



Completion Report

Project Number: 32143
Loan Number: 2007-KGZ(SF)
December 2010

Kyrgyz Republic: Community-Based Early Childhood Development Project

CURRENCY EQUIVALENTS

Currency Unit	–	som (Som)
		At Appraisal At Project Completion 5 August 2003 31 March 2010
Som1.00	=	\$0.0247 \$0.221018897
\$1.00	=	Som40.4850 Som45.2450

ABBREVIATIONS

ADB	–	Asian Development Bank
ADP	–	additional drug package
CFC	–	child and family coordinator
DHS	–	Demographic and Health Survey
DMF	–	Design and Monitoring Framework
ECD	–	early childhood development
EIRR	–	economic internal rate of return
EPI	–	Extended Program of Immunization
FGP	–	Family Group Practice
FSU	–	former Soviet Union
IDA	–	iron deficiency anemia
IDD	–	iodine deficiency disorder
IEC	–	information, education, and communication
IMCI	–	Integrated Management of Childhood Illnesses
IMR	–	infant mortality rate
MDG	–	Millennium Development Goal
MHIF	–	Mandatory Health Insurance Fund
MLSP	–	Ministry of Labor and Social Protection
MOEC	–	Ministry of Education and Culture
MOES	–	Ministry of Education and Science
MOF	–	Ministry of Finance
MOH	–	Ministry of Health
NGO	–	nongovernment organization
PCO	–	project coordination office
PMO	–	project management office
SDR	–	special drawing rights
TA	–	technical assistance
U5MR	–	under-five mortality rate
UNICEF	–	United Nations Children’s Fund
USAID	–	United States Agency for International Development
VIF	–	Village Initiative Fund
WHO	–	World Health Organization

GLOSSARY

ayil okmotu (AO)	–	village authority
<i>accoucheur</i>	–	primary health care post
(midwife) posts (FAP)		
feldsher	–	primary health care worker
oblast	–	province
raion	–	district

NOTES

- (i) The fiscal year (FY) of the Government of the Kyrgyz Republic and its agencies ends on 31 December.
- (ii) In this report, "\$" refers to US dollars.

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BASIC DATA

A. Loan Identification

1.	Country	The Kyrgyz Republic
2.	Loan Number	2007-KGZ(SF)
3.	Project Title	Community-Based Early Childhood Development Project
4.	Borrower	The Kyrgyz Republic
5.	Executing Agency	President's Office of the Kyrgyz Republic
6.	Amount of Loan	SDR7,545,000
7.	Project Completion Report Number	PCR: KGZ 1216

B. Loan Data

1.	Appraisal	
	– Date Started	6 June 2003
	– Date Completed	18 June 2003
2.	Loan Negotiations	
	– Date Started	21 August 2003
	– Date Completed	22 August 2003
3.	Date of Board Approval	29 September 2003
4.	Date of Loan Agreement	14 January 2004
5.	Date of Loan Effectiveness	
	– In Loan Agreement	14 April 2004
	– Actual	10 March 2004
	– Number of Extensions	No
6.	Closing Date	
	– In Loan Agreement	30 June 2009
	– Actual	31 March 2010
	– Number of Extensions	1
7.	Terms of Loan	
	– Interest Rate	1% per annum during the grace period and 1.5% per annum thereafter
	– Maturity (number of years)	32
	– Grace Period (number of years)	8
8.	Terms of Relending (if any)	
	– Interest Rate	
	– Maturity (number of years)	
	– Grace Period (number of years)	
	– Second-Step Borrower	

9. Disbursements

a. Dates

Initial Disbursement	Final Disbursement	Time Interval
28 April 2004	1 June 2010	73 months
Effective Date	Original Closing Date	Time Interval
10 March 2004	30 June 2009	63 months

b. Amount (SDR)

Category or Subloan	Original Allocation	Last Revised Allocation*	Amount Canceled**	Net Amount Available	Amount Disbursed	Undisbursed Balance
1. Civil Works	588,000	521,500	44,118	477,382	477,382	0
2A. Furniture	481,000	550,000	152,535	397,465	397,465	0
2B. Equipment	391,000	515,000	39,932	475,068	475,068	0
2C. Supplies	2,230,000	1,728,000	188,883	1,539,117	1,539,117	0
3. Training	429,000	766,500	358,585	407,915	407,915	0
4. Community and Information, Education, and Communication Campaigns	104,000	75,000	18,499	56,501	56,501	0
5. Village Initiative Fund	1,165,000	2,103,000	241,254	1,861,746	1,861,746	0
6. Surveys	22,000	85,000	56,549	28,451	28,451	0
7. Consulting Services	364,000	220,500	23,489	197,011	197,011	0
8. Monitoring and Data Acquisition	27,000	38,000	25,372	12,628	12,628	0
9. Project Management	485,000	615,500	290,491	325,009	325,009	0
10. Interest Charge	162,000	162,000	1,881	160,119	160,119	0
11. Unallocated	1,097,000	165,000	165,000	0	0	0
Total	7,545,000	7,545,000	1,606,588	5,938,412	5,938,412	0

