needs. Training for middle level personnel (including nurses) is not sufficient. Nurses with higher education degree and their position in the present medical system have not been clear yet
10) Lack of communication and information sharing on drug inventory between medical facilities and Dori-Darmon is observed. Re-training program for pharmacist is not systematically conducted. Drug shortage at primary and secondary medical facilities is pervasive.
11) There is no uniform style or coordination between several health information databases system developed by international organization, donors and RIAC. There are insufficient training and guidance for improvement of rational and systematic management of reporting, statistics and information system.
12) Limited medical equipment and essential drug in PHC level is observed in the outside of the World Bank project area.
13) Number of SVP visits and home visits are increasing in the World Bank project areas. However, the existing IEC methodology and activities do not meet with demands of social system after the independence.
14) MMR and IMR in last decade have decreased alongside the social development and governmental MCH grogram. However, basic indicator still applies former Soviet definition and it has a gap between international standard.
15) There are complicated referral systems of specialized facilities for sanitation, hygiene and infectious diseases prevention. The relation with other referrals and capable laboratory tests are not always appropriately taking place.

3. MASTER PLAN

3.1 Target Year and Population Projection

A planning timeframe for healthcare reform and medical services improvement is set based on the target year of 2005 (short-term), 2010 (mid and long-term). In addition, the final target year of the next "National Program of Health Care Reform" is considered as the target year of super goal in M/P. The total population of the Uzbekistan in the target year of 2010 is estimated based on the UNFPA's low variant scenario of 1.31% (2000~2005) and 1.31% (2005~2010). Thus, the total population of Uzbekistan will be 28.0 million in 2010 (a round figure). Health expenditure per GDP in 2010 is expected to be 197.6 to 395.2 billion sums (201.6 to 403.2 thousand US$). Health expenditure per capita shows 7,000 to 14,000 sums (7.2 to 14.4 US$).

3.2 Overall Goal, Objectives and Strategies of the Master Plan

(1) Overall Goal

To improve the national health situations of all the population in Uzbekistan through removing the inhibiting factors in existing medical services system.

(Monitoring indicator for Target Year)

	2001	2005	2010
IMR: Infant Mortality Rate (per 1,000 Birth)	51.0	46.1	40.1
MMR: Maternal Mortality Rate (per 100,000 Birth)	34.1	31.7	28.6
U5MR: Under 5 Mortality Rate (per 1,000 Birth)	67.0	60.6	52.7

(2) Objectives and Strategies

Objective A [Humanity & Equity]

"Improvement of the quality of medical services and enhancement of equal access to medical services for all population"

- **Strategy A1**

  Improvement and establishment of the qualified Primary Health Care and Maternal and Child Health Care services

- **Strategy A2**

  Improvement of the quality for clinical services and administrative capability of medical facilities

- **Strategy A3**

  Improvement of the medical technology and research activities

Objective B [Efficiency & Sustainability]

"Establishment of effective system of medical services for the population's health"

- **Strategy B1**

  Defining of the medical facilities referral and improvement of patients' referral system
- **Strategy B2**

  Improvement and rationalization of Rayon and Oblast level medical services
- **Strategy B3**

  Improvement of effective medical facilities, equipment, drug supply and in-hospital functions
- **Strategy B4**

  Establishment of health management information system

Objective C [Cost Effectiveness & Sustainability]

"Improvement of the effective use of the health financing and introduction of new financing mechanism"

- **Strategy C1**

  Improvement of effective use of health budget
- **Strategy C2**

  Strengthening of the financing management capability for governmental administration and medical facilities
- **Strategy C3**

  Improvement of the preventive medicine and encouragement of medical treatment at earlier stage, to minimize medical treatment cost
- **Strategy C4**

  Introduction of the new health financing system (universal coverage of health insurance) and establishment of legislative bases for it.

4. PROPOSED PRIORITY PROGRAMS

4.1 Health Financing: 2004–2010

The overall goal of this program is to develop a health financing system that will improve the capacity of the health sector to secure the health of the present and future generations of the population in Uzbekistan. The main objectives and components are;

1) To improve the financial base of the health care system through budget allocation reforms across all levels of care,

- Guarantee of Free Package of Services
- Budget Allocation Reforms
- Mixed Financing Reform
- Secure Foreign Assistance, investments and credits to the health sector

2) To facilitate the establishment of a market in health services, while at the same time providing for clear mechanisms to protect poor and vulnerable groups
   - Introduction of a Price System in Public Health Care Facilities
   - Private Sector Development Activities

3) To introduce risk pooling and purchasing elements in the health system through a health insurance system (see the "Priority Program 4.2"), and
   - Planning the Development of a compulsory system of health insurance
   - Development of the Legal Base for the program
   - Development of Information Systems and reporting forms for Health insurance

4) To strengthen capacities to develop, support, manage and monitor health financing system reforms.
   - Adoption and installation of a national health accounts system to monitor system performance
   - Capacity building activities to implement and manage a health reforms
   - Creation of a Core Health Financing Group within the MOH

The period covered by the plan is 2004-2010. Ministry of Health with general directions provided by a multi-sectoral body involving the Ministries of Finance, Macroeconomics, Statistics, Cabinet of Ministers and other agencies. Also, a Health Financing Policy Unit (HFPU) within the Ministry of Health will be organized to provide project oversight.

4.2 National Health Insurance Program for Uzbekistan

The objective is to develop risk pooling and purchasing functions through the health insurance system: a health financing framework that takes into account health systems, financing functions, and financing sources. There are four major sources for funds.

1) General revenues of national or local governments largely generated through taxes;
2) Compulsory health insurance or mandatory insurance schemes. Payment for such obligatory systems is considered a tax.

3) Voluntary health insurance schemes, which are entered into and paid by individuals or other groups on behalf of individuals; and
4) Out-of-pocket payments, which are individual or household payments made to procure a service. The payments are in the form of user charges (direct payments) or premiums for insurance coverage.

Features of the proposed health insurance system are;

1) The system comes into place gradually.
   a. Reforms in alternative provider payment schemes
   b. Prepayment experiments at mahalla levels and in some enterprises
   c. Develop facility-based pooling of out-of-pocket payments
   d. Adopt a disease classification system and improved information systems
   e. Legal basis for compulsory health insurance
   f. Determination of the criteria for coverage and expansion
2) Compulsory pooling of funds in most cases happens a year or two after the legal base for compulsory insurance is established.
3) A single insurance fund system, with a National Health Insurance Agency (NHIA) responsible for funds collection and premiums pooling will be the most viable system.
4) Local budget systems for health facilities should be used under the new provider payment schemes.
5) Payments to providers will be based on negotiated rates and case payments.

