EVOLUTION OF MATERNAL AND CHILD HEALTH POLICY IN UZBEKISTAN: FROM INFRASTRUCTURE MODERNIZATION TO SYSTEMIC AND BEHAVIORAL HEALTH REFORMS

Jaloliddin Yigitaliev,
Family Physician, 67th State Family Polyclinic
E_mail: jyigitaliyev.2002@gmail.com

Abstract. *Over the past two decades, Uzbekistan has undertaken successive reforms in the field of maternal, neonatal, and child health (MNCH), resulting in substantial improvements in demographic outcomes and the quality of clinical services. This paper analyzes the evolution of MNCH policy through three major intervention phases: the Asian Development Bank's Woman and Child Health Development Project (2005–2012), nationally driven institutional reforms (2012–2022), and the Ishonch Fund initiative (2023–2026) developed with UNICEF, WHO, and UNFPA. Using a qualitative comparative approach, the study identifies structural achievements, persistent disparities, and emerging governance challenges. The findings demonstrate a paradigmatic shift from infrastructure-oriented modernization toward integrated models emphasizing capacity-building, digital accountability, and community participation. Yet, regional inequities, deficiencies in neonatal care, and limited institutionalization of quality assurance remain key barriers to sustainability. The paper concludes by proposing mechanisms for embedding transparency, digital monitoring, and continuous clinical mentorship into long-term MNCH governance.*

Introduction

Maternal and child health remains one of the core priorities of public health policy in Uzbekistan. Since independence, the country has progressively moved from an inherited Soviet centralized medical system toward a more decentralized, multi-level health governance structure. This transformation has occurred amid broader socio-economic reforms, population growth, and rapid urbanization. International development agencies have consistently played a role in shaping policy direction, especially in the early stages of sectoral modernization.

Figure 1. Neonatal Mortality Trend

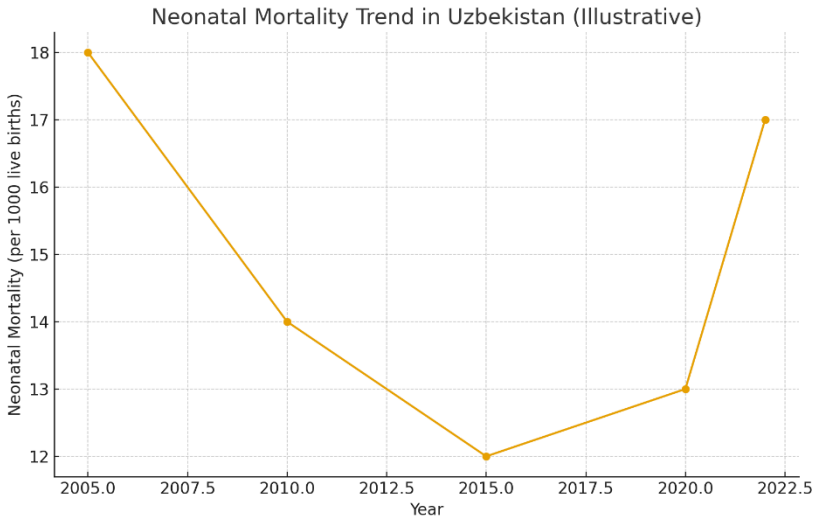

Figure 1 demonstrates fluctuations in neonatal mortality over time. After initially decreasing, the rates increased again by 2022, indicating persistent challenges in neonatal care quality.

The trajectory of MNCH development reflects three overlapping but conceptually distinct reform logics: (1) **infrastructure and access**, (2) **institutional standardization and clinical specialization**, and (3) **systemic accountability and behavioral change**. Understanding this transition is essential because improved health indicators alone do not automatically translate into robust institutional resilience. Sustainability depends on consistent professional capacity, governance transparency, and community trust — factors now at the forefront of contemporary public health research.

This study therefore positions MNCH reform in Uzbekistan within a broader framework of health system strengthening and socio-institutional change, examining how programmatic design influences long-term sectoral outcomes.

Methodology

This study applies a **qualitative comparative analysis** (QCA) of three major MNCH interventions. The methodology draws on:

- Project evaluation reports (ADB, 2014; UNICEF, 2023)
- National health policy documents and statistical bulletins
- WHO and UNFPA MNCH indicator frameworks
- Secondary scholarly review literature on health system governance in Central Asia

Three analytical dimensions guide the comparison:

Analytical Dimension	Focus of Inquiry
Structural Modernization	Infrastructure, equipment, supply chain capacities

Human Capital Formation	Training systems, clinical competencies, mentoring
Governance & Accountability	Data systems, transparency, patient engagement, sustainability

This framework enables identification of institutional learning patterns and structural constraints that persist across reform cycles.