* Latest date of category reallocation: 20 March 2009

** Amount at the loan closing stage: 2 June 2010.

b. Amount (\$)

Category or Subloan	Original Allocation	Last Revised Allocation*	Amount Canceled**	Net Amount Available	Amount Disbursed	Undisbursed Balance
1. Civil Works	819,000	790,214	65,044	701,549	701,549	0
2A. Furniture	670,000	833,399	224,887	610,098	610,098	0
2B. Equipment	544,000	780,365	58,873	731,447	731,447	0
2C. Supplies	3,103,000	2,618,388	278,476	2,336,149	2,336,149	0
3. Training	597,000	1,161,455	528,673	617,403	617,403	0
4. Community and Information, Education, and Communication Campaigns	145,000	113,645	27,273	86,447	86,447	0
5. Village Initiative Fund	1,621,000	3,186,615	355,688	2,870,637	2,870,637	0
6. Surveys	30,000	128,798	83,372	41,487	41,487	0
7. Consulting Services	506,000	334,117	34,630	301,440	301,440	0
8. Monitoring and Data Acquisition	38,000	57,580	37,407	18,626	18,626	0
9. Project Management	675,000	932,649	428,280	497,891	497,891	0
10. Interest Charge	226,000	245,474	2,773	244,908	244,908	0
11. Unallocated	1,526,000	250,020	243,264	0	0	0
Total	10,500,000	11,432,719	2,368,640	9,058,082	9,058,082	0

* Amount in US dollars represents the actual dollar equivalent of the special drawing rights at the date of the latest category reallocation: 20 March 2009.

** Amount in US dollars represents the actual dollar equivalent of the special drawing rights at the loan closing stage: 2 June 2010.

10. Local Costs (Financed)	
- Amount (\$)	2,574,159
- Percent of Local Costs	46.68
- Percent of Total Cost	28.42

C. Project Data

1. Project Cost (\$'000)

Cost	Appraisal Estimate	Actual
Foreign Exchange Cost	5,383	6,484
Local Currency Cost	8,087	3,776
Total	13,470	10,260

2. Financing Plan (\$'000)

Cost	Appraisal Estimate	Actual
Implementation Costs	13,470	10,015
Borrower Financed	2,570	702
ADB Financed	10,274	8,813
Other External Financing (Communities)	400	500
Total		
IDC Costs	0	0
Borrower Financed	0	0
ADB Financed	226	245
Other External Financing	0	0
Total	13,470	10,260

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

3. Cost Breakdown by Project Component (\$'000)

Component	Appraisal Estimate	Actual
Child Health and Nutrition	3,308	3,013
Early Childhood Care and Education	2,739	2,410
Capacity Building	2,315	3,490
Project Management Support	1,502	1,050
Taxes and Duties	1,700	52
Subtotal	11,564	10,015
Contingencies	1,680	0
Interest Charges	226	245
Total	13,470	10,260

4. Project Schedule

Item	Appraisal Estimate	Actual
Date of Contract with Consultants	4Q 2003	3Q 2004
Civil Works Contract		
Date of Award	2Q 2004	3Q 2004
Completion of Work	3Q 2005	3Q 2005
Equipment and Supplies		
First Procurement	1Q 2004	2Q 2004
Last Procurement	1Q 2008	4Q 2009
Completion of Equipment Installation	3Q 2008	1Q 2010

Q = quarter.

5. Project Performance Report Ratings

Implementation Period	Ratings	
	Development Objectives	Implementation Progress
From 29 September 2003 to 30 October 2008	S	S
From 1 November 2008 to 31 March 2010	HS	S

HS = highly successful, S = successful.

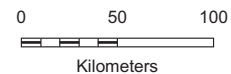
D. Data on Asian Development Bank Missions

Name of Mission	Date	No. of Persons	No. of Person-Days	Specialization of Members
Fact-Finding	10–28 February 2003	4	32	a, b, c, d
Appraisal	6–18 June 2003	3	36	a, c, e
Pre-Inception	2–12 December 2003	4	16	a, c, f, g
Inception	21–30 April 2004	3	20	a, c, f
Review	6–17 September 2004	2	12	a, c
Review	11–16 November 2004	1	2	a
Review	10–23 March 2005	2	10	a
Review	16–25 November 2005	2	9	a, c
Review	25 January–6 February 2006	2	2	a, c
Midterm	18–28 September 2006	3	16	a, c, h
Review	5–16 February 2007	1	12	a
Review	18–25 September 2007	2	8	a, i
Review	6–14 November 2008	2	11	a, g
Review	8–14 April 2009	2	10	a, g
Review	10–17 September 2009	3	6	a, c, g
Project Completion	23 March–10 April 2010	3	48	a, c, h
Review				

a = social protection specialist, b = young professional, c = project implementation officer, d = implementation and management specialist/consultant, e = senior counsel, f = project specialist, g = project analyst, h = assistant project analyst, i = community-driven specialist/ consultant.