The development stage will require capabilities to undertake the following activities;

1) Determine benefit package
2) Development and understanding of the price system in health care
3) Determine the Actuarial determination of premiums and contribution structure
4) Development of accreditation systems
5) Outline basic insurance functions
6) Research of health insurance experience to improve design of the proposed system

4.3 Improvement of Medical Services at Rayon Level

The overall goal of this program is to establish the strengthened rural medical services system at Rayon level. The objective is to establish overall improvement program for medical services, and to set a qualified model with CRH taking a central role. The results

of the program and know-how are to be expanded to the national level.

Implementation agencies of the program are Ministry of Health, health departments of Oblast and Rayon, and recipient RCH. The duration of this program is three years, taking the stage-wise approach. The components and activities shown below;

Step 1 : Formulation of pilot model program and detailed action plan for the Rayon level medical services system (feasibility study)

Step 2 : Establishment of management system for PHC Services in Model Rayons (technical assistance, overseas training, equipment provision, organizing the steering and technical committee)

a. Improvement of model Central Rayon Hospital (CRH) by provision of equipment and expert
b. Strengthening of medial services capability in model CRHs
c. Establishment of PHC services system centered on CRH (in cooperation with SVP)
d. Strengthening of coordination and cooperation with higher referral facilities such as Oblast general hospital, specialized hospitals/dispensaries

Step 3 : Formulation of package model for expansion to nationwide level

Step 4 : Expansion of the package model to other Rayons (recommendation of another project)

4.4 Improvement of Oblast Medical Services System and Oblast General Hospital

The overall goal is to establish the strengthened and effective Oblast medical services system through the improvement of the Oblast General Hospital; a model for consolidated and centralized medical services system will be presneted for the Oblast medical services at Oblast General Hospital. Results and know-how will be expanded to the nationwide level.

Implementation agencies are Ministry of Health, health departments of Oblast and recipient Oblast General Hospital. Implementing unit will be organized with representatives of related medical facilities. Duration of this program is three and half years from 2004 to 2008 (3.5 years), taking the stage-wise approach. The components and activities are shown below;

Step 1 : Formulation of pilot model program, detailed action plan and design for the Oblast medical services system and Oblast General Hospital (feasibility study)

Step 2 : Establishment of hospital management system and medical services system at the model Oblast General Hospital (technical assistance, provision of training for the staffs including overseas training, equipment and construction and/or renovation of facility, organization the steering, technical and coordination committee)

a. Integration and improvement of hospital functions
b. Centralization /consolidation of laboratory functions
c. Consolidation of Oblast General Hospital and other specialized medical facilities and Emergency Center
d. Consolidation of Oblast General Hospital and other specialized medical facilities
e. Consolidation of above Oblast General Hospital and Emergency Center

Step 3: Formulation of package model for expansion to national level

Step 4: Expansion of model hospital/system to other Oblasts (recommendation of another project)

4.5 Establishment of Health Management Information System

The goal of this program is to increase the ability of the health administrators to plan, monitor and take corrective action in the management of health care services. And objective is to make available timely, updated and interrelated information on all aspects of health and family welfare services delivery to all levels of health management.

Implementation agencies are RIAC (Republican Information Analytical Center) headquarters at the republican level, Oblast Health Statistics Bureau, and Rayon Organizational and Methods Unit at Oblast and Rayon level. Duration of this program is five years: four years for implementation and on the 5th year the review of the implementation will take place.

The components and activities of this program are shown below;

1) Simplification of registers and reports
2) Development of feedback system
3) Developing performance indicator system
4) Training of the key HMIS personnel

5) Equipping the Oblasts and Rayons with computers
6) Refinement and installation of MEDSTAT (medical statistics package) in Oblasts and Rayons
7) Establishing interdepartmental coordination mechanism
8) Review of the HMIS

4.6 Improvement of Blood Transfusion System

Overall goal of this program is to strengthen the capability of blood test, to establish safe blood use, to secure the supply and demand balance, and to obtain the cost-effective blood transfusion system by introduction of the blood donation system. The blood transfusion system, of which safety is secured, can prevent further expansion of serious infectious diseases such as HIV. This program requires collaboration and partnerships with international donor organizations and NGOs that are active in this field, and with community organization Mahalla.

At the Republican level, the implementation committee will be organized under the Ministry of Health, including director of Republican Blood Center. Oblast Health Department and Oblast level Blood Center and Oblast General Hospital are Oblast level implementation body. The duration of this program is three years, taking the stage-wise approach. The components and activities are shown below;

Step 1 : Formulation and preparation of the pilot model program, detailed action plan and design for the blood transfusion system at Oblast level (feasibility study)

Step 2 : Establishment of model blood transfusion system at the model blood transfusion center at Oblast level (technical assistance, training of the staffs for blood transfusion management and laboratory test including overseas training, equipment provision, organization of the steering, technical and coordination committee)

a. Establishment of the consolidated central blood test center and integrated blood transfusion center
b. Establishment of the consolidated blood transfusion management (blood collection, blood test, storage and supply)
c. Strengthening of the central blood test laboratory
d. Promotion of the blood transfusion system by voluntary blood donation
e Integration and rationalization of blood transfusion system at Oblast level

Step 3: Formulation of package model for expansion to national level through the above program implementation and monitoring of results

Step 4: Expansion of model system to other Oblasts (recommendation of phase II project)

4.7 Area-wise Programs

This Master Plan also proposes programs taking the area-wise approach as follows.

(1) City Type Medical Services Model

1) City type PHC model as the first access point for the out-patients will be established: GVP (city physician's point) and/or PHC facility. And at CCH (Central City Hospital), the first access point for in-patients and extensive system will be in place.
2) The capability of Ministry of Health for monitoring and supervising the private sector will be strengthened, and standards and guidelines for securing the quality of private sector medical services will be established.
3) The capability of the specialized institutes at top referral will be enhanced: advanced specialized medical services, education and fostering the specialized doctors and research activities will be achieved.

(2) Medical Services Model for Remote Areas

1) More efficient patient referral system from lower to higher level medical facilities will be established with provision of communication instrument and transportation vehicles.
2) In case extremely remote area, medical services at FAP under the control of the CRH and SVP will be provided and strengthened.
3) By the provision of legislative bases, priory distribution of medical resources (finance, human resources, drug and equipment) will be arranged for the remote areas.
4) Specifically, in remote areas, a system of drug supply based on community's participation and initiative will be recommended; Mahalla drug stores and/or revolving fund for purchasing drugs.