Results and Comparative Analysis

The ADB program was foundational in addressing critical infrastructural deficits in primary healthcare and maternity services. More than 1,300 rural medical points were renovated, and a national blood safety system was established. Training activities resulted in the upskilling of over 17,000 medical personnel. Infant and maternal mortality rates declined significantly during this period.

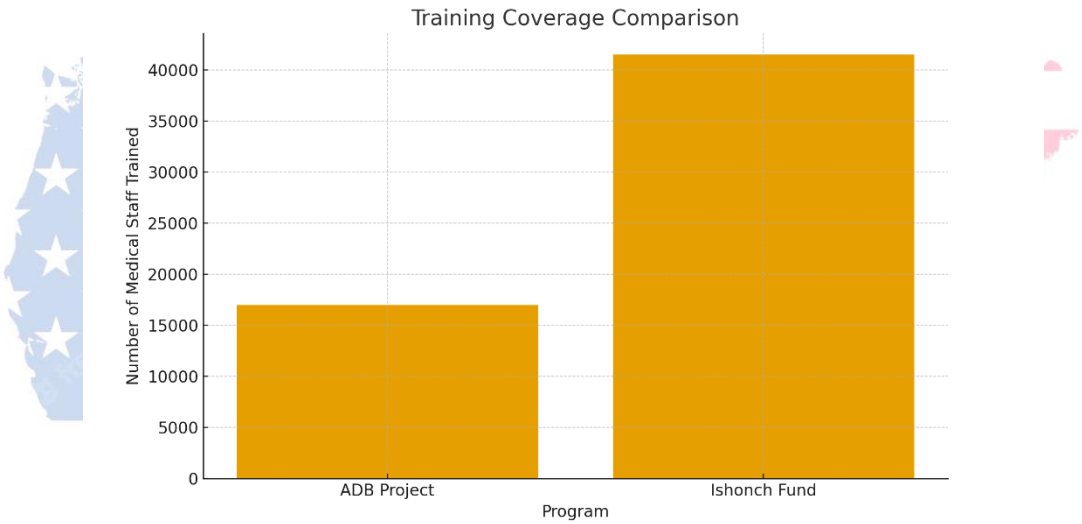

Figure 2. Comparison of Training Coverage

This bar chart compares the scope of capacity-building under two major national programs. The Ishonch Fund trained more than 41,000 medical workers, significantly more than the 17,000 trained under the ADB project.

However, the design of the intervention was predominantly **vertical** and **technocratic**. The project lacked mechanisms for institutionalizing monitoring practices, and human resource training did not incorporate sustained mentoring. As a result, improvements were uneven across regions and partially vulnerable to turnover in clinical personnel.

3.2 Phase II: National Institutional Reforms (2012–2022)

This phase marked the expansion of specialized perinatal centers and the standardization of screening protocols. The development of national clinical training modules and newborn screening programs contributed to more consistent service delivery frameworks.

Yet, structural inequalities persisted. While institutional capacity increased in urban centers, **peripheral and rural regions continued to experience shortages in neonatal emergency care**, skilled neonatologists, and equipment maintenance. Neonatal mortality remained disproportionately high relative to overall infant mortality, indicating systemic fragility in the "first hours and days of life" continuum of care.

The Ishonch Fund represents a paradigm shift by integrating **clinical excellence, behavioral communication, digital governance, and anti-corruption transparency**. The program trained more than 41,500 health workers and introduced digital patient feedback mechanisms, independent quality audit boards, and behavioral change communication campaigns.

This phase explicitly recognizes that **public trust is a health system outcome**, not merely a social byproduct. Nonetheless, implementation challenges remain — including limited digital literacy among clinical staff, variability in facility-level adherence to infection control standards, and persistent informal payments, particularly at discharge points.

Discussion

The historical shift from infrastructure-centric interventions to governance-driven reforms aligns with international research emphasizing that **sustainable MNCH improvement is primarily a question of systemic accountability and knowledge retention**, rather than resource inputs alone. However, institutional memory and workforce stability remain fragile in settings with high staff rotation, regional inequality, and patronage practices.

The challenge ahead is therefore **not the absence of policy**, but the unevenness of execution. **Conclusion and Recommendations**

Uzbekistan has made substantial progress in improving MNCH outcomes. Yet, sustainability requires:

1. **Institutionalizing continuous mentorship** rather than episodic training
2. **Embedding digital monitoring systems nationwide**
3. **Addressing regional disparities through differentiated financing models**
4. **Developing anti-corruption accountability boards at the regional level**
5. **Strengthening neonatal intensive care competencies and referral systems**

The long-term success of the Ishonch Fund will depend not on its financial scale, but on the permanence of its governance mechanisms.

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