KYRGYZ REPUBLIC
**COMMUNITY-BASED EARLY CHILDHOOD
 DEVELOPMENT PROJECT**
 (as completed)

KAZAKHSTAN



- Project Area
 - National Capital
 - Provincial Capital
 - City/Town
 - Main Road
 - Other Road
 - Railway
 - River
 - District Boundary
 - Provincial Boundary
 - International Boundary
- Boundaries are not necessarily authoritative.

This map was produced by the cartography unit of the Asian Development Bank. The boundaries, colors, denominations, and any other information shown on this map do not imply, on the part of the Asian Development Bank, any judgment on the legal status of any territory, or any endorsement or acceptance of such boundaries, colors, denominations, or information.

71°00'E

78°00'E

PEOPLE'S REPUBLIC
 OF CHINA

UZBEKISTAN

TAJIKISTAN

TAJIKISTAN

71°00'E

78°00'E

42°30'N

42°30'N

38°00'N

38°00'N

I. PROJECT DESCRIPTION

1. Early childhood development (ECD) refers to the physical and psychosocial development that takes place in the first several years of life. Evidence is growing that ECD has long-lasting effects and is critical to human development. Before the collapse of the former Soviet Union in 1991, young children in the Kyrgyz Republic received a comprehensive package of ECD services, comprising child health care, nutrition, and nursery and/or preschool programs. Pregnant women had access to antenatal care that helped maintain maternal health and mitigated risks associated with pregnancy. Poverty was far less prevalent than it is today. The favorable ECD situation changed dramatically in the decade after 1991, with ECD deteriorating largely as a consequence of economic contraction, increased poverty, and decline in social services. Child health and nutrition worsened, a large number of preschool institutions were closed down, and parents were left without sufficient resources or knowledge to care for children at home. The decline of ECD-related services had a negative impact on the general development potential of children in the country. Achieving the Millennium Development Goals (MDGs) by 2015 became unlikely, with major efforts required to meet the targets of reducing the infant mortality rate (IMR) and under-five mortality rate (U5MR) and sustaining universal primary education by arresting the problem of increasing dropouts.

2. Recognizing the importance of child development, the Government of the Kyrgyz Republic asked Asian Development Bank (ADB) to finance the Community-Based Early Childhood Development Project. The aim of the project, approved in 2003, was to enhance the development of young children between birth and 8 years of age by providing holistic interventions to improve health, nutrition, and psychosocial development.¹ The performance indicators were to (i) reduce the IMR, reduce U5MR, (iii) reduce the incidences of iodine deficiency disorder (IDD), (iv) reduce the prevalence of iron deficiency anemia (IDA) both among children and pregnant women, and (v) improve the psychosocial development of preschool children. The project was composed of three components: (i) child health and nutrition, (ii) early childhood care and education, and (iii) capacity building. The project was to focus on the 12 poorest raions (districts) in Jalal-Abad, Naryn, and Osh oblasts (provinces),² while ensuring that the extended program of immunization would cover the needs of all eligible children in the country. Technical assistance (TA) was also provided to improve the government's capacity for pursuing an effective ECD program. To ensure strong leadership and effective implementation through multiple ministries and central and local government bodies, the president's office was selected as the executing agency.

II. EVALUATION OF DESIGN AND IMPLEMENTATION

A. Relevance of Design and Formulation

3. The project design was *relevant* and consistent with the priorities of the government and ADB at appraisal and completion. It was directly relevant to the human development needs of the Kyrgyz Republic stated in the government's Comprehensive Development Framework and Education Strategy to 2010. It was also intended to reduce the IMR and U5MR and sustain universal primary education, consistent with the MDGs. The government highlighted the importance of preschool education through its *National Action Plan on Education for All (2002)*³

¹ ADB. 2003. *Report and Recommendation of the President to the Board of Directors: Proposed Loan and Technical Assistance Grant to the Kyrgyz Republic for the Community-Based Early Childhood Development Project*. Manila.

² The target raions were: Alai, Chon-Alai, Nookat, and Kara-Khulja in Osh oblast; Toktogul, Chatkal, and Toguz-Torou in Jalal-Abad oblast; and Ak-Tala, At-Bashy, Kochkor, and Jumgal in Naryn oblast.

³ Kyrgyz Republic. 2002. *National Action Plan on Education for All*. Bishkek

and *Country Development Strategy 2006–2010*⁴ when the first impacts of decreased preschool education attendance on school performance were acknowledged. The Law on Protection of the Kyrgyz People's Health stipulated the government's responsibility for protecting children's rights to living conditions required for sound physical, cognitive, and psychosocial development, and the obligation of citizens to take care of children's health, physical, cognitive, and psychosocial development. It was also consistent with ADB's policy on education (2002),⁵ in which early childhood development was a priority subsector, and policy for the health sector (1999),⁶ which prioritized support for primary health care that benefits the poor and identified priority cost-effective health interventions.