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ABBREVIATIONS

ADB	Asian Development Bank
AIDS	Acquired Immunodeficiency Syndrome
ARI	Acute Respiratory Infections
BEC	Brigades of Emergency Care
BSEC	Brigades of Specialized Emergency Care
BTS	Blood Transfusion Station
BTU	Blood Transfusion Unit
C/P	Counterpart
CCH	Central City Hospital
CDC	Center for Diseases Control and Prevention
CEE	Central and Eastern Europe
CGSEC	Center of Governmental Sanitation and Epidemiology
CIS	Commonwealth of Independent States
CME	Continuous Medical Education
CRH	Central Rayon Hospital
CSSES/SES	Center of State Sanitary, Epidemiological Surveillance
CVD	Cardiovascular Diseases
DFID	Department for International Development, UK
DOTS	Directly Observed Treatment Shortcourse
DRG	Diagnostic Related Group
ECG	Electric Cardiograph
ELISA	Enzyme Linked Immuno Adsorbent Assay
EPI	Expanded Programme on Immunization
EU	European Union
F/R	Final Report
FAP	Outreach Nurse/Midwifery's (Russian acrrounym)
GAVI	Global alliance for vaccines and immunization
GDP	Gross Domestic Product
GIS	Geographic Information System
GNP	Gross National Product
GP	General Practitioner
GVP	City Physicians Post (Russian acrrounym)
HB	Hepatitis B
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HEI	Health Education Institute
HE	Higher Education
HIS	Health Information System
HIV	Human Immunodefficiency Virus
HMIS	Health Management Information System
HRD	Human Resources Development
HRG	Healthcare Resources Group
IC/R	Inception Report
ICD	International Code of Diseases
ICRC	International Committee of Red Cross
ICU	Intensive Care Unit
IDD	Iodine Deficiency Disorders
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
ISCED	International Standards for Classification of Education
IT/R	Interim Report
IUD	Intrauterine Device
JICA	Japan Intrenational Cooperation Agency
KAP	Knowledge, Attitude and Practice

KfW	Kreditanstalt für Wiederaufbau (German acrrounym)
M/M	Minutes of Meeting
M/P	Master Plan
MCH	Maternal and child health care
MDG	Millennium Development Goal
MEDSTAT	Medical Statististics package
MMR	Maternal mortality rate
MOH	Ministry of Health
MSCP	Medical Service of Civil Protection
MSF	Medicine Sans Frontier
NGO	Non-Governmental Organization
NHI	National Health Insurance
NHIA	National Health Insurance Agency
NICU	Neonatal Intensive Care Unit
NIS	Newly Independent States
NPO	Non-profit organization
Ob/Gy	Obstetrics and Gynecology
ODA	Official Development Assistance
OECD	Organization for economic Cooperation and
OHSB	Oblast Health Statistic Bureau
ORS	Oral Rehydration Salt
OSCE	Objective Structure of Clinical Examinations
PHC	Primary Health Care
RIAC	Republican Information Analytical Center
ROMU	Rayon Organization and Methodology Unit
RRCEM	Republican Research Center of Emergency Care
RU	Republic of Uzbekistan
RVRBS	Relative Value Resource Based Scale
S/W	Scope of Work
SHE-HP	Sanitary, Hygiene, Epidemiology and Health Promotion
STD	Sexually Transmitted Diseases
STG	Standard Treatment Guideline
STI	Sexually Transmitted Infection
SUB	Rural Neighborhood Hospital (Russian acrrounym)
SVA	Rural Out-patient Post (Russian acrrounym)
SVEI	Secondary Vocational Educational Institution
SVP	Rural Health Post (Russian acrrounym)
TACIS	Technical Assistance for CIS
TashMI	Tashkent Medical Institute
TB	Tubeculosis
TFR	Total Fertility Rate
TIMPE	Tashkent Institute of Medical Postgraduate Education
UK	United Kingdom
UN	United Nations
UNAIDS	United Nations Joint programme on AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugee
UNICEF	United Nations Children's Fund
UNODCCP	United Nations Office for Drug Control and Crime
USAID	United State Agency of International Development
USSR	Union of Soviet Socialist Republlics
WB	World Bank
WHO	World Health Organization
ZAGS	Population Registration System (Russian acrrounym)

PART I. GENERAL OUTLINE

CHAPTER 1
INTRODUCTION

PART I GENERAL OUTLINE

1. INTRODUCTION

1.1 Background of the Study

The Republic of Uzbekistan is located at the center of the Asian continent. The country's land area is 447,400 km^2, or approximately 1.2 times that of Japan. Sixty percent of this land area is desert, bounded on the country's eastern and western borders by high mountain ranges. National population as of 2002 was 25.4 million (Socio-economic data, Cabinet Minister, Uzbekistan), of which 2.5 million (10% of all population) reside in the capital Tashkent, the largest city in central Asia. The population of Uzbekistan has shown steady and sound growth. Estimated population growth in 1998 was a low 1.4% (WHO Euro Office statistics, 1999). Population density varies significantly depending on the region.

Agriculture centering on cotton production is the primary industry accounting for 43.4% of all employment. The growth of country's economy owes much to the cotton production and mineral resources. Per capita GDP in 2002 was US$ 347 (Socio-economic data, Cabinet Minister, Uzbekistan, currency conversion: 980 sum/US$).
The country lies within a dry continental climatic zone featuring major fluctuations in air temperature throughout the year. Rainfall is generally meager, occurring mainly from winter to spring. There is virtually no precipitation during the summer.

In terms of disease, the country evidences a complex pattern between developing countries and industrialized countries, in the range from respiratory, digestive tract and infectious diseases to circulatory and new pathogen induced diseases. Furthermore, this structure of diseases varies significantly depending on the region. Also, due to the country's double landlocked geography, a lack of marine products in the national diet causes a high incidence of iodine deficiency disorder and goiter. In addition, diseases emanating from rapid sociological change including traffic accident, alcoholism, diseases caused by life habit are observed.

Specifically with regard to maternal and child health care, the infant mortality rate (IMR) per 1,000 births has declined from 35.2 in 1991 to 22.3 in 1998 (Health Care System in Transition, WHO Euro Office, 2001). Nevertheless, skewed levels of income and sanitary

conditions exist between regions within country.
Since independence in 1991, Uzbekistan has labored to implement democratic institutions and reforms. Against this background, an overall surplus of doctors and hospital beds exists due to lingering influence from the period of Uzbekistan integration into the former Soviet Union. On the other hand, problems have emerged with regard to the quality of medical services in certain rural areas. With the collapse of the previous socialistic structure, obtaining sufficient health care funding has become extremely difficult with repercussions in terms of maintaining an adequate level of medical services.
As a result, Uzbekistan is confronted with the urgent need to establish a new health care and medical service system with particular emphasis on a sound funding mechanism for medical services and an appropriate balance in medical service levels among regions.

In light of the above circumstances, the Government of Uzbekistan formulated a "National Program of Health Care Reform (1998~2005)" delineating policy for improving the country's health sector. In line with promulgated policy, a range of projects are being implemented by international organizations, donors and NGOs aiming at strengthening primary health care (PHC) and maternal and child health care, as well as combating infectious diseases and so on.

Specifically, the Government of Japan up to this time has extended various grant aid and technical cooperation (in the area of medical training, etc.) under a cooperative theme of restructuring health care and medical services. In December 2000, the Japanese delegation dispatched for integrated study of economic cooperation with Uzbekistan reconfirmed the necessity of improving the country's health care and medical services.

The Government of Uzbekistan subsequently requested that the Government of Japan assist in preparing a Master Plan (hereinafter referred to as "M/P") for nationwide improvement in the health care and medical services field. In response, the Government of Japan has decided to conduct "The Study on the Restructuring of Health and Medical System in Republic of Uzbekistan" (hereinafter referred to as "the Study"). Japan International Cooperation Agency (hereinafter referred to as "JICA"), that is the official agency responsible for implementation of technical cooperation program of the Government of Japan, dispatched a Preliminary Study Team in February 2002 and a Scope of Works (hereinafter called as "S/W") being signed between the two nations on February 21, 2002. In accordance with the S/W, JICA dispatched a study team (hereinafter referred to as 'JICA

Study Team') to Uzbekistan on November 4, 2002, to start the activities of the Study.

1.2 Objectives of the Study

The objectives of the Study are as follows;

(1) To prepare a Master Plan for nationwide improvement of health care and medical services in Uzbekistan, aiming at to create a framework for the effective implementation of the "National Program of Health Care Reform (1998~2005)". This Study is to provide the substantial basis for the next national health plan in accordance with the results of co-evaluation with Ministry of Health of Uzbekistan on the above-mentioned program. Under the Study, salient survey items are (i) a sound mechanism for health financing, (ii) efficient use of medical facilities and human resources, and (iii) enhanced primary health care services in rural areas.

(2) To conduct technology transfer of survey methodology to the Uzbekistan counterpart (hereinafter referred to as "C/P") personnel through the Study.

1.3 Study Area

The Study covers the whole area of the Republic of Uzbekistan. The specific areas of baseline survey comprise the six (regions) oblasts of Tashkent (including Tashkent City), Bukhara, Samarkand, Navoi, Ferghana and Republic of Karakalpakstan. Furthermore from the foregoing six Oblasts, two Rayons for each Oblast(total of twelve Rayons) were selected. The outline of selected Rayons is shown in "Chapter 15 Baseline Survey".

1.4 Time Frame of the Study

The Study spans approximately 12 months, from the end of October 2002 to the middle of October 2003. The Study is to be carried out in two phases: Phase I Study from October 2002 to March 2003 and Phase II Study April 2003 to October 2003.

1.5 Study Approach

The Study was undertaken in collaboration with Uzbekistan C/Ps. In addition, the

existing National Program was co-evaluated by both the Uzbekistan and Japanese sides, and more importantly the partnerships with related donors and NGOs are given attention.

1.5.1 First Year Study (Phase I)

1) To analyze possible constraints and best practices from (i) the implementation status of the existing National Program of Health Care Reform, (ii) activities of international organizations and donors, (iii) conditions pertaining to both supplier and demander of health care and medical services, (iv) status of the medical services administrative system, (v) health financing, (vi) realities of industry, economy, society and pathological pattern of the country.

2) To formulate a drafting provisional Master Plan for health care and medical service improvement that is in line with the level of country development and aimed at achieving specifically set short, mid and long-term objectives.

1.5.2 Second Year Study (Phase II)

To finalize a Master Plan (M/P) for improving the health care and medical services system throughout Uzbekistan based on the results of phase I study and analysis, discussions with the Uzbekistan side regarding the content of the Interim Report (IT/R), and the findings from any supplementary surveys deemed necessary.

The flow chart of the Study approach and master plan formulation is shown in next page.