4. While the Ministry of Health (MOH) was planning to rationalize *feldshers accoucheur* (midwife) posts (FAPs) under *Manas*⁷ (the first health sector reform strategy), ADB decided to invest in FAPs. In remote villages, FAPs were the only accessible facilities to deliver primary health care. Here, the project was inconsistent with the MOH's strategy, but was relevant to the government's overall goals to achieve MDGs 4 and 5. *Manas Taalimi*⁸ (subsequent health sector reform strategy), has recognized the importance of FAPs, and has also paid attention to maternal and child health, which was not included in the first health sector reform strategy.

5. The project's design was complex, but appropriate for implementing an integrated approach to child development that involved health, nutrition, and education and care issues. It emphasized building the capacity of the *ayil okmotus* (village authorities) and communities to plan, improve, and sustain child development. Developed with strong community participation, the project contained a special fund facility to support community-based projects to improve access to ECD services at the community level. This promoted community ownership. The project's design also supported the government's decentralization and community development policies articulated in the comprehensive development framework.

B. Project Outputs

6. The project had three components with numerous correlated outputs. All outputs were achieved during the lifetime of the project. Details of the project's outputs and performance against the original targets are in Appendix 1. At the end of the project, the overall physical accomplishment was 100%.

1. Child Health and Nutrition

7. This component aimed to improve the quality of primary health care and nutrition through the following expected outputs: (i) maintained delivery of vaccines under the Extended Program for Immunization (EPI) and cold chains, (ii) training of primary health workers in Integrated Management of Childhood Illnesses (IMCI), (iii) improved access to essential drugs, (iv) rehabilitated and equipped FAPs, and (v) an increased awareness of IDD, IDA, and nutrition behavioral change. The project satisfactorily delivered the outputs and also increased the government's self-reliance on financing EPI vaccines, building a nationwide IMCI supervision system, and establishing rural pharmacies by public-private partnership.

⁴ Kyrgyz Republic. 2006. *Country Development Strategy (2006-2010)*. Bishkek

⁵ ADB. 2002. *Our Framework Policies and Strategies: Education*. Manila.

⁶ ADB. 1999. *Policy for the Health Sector*. Manila.

⁷ Kyrgyz Republic. 1996. *Manas Health Sector Strategy (1996-2005)*. Bishkek

⁸ Kyrgyz Republic. 2006. *Manas Taalimi Health Sector Strategy (2006-2010)*. Bishkek

8. **Sustaining universal immunization of children.** The project supported the supply of vaccines and cold chain refrigerators for the entire country. The country had been maintaining high child immunization coverage using 100% donor-financed vaccines at project appraisal. Immunization, the most important intervention for saving infant and child lives, should be a priority of the government's own stable financing, rather than relying on unpredictable donor funds. Thus, during the first year of project implementation, ADB reached an agreement with the MOH to support vaccine supplies on a declining scale: 70% of the national EPI vaccine requirements in 2004 and 2005, 60% in 2006, 50% in 2007 and 40% in 2008. In 2008, the government financed 60% of the requirements (Appendix 2). Cold chain refrigerators were procured for 47 raion sanitary and epidemiology services and 150 vaccine centers across the country. The MOH has been regularly maintaining them and keeping them operational.

9. **Training of primary health workers on IMCI.** The project completed all planned training in IMCI. IMCI is a way to improve health workers' case management of childhood illnesses. The project trained 271 primary health workers in IMCI in the 12 raions. The training was followed up by three supervisory visits by the trainers and raion and oblast IMCI coordinators from the State Medical Institute for Continuous Training to ensure that health workers could correctly practice IMCI. Dissatisfied with the level of IMCI practice, the project through the MOH developed supervisory capacity at the oblast and raion levels. The project financed supervisory training and workshops for family medical center directors throughout the entire country.

10. **Improving access to essential drugs.** This output was fully achieved through establishing rural pharmacy networks. As lack of access to essential drugs was a major barrier to treating sick children in a timely manner, the project supported the supply of essential drugs. The MOH's development of a transparent distribution system for essential drugs was a condition for disbursement. At appraisal, the Mandatory Health Insurance Fund (MHIF) of the Kyrgyz Republic had just started introducing an additional drug package (ADP) to subsidize essential drugs. Although children and pregnant women were covered by MHIF, few of them in rural areas could benefit from it.

11. The project persuaded the MOH to add the IMCI drugs to the essential drug list. In 2002 the MOH also allowed health workers to act as dispensers, after they had been trained to do so. This in itself did not effectively increase access to essential drugs in rural areas, but later contributed to the development of public-private rural pharmacy networks. In 2006, the MOH with support from ADB helped improve a promising model piloted in Jumgal raion by a nongovernment organization (NGO) with the Swiss Red Cross's assistance. The project modified the model to create village pharmacy networks by giving incentives to private pharmaceutical retailers to open pharmacies in remote villages. The government provided the premises for the pharmacies, while the project financed an initial supply of essential drugs, equipment, and training of health workers to be dispensers. Under the project, the MOH enforced price regulation for IMCI drugs but allowed pharmacies to sell any other registered drugs or toiletries to make a profit.