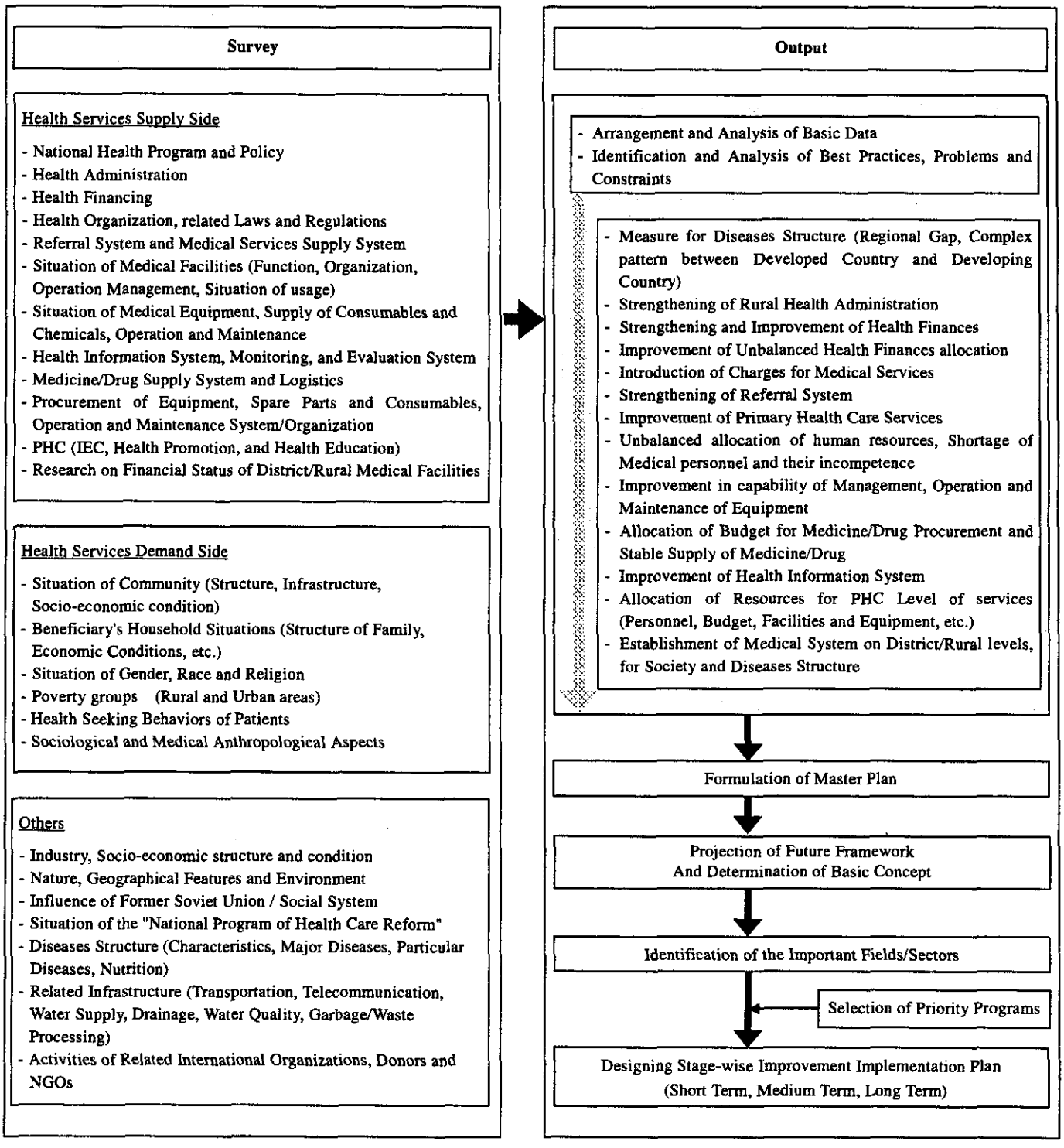

Figure 1.1 Flow Chart of Master Plan Formulation

CHAPTER 2
SOCIO-ECONOMIC CONDITIONS OF UZBEKISTAN

2. SOCIO-ECONOMIC CONDITIONS OF UZBEKISTAN

2.1 Geography

Uzbekistan is a young, independent, and one of the largest countries in central Asia. After a collapse of former Soviet Union, Uzbekistan was re-established as an independent country on August 31, 1991, and became a member of the Commonwealth of Independent States (CIS). The first president, Mr. Islom Karimov was elected in December 1991.

Uzbekistan is a landlocked country with a land area of 447.4 thousand square kilometers. It is bordered by 5 countries and lies across two major rivers of Amu Darya and Syr Darya, the southern portion of the Aral Sea and branches of mountain ranges West Tien-Shan and Gissaro-Allay. Largely dry, comprised as it is by deserts and flat plains which cover much of its land area, one third of its area are valleys and mountains.

There are 12 Oblasts (Regions), 1 Tashkent City and autonomous Republic of Karakalpakstan, 121 cities including the capital of Tashkent City and 163 Rayons (districts) in Uzbekistan. The municipal unit at the community level is called "Makhalla". There is "an Aral Sea problem" caused by the lack of flowing water due to the large scale irrigation of cotton.

2.2 Socio-economic Conditions

This unique landscape yields a rich source of natural resources such as natural gas, gold, uranium and other minerals and heavy metals. With its considerable gas reserves and relatively well-educated population, it enjoys significant economic potential.

The country managed to post modest growth in Gross Domestic Product (GDP) despite dramatic collapse in national outputs elsewhere in the region (Table 2.1). It posted positive GDP growth of 4.2 % for 2000 and 2001. Annual inflation rates have been high (at 27 % and 22% in 2001 and 2002, respectively); but not as high if compared to the average (41.6%) in the previous period, as reported by World Bank. GDP per capita in 2002 was about 294 thousand in Uzbek Sums, rose from the previous year by 33 per cent. At the conversion rate of the US$1 to UzS980, the GDP per capita figure was $347, putting the country in a low income category. Income inequality, as measured by the Gini ratio,

was 0.33. This moderate inequality belies a high level of poverty of 45 percent reported for the same period, 1998. Using a poverty threshold of US$ 2.15 per day, the poverty level reported in 1999 was 22 percent.

Regional variations in income and access to services were observed. Per capita income in Tashkent was 4 times the per capita income noted in Samarkand (ADB, *Economic Outlook 2003*). Kashkadarya's poor were 7 times poorer than those in Tashkent City. Safe water and sanitation facilities were available to only a quarter and about 2 % of rural population (World Bank, 2003).

Table 2.1 Economic Indicators, Uzbekistan

	2001	2002	1996-2000, Average*
Annual GDP Growth (average, %)	4.2	4.2	3.3 (real terms)
Annual Inflation (average, %)	26.6	21.6	41.6
GDP Per capita, current prices, soms	196,543	294,458	
Gini Ratio			0.33** (1998)
% of Population below national poverty line*			45 (1998) 22 (below $2.15 per capita per day, 1999)

Source: * Joint IFI Paper on Growth and Debt, Feb. 2002, IMF-WB
** Human Development Report 2001, UNDP (interpreted as 0 being most equal and 1 as most unequal)
All Other data provided to JICA Study Team, Dept. of External Economic Relations, Cabinet of Ministers, January 14, 2003

The structure of the economy as shown in Table 2.2 shows a typical developing economy profile, with services comprising the biggest share of GDP, followed by agriculture and industry. Services accounted for more than 40% of domestic output and more than half of the employed population. The service sector includes retail trade, banking and finance, education sector, construction, among others. Public services dominate the services sector. However, growth in the services sector has declined in past years due to import controls (ADB, 2003).

Agriculture accounted for one- third of its domestic output, employing about 34% of the workforce. Uzbekistan contributes one-fourth of the world's cotton output, and is the world's second biggest exporter in cotton. Income from cotton exports comprised 40% of its exports. This reliance on primary commodity exports (cotton, gas, oil and gold) makes the country highly vulnerable to external shocks affecting its markets.

Table 2.2 Structure of the Economy, as Percent of GDP, 2000

	As % of GDP*	As % of Employed**
Agriculture	33	34.4
Industry	25	12.8
Services	43	52.8

Sources: * World Development Report, 2002
Reference: Joint IFI Paper on Growth and Debt, Feb. 2002, IMF-WB
** Estimated from Men and Women of Uzbekistan:
A Statistical Collection, State Statistic Dept. of Min. of Macro & Statistics

Industrial development has brought about considerable progress, with the country demonstrating manufacturing capabilities in automobiles, electric, oil-refining, chemical-pharmaceutical and other industries. Technical re-equipment and reconstruction of enterprises led to a rise in the volume of industrial fixed capital from 42 to 52 percent in the period 1995-1999 (UNIC report). Industry however absorbed only 13 percent of the employed. Employment does not guarantee escape from poverty because of low wages and wage arrears.

2.3 Health Status in Uzbekistan

2.3.1 Populations and Demographic Structure

Table 2.3 shows a country population of 25.4 million (2001), which is the largest in the central Asian region and the third largest among the former Soviet Union countries. Forty percent (40%) of the population is under the age of 15, and with the addition of 6.5% who are above the age of 60, the rest of the population (54%) are in the economically active age group of 16-59 years. This current scenario of population composition showed a slight improvement compared to a dependency scenario that existed 3 years ago. Compared to the last decade (1991), the latest (2001) figures reveal the reverse migration to the rural areas from urban areas. This is an interesting development that requires further investigation. This posed an enormous challenge in terms of providing basic services and employment.