12. After successful piloting in three raions starting in 2007, the model was rolled out to six more raions. In 2005, fewer than 100 pharmacies existed in the 12 raions. As of March 2009, two private firms were running an additional 123 pharmacies (including three pharmacies opened by the private firm's own initiative) in nine of the 12 raions. Now 90% of the people in the nine raions have access to pharmacies compared to only 30% before the rural pharmacy networks were established. A monitoring report of the first three raions⁹ showed that the majority of the

⁹ Health Care Institute. 2009. *Monitoring of Pilot Projects on the Establishment of Pharmacy Nets in Toktogul, Alay, and Kochkor raions under the Community-Based Early Childhood Development Project.* Bishkek.

population now has access to drugs, and drugs have become cheaper, and are perceived as of better quality. The project has thus improved access for the rural population to essential drugs, and to some extent to MHIF ADP. The next step is to ensure equitable access among the insured rural population to ADP. Details of the implementation of the public–private partnership for sustainable drug supply are in Appendix 3.

13. **Rehabilitation of FAPs.** The project completed planned rehabilitation of 84 FAPs that had been long neglected and required major repairs, equipped all FAPs according to the MOH's equipment list and specifications, and rehabilitated 23 family group practices. In addition, minor repairs of and/or equipment supply to 47 FAPs and 36 other health facilities (family group practices and territorial hospitals) were financed by the village initiative fund (VIF). The project also provided all FAPs in the project raions with electric heaters to save on utility bills. All of the improved facilities are in use and operational.

14. **Building awareness of IDD, IDA, and behavioral change.** Planned outputs were fully delivered (Appendix 4). Communities, retailers, and health workers, with the project's assistance, regularly monitored the quality of salt, and 95% of households regularly used iodized salt. The project conducted a series of other awareness-building activities according to an information education and communication plan developed with the assistance of a national communication consultant. A nutrition strategy and an action plan were developed with the assistance of a national nutrition consultant. Nutrition was included in IMCI training and parent training under component 2. Iron tablets and syrup were among the essential drugs sold at the pharmacies, as discussed above. The end-line survey showed that the percentage of pregnant women diagnosed as anemic and taking iron tablets increased from 77% in 2004 to 84% in 2009. (The 2004 figure appears to be overestimated.) However, other nutrition-related behaviors such as child feeding showed mixed results, and in general, improved only modestly.

15. The project's additional output was Parliament's adoption in January 2009 of the mandatory flour fortification law to mitigate micronutrient deficiencies as a major cause of various developmental delays and increased morbidity and mortality.¹⁰ The project, together with UNICEF, engaged in major advocacy efforts.¹¹

2. Early Childhood Care and Education

16. Major outputs under the early childhood care and education component were (i) establishing new community- and home- based preschools and providing them with learning materials, (ii) establishing one resource kindergarten per raion, (iii) revising and developing strategies and standards for preschool programs, (iv) improving childcare practices at home by training parents, (v) improving grade 1 education by training teachers, and (vi) rehabilitating currently operating kindergartens and a limited number of grade 1 classrooms. Most of the expected outputs have been fully achieved, except for those related to grade 1. Specifically, rehabilitation of facilities and textbook provision were subsequently dropped from the project, as these issues were to be adequately addressed under the Second Education Project (see para. 43).

¹⁰ Law on Fortification of Baking Flour was signed by the President on 17 March 2009.

¹¹ There were two major food fortification projects financed by ADB's Japan Fund for Poverty Reduction (JFPR) in Central Asia between 2001 and 2007. The development of a mandatory flour fortification law started during the second JFPR project. (ADB. 2004. Grant Assistance to Kazakhstan, the Kyrgyz Republic, Mongolia, Tajikistan, and Uzbekistan for Sustainable Food Fortification. Manila.)

17. **Community- and home-based preschools.** This subcomponent was successfully implemented. The project was intended to support the establishment of community- and home-based preschools through support of a child development committee to be instituted at the community level, development of a training module, training of preschool teachers, and provision of learning materials. As envisaged, 116 child and family coordinators (CFCs) were temporarily contracted and trained to work with *ayil okmotus*, mobilize communities, and initiate preschool programs in the community. The CFCs helped communities establish and make operational child development committees in 325 communities (82% of the total number of communities in the project area).

18. The project helped develop different preschool models, in particular two-shift preschools, play groups, half-day preschools, and preschools within schools, the latter two of which have been suggested as the most sustainable and cost-effective models. To date, the number of community-based preschools initiated by the committees has reached 324, enrolling about 13,140 children from ages 1 to 7 (Appendix 5) and contributing to the three-fold increase in the number of children enrolled in grade 1 after attending preschool programs from 2004–2008. The adoption of various models and the project's contribution to preschool establishment through providing learning materials, essential furniture, and developmental and educational toys stimulated the expanded network of preschools. Various training packages were prepared with project support and approved by the Ministry of Education and Science (MOES), and are widely used for training a total of 663 state- and community-based preschool and grade 1 teachers. They were also used by other development partner-financed programs across the country, beyond the 12 project raions.

19. The formal inclusion of alternative models of preschools in the preschool standards, and the establishment of a legal and regulatory framework for the establishment of preschool programs proved to be the project's major contributions to ECD in the country. (Key regulations, guidelines, and modules developed under the component are listed in Appendix 6.) Although the project's first preschools were established in 2005, the fact that a legal and regulatory framework, including standards, to provide a proper foundation for their establishment and operation was officially approved only in 2007, was a challenge for implementation. As coverage of preschool programs has been substantially improved, more attention should be paid to the quality of these programs. Systematic upgrading of teachers' skills, starting from pre-service training, will be required to further improve the quality of preschool programs. The retention and recruitment of preschool teachers also poses a serious challenge to sustaining the preschools.

20. **Resource kindergartens.** As envisaged in the project, the MOES selected 12 resource kindergartens, one in each project raion, to serve as hub kindergartens to advise and supervise a group of community- and home-based kindergartens. The resource kindergartens were supplied with learning materials, audio and video equipment, and in-service teacher training that significantly improved their performance as supervisors and advisors for preschools. Started effectively in 2008, resource kindergartens' regular supervision helps maintain the quality of preschool programs. This alone, however, cannot replace pre-service training for new preschool teachers and the institutionalization of a 14-day training program developed by the project and offered by pedagogical pre-service institutes. Resource kindergartens would also provide an opportunity for any new preschool teachers to receive the training if *ayil okmotus*, communities, or the MOES are able to finance their participation.

21. **Revised preschool standards.** The project supported the preschool education development concept approved in 2005, which included the development of the new preschool standards. Through consultation with all stakeholders, the project helped develop the preschool

standards that the government approved on 14 January 2007. The new standards led to the development of a new law, approved in April 2009, which provides a legal basis for establishing and operating preschool programs and institutions. The law and the standards allow local governments and communities to establish kindergartens and created opportunities to change financing arrangements for state kindergartens. The project also helped the government draft regulations on community-based preschools (kindergartens). It would be advisable, however, to promote cost-effective models of preschools by keeping the standard requirements (teachers, support staff, etc.) to a minimum to ensure that free or low-cost access to preschool programs is made available to rural children.

22. **Improved child care practices at home.** Parents' lack of awareness of the importance of early child education and development and lack of practical skills had negatively influenced not only the creation of a supportive environment at home, but also an understanding of the significance of preschool programs. The project envisaged support for development of parental education materials and training on better childcare at home. TV programs, developed under the project in cooperation with UNICEF and the Aga Khan Foundation, and training programs for parents in selected raions were the first steps in providing the required information on early child education. Further, the project supported training of about 43,020 parents on better childcare at home (the target of 50,000 parents turned out to be an overestimate). More than 25,000 parents have been provided with training materials on childcare.

23. **Rehabilitation of kindergartens.** Some kindergartens needed repairs to create a safe learning environment for children. The project supported major rehabilitation of 30 state kindergartens selected on the basis of accessibility and need, and their capacity to support community-based preschools. According to the project management office (PMO), monitoring reports, repaired facilities, and learning materials and supplies were generally well utilized at the resource kindergartens in all project raions.

3. Capacity Building

24. The key outputs to be delivered under the capacity-building component were (i) community-based activities for improving ECD financed by the VIF established by the project, (ii) strengthened capacity of ayil okmotus and communities to plan and carry out activities for child development with the assistance of CFCs appointed at each AO, and (iii) improved monitoring of child development indicators. All outputs were successfully delivered.

25. **VIF and local capacities.** The VIF was to provide the ayil okmotus and communities in the project raions with the financial resources to address their specific needs in ECD. The communities would share 20% of the project cost. The VIF was established in April 2005 by government order, which set up eligibility criteria, principles, and procedures for funding. The number of projects supported by the VIF during implementation increased rapidly, evidencing an improved awareness of ECD in project raions. Reallocation was made from savings to VIFs to meet the increased demand. In total, 983 projects were considered for VIF support and 589 were approved by the government and ADB. Of them, 460 projects were for establishing or upgrading community-based preschools, and 120 were for rehabilitating health facilities (Appendix 7). The CFCs, who were competitively selected and trained, were instrumental to successful community activities under the VIF, preschool, and parents' education components. Success can also be attributed to the appropriately detailed VIF design at appraisal, and to careful planning and monitoring by PMO staff.

26. Local government representatives appreciated the project's transparent management. The oblast project coordination offices kept oblast and raion administrations, ayil okmotus, and communities informed of project activities, and often involved them in project review. VIF-financed projects were publicized in a national newspaper and independent audits of VIF projects were conducted regularly. By implementing the VIF and relevant training and consultation workshops, the project built local capacity to identify the needs of children and opportunities for ECD improvement, promoted participation in ECD activities, and supported the government's policy of decentralization. Although the government did not comply with the loan covenant on CFCs to be integrated into the government system, many CFCs continued to help the communities in other capacities.

27. **Improved ECD monitoring.** The project helped improve ECD monitoring. A child development questionnaire was prepared and added to the social passport survey for annual monitoring of child development issues. The Ministry of Labor and Social Protection (MLSP) conducted the survey to update the database on the economic status of each household in the country since 2000. Computer hardware was procured, and software developed for social passport data management was successfully installed and is used by the MLSP's raion staff (social workers). The skills of 128 social workers were upgraded through training on the use of the revised social passport and data management. Apart from regular social passport monitoring, surveys were conducted at the beginning and end of the project to establish the baseline and end values of ECD indicators, which were not available in official statistics and required household interviews.¹² Others studies were also undertaken to monitor indicators related to health and education service providers.