Table 2.3 Population Profile,2001

		1989-1999, Annual Ave.***
Population*	25,115,756 (2002)	22,016,360
% of Population**		
below 15 years old;	39.8	42.0 (1998)
b/w 16-59 yrs.old	53.7	51.7 (1998)
above 60 yrs. Old	6.5	6.3 (1998)
Percent of Permanent Residents**		
In Urban	37	40 (1991)
In Rural	63	60 (1991)

* Data provided to the JICA Study Team by Cabinet of Ministers, Dept.of External Economic Relations
** Estimated from Men and Women of Uzbekistan: A Statistical Collection, State Statistic Dept. of Min. of Macro & Statistics, RU
*** UNICEF, A Decade of Transition, 2001

The country enjoys a liberal social state policy, with 40 percent of government revenues devoted to the social sector – education, health and social protection. There is wide access to land and nearly universal homeownership. Nonetheless, access to basic services like water and basic sanitation and natural gas for heating is a problem.

Crude birth and death rates stabilized is at modest rates. The official life expectancy figure is high at 71.3 years but the International data adjusted for comparative purposes shows a slightly lower figure of 69 years. Total fertility rate, or the number of births per woman, is high at 2.7 per cent, but this is 1 percent lower than the figure registered a decade ago. The overall demographic scenario is therefore one of just having crossed the demographic transition but not quite completing it yet.

The natural, economic and demographic factors are combined putting pressure on the environment. Unsustainable agricultural production processes have contributed to a fragile environment, causing irreversible ecological damage. Increasing desertification has caused considerable changes in air and water quality levels. Contaminated dust has been found to be increasing in concentration. Drinking hardness has increased and so the salinity of soil.

Consequently, the health status of the population has been affected. The leading causes of mortality show that cardiovascular diseases (CVD) and respiratory diseases are the significant cause of death. In these two disease causes, as well as in parasitic and digestive problems, the rates for Uzbekistan markedly exceed Western Europe indicators. It is only in the indicators of injuries from accidents/ poisoning and malignant neoplasm, Uzbekistan is favorably better than Europe's rates.

2.3.2 Mortality and Disease Structure

Analysis of the mortality and morbidity statistics reveal the situation of double burden of disease, a typical pattern for developing economies. On the one hand, the majority of the population suffers from what can be considered preventable deaths and illness, at the same time there is a growing share of chronic and expensive diseases causing deaths and illness. While it may not be very alarming now, it calls for public health interventions and investments to control the future expensive curative interventions.

Generally chronic diseases are related to lifestyle, poor diet and behaviors. Cardiovascular diseases are the largest contributor of mortality and morbidity in Uzbekistan and are about 5 times higher than that of western countries statistics. The age standardized death rate due to chronic liver diseases and cirrhosis. This seems to arise from traditional factors such as alcohol, smoking, a high fat diet, a diet in low antioxidants and poor detection and treatment of hypertension. Malignant neoplasm is also associated with the substantial increase in ischeamic heart diseases and chronic intestinal disease.

The main causes of maternal deaths are hemorrhages, toxemia of late pregnancy, septic complications, and extra-genital diseases. A decrease in maternal mortality rate has significantly influenced the decrease in infant mortality. And decrease in infant mortality rate is caused by decrease of the number of deliveries of young and old women who are in the high-risk group. Also noted are the moderate first marriage age that now averaged over 20 years old, birth spacing up to 3 to 4 years, and increase of contraceptive use among reproductive age group.

Morbidity rates show high rates of vaccine preventable infectious diseases. The psychiatric cases are relatively high compared to TB and infectious hepatitis. The incidence of AIDS is generally attributed to the urban drug user group.
The incidence of disability is roughly the same as the average of Central Asian countries. Again disability rate is high among working age group, and the major causes of disability are circulatory system, nervous system and sense organs.

2.3.3 Epidemiological Survey on the Major Diseases

SHE-HP system (System of Sanitary, Hygiene, Epidemiology and Health Promotion) was established in the Soviet healthcare system and had a strong structure and financial base. This system has been given great attention since the first day of independence of the Republic of Uzbekistan. During the healthcare system reform, healthcare preventive issue was emphasized and its main provider is SHE-HP system.

(1) Legislative Base

There are a number of laws of the Republic of Uzbekistan on this system, for instance, "Law on AIDS", "Law on the governmental sanitary and epidemiology control service" etc. There are also quite a few number of orders from Ministry of Health and legislative documents regulating this sector.

But "Republican Centers of Health" including regional and rayon branches was formed on the basis of established service of sanitary-and-education of the population department. But the regulations of "Republican Centers of Health" contains a list of goals and objectives, most of which overlap with those of Ministry of Health, RIAC (Republican Information Analytical Center), Republican CGSEC (Center of Governmental Sanitation and Epidemiology Control), Scientific Research Institute of Sanitary, Hygiene and Professional Diseases.

(2) Human Resources, Education and Science

At present time, 2nd Tashkent State medical institute is the only which trains the physicians for service of state sanitary-and-epidemiology control.

(3) Vaccination

Vaccination is provided by two systems – SHE and PHC system. SHE system provides a centralized delivery of vaccines to PHC facilities, and also controls the process of vaccination provided by them among the population. However, there is no clear system of centralized purchasing and delivering of vaccines and bacteriologic pharmaceuticals. They are received mostly as an aid from donor organizations, and budgetary financing of vaccination is extremely limited.

(4) Laboratory Equipment, Reagents and Transport

Laboratory equipment in the state sanitary epidemiological control system is mostly old from the Soviet Union period. The former way of centralized equipment and reagents delivery is not functioning any more. Transport, necessary for providing adequate sanitary-and-epidemiological control locally, has not been available for several years.

2.3.4 Nutrition Conditions

According to the WHO report, average daily calorie consumption per head was about 2600 kcal in1998. On the other hand, there is overweight among the population aged 20-59 years which accounts for nearly 20% in random group sampling. This causes an unbalanced dietary practices and high carbohydrate consumption in predominant part of ordinary population.

Among children, stunting, wasting and underweight are still large number. Malnutrition rates are consequently higher in rural areas, especially by income quintile, the poorer groups tend to do worse than the upper income groups. Micronutrient deficiency such as vitamin A deficiency, Iodine deficiency disorders (IDD), anemia is going to be recognized as serious illness. Goiter prevalence was over 40% and 60% of population suffer from IDD. 60% of reproductive age women and 70% of under 5 years children are anemic. 40% of population of Karakalpakstan is suspected as suffering from vitamin A deficiency. However, there is no accurate data for those micronutrient deficiencies. Sustainable monitoring system needs to be developed.