C. Project Costs

28. At appraisal, the project costs were estimated at \$13.47 million equivalent and were to be financed by (i) an ADB loan of \$10.5 million from the Asian Development Fund, (ii) \$2.57 million from the Government of the Kyrgyz Republic, and (iii) \$0.4 million from the communities. Some minor reallocations were made between project categories to address project requirements. Ultimately, the project was implemented within its estimated costs, utilizing about \$10.26 million or 76% of the appraisal estimate. ADB's actual expenditures amounted to \$9.06 million. The government's actual expenditures amounted to \$0.7 million. The communities contributed \$0.5 million. The final project costs and financing plan are in Appendix 8.

D. Disbursements

29. At completion, loan disbursements under the project loan amounted to \$9.06 million (SDR5.94 million equivalent or 79% of the loan amount). The majority of ADB disbursements were \$3.68 million for vaccines, equipment, and furniture; \$2.87 million for the VIF; and \$0.7 million for civil works, 41%, 32%, and 8% of the project funds, respectively. The amount of \$2.37 million equivalent (SDR1.6 million) was cancelled upon loan closing.

30. ADB provided the project with an advance of \$0.5 million in April 2004 to defray various small expenditures. Because of the large volume of VIF operations and time lag in replenishment, ADB provided an additional imprest advance of \$0.3 million in 2008. The imprest account was used efficiently. While the project's annual disbursements from 2005 to 2006 showed initial delays, disbursements gained momentum from 2007. The statement of expenditure was used for

¹² The surveys included Suzak raion to serve as a comparator to the 12 project raions. The Suzak raion had similar economic situation as the 12 project raions.

payments of \$3,000 and the statement of expenditure procedure was implemented with adequate supporting documents. The yearly disbursements are in Appendix 9.

E. Project Schedule

31. The project generally followed the planned schedule. Some delays were encountered due to political upheaval in 2005, which halted project implementation for about 1 year, but project implementation was normalized by mid-2006 through ADB's active engagement with the new project director. The project was extended by 9 months to allow sufficient time to complete additional activities, especially the replication of successful public-private partnership rural pharmacies to the remaining raions, and finance additional VIF subprojects, taking advantage of loan savings.

F. Implementation Arrangements

32. The project's implementation arrangements were *satisfactory* and the project was generally implemented as planned. The Administration of the President served as the executing agency, ensuring effective coordination of the three implementing agencies, namely the MOES, the MOH, and the MLSP. A project steering committee, with broad representation, was constituted and provided policy guidance and oversight through the project period. Low turnover in the key PMO positions contributed to continuity in the project's operations. A network of coordinators in each of the three oblasts provided crucial support to the PMO in project implementation and served as important links between the PMO and the raions.

G. Conditions and Covenants

33. Compliance with conditions and covenants was *satisfactory*. The government failed to comply with only one covenant for sustaining CFCs' work without financial support from the project after 2 years. The MLSP did not absorb them as staff as promised at appraisal. However, most CFCs continued to contribute to the community works on ECD either informally, as community-based kindergarten teachers, or by becoming *ayil okmotu* members after their contracts under the project were over. Overall, noncompliance did not have a material effect on project outputs. Appendix 10 reviews the final status of each loan covenant.

H. Related Technical Assistance

34. A TA project, Institutional Strengthening for Community-Based Early Childhood Development, was attached to the project.¹³ Its main outputs were (i) an updated, comprehensive strategy for ECD; (ii) preschool standards and policy; (iii) training guidelines for different categories of preschools; (iv) training modules on community mobilization for child and family coordinators and social workers; (v) a monitoring and evaluation design and system for the project; and (vi) a baseline survey and analysis. The TA completion report circulated in 2009 rated the TA *relevant*, as it filled the institutional and capacity gaps in improving and implementing its ECD program and catalyzed major reforms of the overall preschool system, and *highly successful*.¹⁴

¹³ Attached to ADB. 2003. *Report and Recommendation of the President to the Board of Directors: Proposed Loan and Technical Assistance Grant to the Kyrgyz Republic for the Community-Based Early Childhood Development Project*. Manila.

¹⁴ ADB. 2009. *Technical Assistance Completion Report: Institutional Strengthening for Community-Based Early Childhood Development*. Manila.

I. Consultant Recruitment and Procurement

35. At appraisal, consulting services were estimated at 23 person-months of international consultants for project implementation support, and 642 person-months of national consultants for support of child health and nutrition, early childhood care and education, and project management. As the government was reluctant to use loan proceeds for consulting services, the PMO did not procure the services of an international project management consultant.