CHAPTER 3
COORDINATION AND PARTICIPATORY APPROACH

3. COORDINATION AND PARTICIPATORY APPROACH

3.1 Explanation and Discussions on the Inception Report (IC/R)

JICA Study Team submitted and explained the Inception Report (hereinafter referred to as "IC/R") with the Uzbekistan side recipient agency (Ministry of Health) and other related organizations. Following these discussions, the Minutes of Meeting (M/M) on the IC/R was sighed on November 22, 2002 between JICA Study Team and the Ministry of Health. Based upon the IC/R, technical activities have been implemented by JICA Study Team with C/Ps.

3.1.1 Counterpart Meeting on the IC/R

Based upon the IC/R, Uzbekistan side assigned a C/P team for smooth implementation of the Study. The first C/P meeting on the IC/R was held on November 11, 2002, at a conference room of Ministry of Health. Participants included Deputy Ministers, C/Ps (directors of each department and agent), Deputy Directors of each department and agency (see the Appendix Table 3.1).

(1) Objectives

1) To introduce the member of JICA Study Team and C/Ps
2) To share an understanding with C/Ps regarding the general content of the envisioned Master Plan Study
3) To create a consensus among the JICA Study Team and C/Ps
4) To identify major concerns and issues affecting the health care and medical services field in Uzbekistan

(2) Discussions and Comments

1) The initial step of the M/P Study will be to co-evaluate the existing National Program of Health Care Reform of the Republic of Uzbekistan (1998-2005) with Uzbekistan side and JICA Study Team. Uzbekistan side pledged a full collaboration and ownership for the Study.
2) Uzbekistan side accepted five Oblasts for the baseline survey proposed by JICA Study Team. However, it was proposed that one Oblast from Ferghana valley should be included in the Study.

3.1.2 Steering Committee on the IC/R

The first Steering Committee was held on November 21, 2002, at a conference room of Ministry of Health. The Steering Committee was organized by Uzbekistan side, based upon M/M (Minutes of Meeting) in the IC/R, which aims to help realization of necessary coordination for the Study. The Steering Committee is chaired by Mr. Khodjibekov Marat, the Deputy Minister of Ministry of Health, and consists of the representatives from related ministries and organizations as follows:

(1) Members of Steering Committee

1)	Cabinet of Ministers	Mr. Bolkunov Vladislav Senior Specialist of Social Complex
2)	Ministry of Macro Economics and Statistics	Mr. Khasanov Abdukhalil Director of Social Development Department
3)	Agency of Foreign Economic Relations	Mr.Khodjimetov Makhmud Senior specialist of the Pacific Ocean Region,
4)	Ministry of Finance	Mr. Maksudov Sukhrov Specialist
5)	Ministry of Health	Mr. Khodjibekov Marat Deputy Minister Mr. Sidikov Abdunamon Head of International Contacts and Relations Department

(2) Objectives

1) To report the overview of the envisioned Master Plan Study to concerned Uzbekistan officials.
2) To create a consensus between the Study Team, the Government of Uzbekistan officials regarding health care and medical services issues, and promote cooperative structure among all concerned parties.
3) To confirm the significance of strengthening health finance sources, and presentations on the health insurance systems of the major industrialized countries to be held.
4) To identify major concerns and issues affecting the health care and medical services sector in Uzbekistan.

(3) Discussions and Comments

1) To achieve the objective, which is to improve health situation of people in Uzbekistan, JICA Study Team requested the Study be collaborated and coordinated with related Uzbek officials.
2) JICA Study Team gave an overview on health financing and public health insurance in other countries.
3) In response to the question from the Member of Steering Committee regarding the plausible model of health insurance system for Uzbekistan, JICA Study Team explained that the appropriate model should be prepared through the exchange of information and analysis of field survey results collaborating with Uzbekistan side.
4) Chairman confirmed the contents of IC/R approved by the Steering Committee, and requested all related ministries collaborate and cooperate for the Study.

3.1.3 Roundtable Meeting on the IC/R

The first Roundtable Meeting was held on November 25, 2002 at Uzbekistan Press Center in Tashkent. There were about 30 participants from international organizations, donors and NGOs active in the health care and medical services sector in Uzbekistan (see the Appendix Table 3.2).

(1) Objectives

1) To share the understanding on general contents of the envisioned Master Plan Study with international organizations, donors and NGOs.
2) To create a consensus among the Study Team, international organizations, donors and NGOs regarding health care and medical services issues, and facilitate a cooperative and collaborative relations among all concerned parties
3) To identify major concerns and issues affecting the health care and medical services sector in Uzbekistan
4) To identify the status of program implementation, level of benefit, and issues regarding each international organization/donor/NGO.

(2) Discussions and Comments

1) The main donors showed strong interest in the JICA Study and expressed that they would cooperate and collaborate along the process of the Study.
2) It is important to exchange information among donors that have been carrying out

health development programs in Uzbekistan, and to share various experiences, problems, and lessons.

3) In the past, coordination among the donors has not taken place. Therefore, it is important again that donors should cooperate with each other for implementing the projects.
4) As World Bank and USAID have implemented the projects in Ferghana Oblast, and this region should be selected as the Study area for baseline survey by JICA.
5) To effectively help exchange opinions, small sessions inviting donors need to be organized on a regular basis.

3.1.4 Workshop on the IC/R

The first Workshop to explain and discuss on the IC/R was held on November 30, 2002, at a conference room of the Ministry of Health. Participants were C/Ps, Directors and/or Deputy Directors of health department of Oblast, Directors of finance department of Oblast and Chiefs of health department of study areas. They are key people in health care services sector in Uzbekistan (see the Appendix Table 3.3). A presentation on health financing system was conducted.

(1) Objectives

1) To share the understanding on the general contents of the envisioned Master Plan Study
2) To create a consensus between the JICA Study Team and participants, and promote a cooperative relationship among all concerned parties.
3) To identify major concerns and issues affecting the health care and medical services field in Uzbekistan.
4) To confirm significance of strengthening health finance sources, and presentations regarding the health insurance systems of the major industrialized countries to be organized.
5) To select study areas for the baseline survey.

(2) Discussions and Comments

1) First, areas for the baseline survey were selected.

Tashkent city :	: Hamza Rayon
Tashkent Oblast	: Zangiota Rayon
Samarkand Oblast	: Samarkand Rayon, Narpay Rayon
Bukhara Oblast	: Korakul Rayon, Jondor Rayon
Navoi Oblast	: Kizil Tepa Rayon, Konimeh Rayon
Republic of Karakalpakstan	: Beruniy Rayon, Tahtakupir Rayon

2) The M/P Study will co-evaluate the existing National Program of Health Care Reform of the Republic of Uzbekistan (1998-2005), involving both Uzbekistan side and JICA Study Team
3) Uzbekistan side pledged a full collaboration for the Study.
4) Securing health finance is important for the appropriate medical services. Health finance system that is applicable to Uzbek needs to be sought through the research on such systems in other countries as well as giving consideration to the situation of this country.

3.2 Working Groups

The JICA Study Team organized Working Groups for analysis of the results and fact findings, and to identify the best practice, issues and constraints in the present health situation in Uzbekistan. At the final stage, these Working Groups will formulate the ways of solution and improvement programs. 12 small technical working groups are organized according to the sub sectors and each development program so that vital discussions take place.

(1) Specialty of Small Groups

12 small technical working groups are organized according to the sub sectors and each development program so that vital discussions take place.

(2) Specialty of Small Groups

1) Group No.1 Health finance, insurance and private medicine
2) Group No.2 Drug supply logistics and medical equipment
3) Group No.3 Maternal and child health care
4) Group No.4 Sanitation, hygiene, and infectious diseases
5) Group No.5 Quality of medical services
6) Group No.6 Human resources development
7) Group No.7 Primary health care and health promotion
8) Group No.8 Emergency medicine
9) Group No.9 Specialized medical care
10) Group No.10 Health information system
11) Group No.11 Nursing education, and
12) Group No.12 Health care management system and legislative

(3) Members of Working Groups

1) Ministry of Health (C/Ps, head and deputy head of department),
2) Other ministries related with health administration (Cabinet of Ministers, Ministry of Finance, Ministry of Macroeconomic and Statistics, Ministry of Higher and Specialized Education, etc.),
3) Medical organizations and enterprises (RIAC, Dori Dorman, Uztibteknics, Uzmedexport, Tibta minot, etc.),
4) International organization (WHO, UNICEF, UNESCO, USAID, CDC, Euro Aid, CDC, GAVI, Health Project, ZdravPlus, etc.),
5) NGOs (Association of Physicians, Association of Nurses, etc.),
6) Directors and specialists of Oblast and Rayon health department,
7) Directors and specialist of medical facilities, and institutes, and
8) JICA Study Team

The first plenary session of working groups was held on 31 January 2003 at a conference room of the Ministry of Health. Participants accepted the organization of 12 small working groups and members, schedule of working groups, objectives and task of each working groups. Each small group started its session on 3 February 2003. Schedule of working groups is shown below;

Table 3.1 Schedule of Working Groups

Date/Period	No. of Meeting	Activities of Working Groups
31 January 2003	1	Organization of working group
3 to 7 January 2003	2	Each small group meetings (sector and subject wise), discussions on the 1st phase survey
Beginning of March 2003	3	Plenary session (for IT/R)
Middle to end of March 2003	4	Each small group meetings (sector and subject wise), discussions on the IT/R and results of 1st baseline survey
April 2003	5	ditto
Middle of May 2003	6	Plenary session (for results of 1st phase survey)
Middle of May to middle of June 2003	7	Each small group meetings (sector and subject wise), discussions on 2nd baseline survey
Middle of July to beginning of August 2003	8	Each small group meetings (sector and subject wise), discussions on 2nd baseline survey
Beginning to middle of August 2003	9	Each small group meetings (sector and subject wise), conclusion of each groups
Middle of August 2003	10	Integrated conclusion meeting

Among above-mentioned groups, Group No. 12 consists of deputy ministers and representatives of the Ministry of Health and JICA Study Team, which has a steering and coordinating function. This steering working group will examine the results of the working groups in each sub sectors, and propose a final conclusion and a plan representing all of the working groups.

3.3 Explanation and Discussions on the Interim Report (IT/R)

The JICA Study Team submitted to the Interim Report (IT/R) for the Phase I Study to the Uzbekistan side represented by Prof. Feruz G. Nazirov, Minister of Health. Discussions were made on IT/R from 5 to 6 March 2003. The list of the attendants is attached as Appendix Table 3.4.

The Workshop for explanation and discussions on the IT/R was held on March 6, 2003, at a conference room of Ministry of Health. Participations were, members of working groups (deputy ministers, C/Ps, directors and/or deputy directors of department, donors and Ministry of Macroeconomics and so on). Attendance list is shown in Appendix Table 3.4.

(1) Objectives

1) To be well known the contents of the IT/R to the participations.
2) To create a consensus between the JICA Study Team and participants, and promote a cooperative relationship among all concerned parties.

3) To identify best practice, problem issues and constraints in medical services in Uzbekistan.
4) To confirm the basic principles for planning of the future framework, basic planning approach for formulation of the Master Plan and improvement programs under the Master Plan.

(2) Discussions and Comments

1) Both of the Uzbekistan and Japanese sides agreed the Study contents of IT/R.
2) The Uzbekistan side requested the expansion of the study area to the Ferghana valley according to its characteristic importance.
3) The necessity of Uzbekistan counterpart(s) training in Japan for the technology transfer was required.
4) Uzbekistan side agreed that approach of health care reform and rationalization of health budget expenditure.
5) The preventive care is important to minimize the medical treatment expenditure.
6) Both of the Uzbekistan and Japanese sides will continue the formulation of improvement programs with good collaboration and relation.
7 The formulation of improvement programs will be in the point of not only sector approach but also overall objective setting approach.

3.4 Explanation and Discussions on the Draft Final Report (DF/R)

The JICA Study Team submitted the Draft Final Report (DF/R) on the results of Master Plan Study to the Uzbekistan side represented by Prof. Feruz G. Nazirov, Minister of Health. Discussions were made on DF/R from 15 to 16 September 2003. The list of the attendants is attached as Appendix (Minutes of Meetings for .DF/R).

The Workshop for explanation and discussions on the DF/R was held on September 17, 2003, at a conference room of Ministry of Health. Participations were members of working groups (deputy ministers, C/Ps, directors and/or deputy directors of department, donors, etc.) and representatives of Oblast health department. Attendant list is shown in Appendix Table 3.5.

(1) Objectives

1) To share the understanding among the participants on the contents of the DF/R.
2) To create a consensus among Uzbekistan side, donors, NGOs and the JICA Study Team.
3) To confirm the objectives and strategies of the Master Plan, sector-wise and area-wise improvement programs and priority programs under the Master Plan.
4) To promote realization of priority programs under the Master Plan.
5) To present GIS (Geographical Information System) developed by the JICA Study Team under the Master Plan Study.

(2) Discussions and Comments

1) The content of the Draft Final Report was accepted by the Ministry of Health.
2) The Uzbekistan side reconfirmed that the health financing reform needs to be resumed with possible introduction of health insurance system.
4) Uzbekistan side agreed to make their best effort in realizing the Master Plan and programs presented in the DF/R.
5) The ownership of the Uzbekistan side shall be taken in the course of implementation.
6) Both sides agreed that Uzbekistan side would send the comments in writing, if any, on the comment of the DF/R.