36. The bulk of procurement under the project was for civil works to repair health-care and educational facilities; goods, including educational and clinic furniture; equipment; and supplies. Numerous small civil works contracts under the project were awarded in accordance with the local competitive bidding process under the government's standard procurement procedures, which were acceptable to ADB. Some delays occurred in 2004 due to the small size of works at facilities spread over the country, resulting in low interest among local firms to bid. The problem was resolved by rearranging works under relevant lots. Major equipment was procured through ADB's international procurement procedures, while other equipment and furniture were procured through local competitive bidding, shopping, and direct purchase procedures acceptable to ADB. No issues were encountered in consultant recruitment and procurement of goods. The recruitment of consultants was in accordance with ADB's *Guidelines on the Use of Consultants*.¹⁵ No major problems were encountered in following ADB's *Guidelines for Procurement*.¹⁶

J. Performance of Consultants, Contractors, and Suppliers

37. The implementation of and outputs from consultancy services were *satisfactory*. No issues with regard to the performance of contractors and suppliers were identified.

K. Performance of the Borrower and the Executing Agency

38. The performance of the borrower and the executing agency was *satisfactory*. The role of the President's office as a coordinator of multiple implementing agencies was critical from the design stage. The President's office strongly supported reforms in preschool standards, essential drug issues, and others. The PMO and oblast project coordination offices consisted of competent specialists, experienced professionals, and younger enthusiastic support staff. They demonstrated strong commitment to implementing the project and regularly monitored activities. Without an implementation consultant, the team quickly learned ADB operations. The government counterparts' feedback about their performance was very positive.

L. Performance of the Asian Development Bank

39. ADB's overall performance was *satisfactory*. ADB headquarters and Kyrgyz resident mission staff were found to be responsive in providing guidance and granting required approvals. At the request of the government, ADB extended the loan in 2009, which enabled it to replicate the public-private partnership model for sustainable drug supply in seven more raions. After inception, ADB fielded 12 successful missions to monitor implementation throughout the project period, which were deemed sufficient in responding to various project needs.

¹⁵ ADB. 2002, 2005. *Guidelines on the Use of Consultants*. Manila.

¹⁶ ADB. 1999, 2005. *Guidelines for Procurement*. Manila.

III. EVALUATION OF PERFORMANCE

A. Relevance

40. The project was *relevant* at the design stage and remained so until its completion. The project was consistent with the government's development plans and strategies at appraisal and remains relevant with the government's current policies and strategies (as discussed in paras. 3–5). The project was also consistent with ADB's Policy on Education (2002)¹⁷ in which ECD was a priority subsector and policy for the health sector (1999) (footnote 4), which prioritized support for primary health care. ADB's new education policy has shifted focus to higher and technical and vocational education, and ECD is no longer a priority area. However, the project's various activities carried out through public–private partnerships, including establishing community-based kindergartens with community contributions and management and creating rural pharmacy networks, have become increasingly relevant to ADB's Strategy 2020.¹⁸

41. The project's design addressed the main issues of early childhood development in the country, with emphasis on the poorest raions. Its relevance was demonstrated by the rapidly expanding network of community-based preschools, although this was an entirely new concept in the country. It was also supported by the communities' and the government's strong commitment to share the cost of the community-based kindergartens and to support the growing network of rural pharmacies.

42. Although the design was largely appropriate, interventions for reducing IDA were insufficient. The original project design foresaw interventions to support reduction of IDA among pregnant women in project raions. The planned activities were not sufficient to significantly reduce IDA prevalence. IDA prevention is complex, and requires a combination of dietary change and supplementation for selected target groups and promotion of fortified flour. Due to the inadequate quality of the data, it is not possible to determine the project's impact on IDA prevalence.

43. The envisaged limited project support to improve grade 1 education was formally dropped by 2005, when the ADB-funded Second Education Project and the World Bank-funded Rural Education Project confirmed their support for reforms in this area.¹⁹

B. Effectiveness in Achieving the Outcome

44. The project is considered *effective* in achieving its three outcomes, as all outcome indicators were achieved.

45. **Improved access of children to and quality of basic child health and nutrition services.** The project achieved the targets of the three indicators for this outcome as follows (see tables in Appendix 11):

- (i) EPI immunization coverage of more than 95% was sustained through 2009, and the government is allocating sufficient funds to meet national requirements. The republican preventive medicine center has confirmed that securing funding for vaccines is no longer a problem and that the government is planning to add two new vaccines by 2015.

¹⁷ ADB. 2002. *ADB's Policy on Education*. Manila.

¹⁸ ADB. 2008. *Strategy 2020: The Long-Term Strategic Framework of the Asian Development Bank, 2008–2020*. Manila.

¹⁹ ADB. 2005. *Report and Recommendation of the President to the Board of Director on a Proposed Grant to the Kyrgyz Republic for the Second Education Project*. Manila.

- (ii) Seventy-four percent of health workers correctly diagnosed and treated child pneumonia and 85% of health workers correctly explained to mothers how to administer antibiotics, according to the 2009 assessment. Diarrhea appears to be correctly diagnosed in the majority of cases, although there were only a few diarrhea cases during the survey. Although the target of 50% correct diagnoses and treatments has been met for acute respiratory infections and diarrhea, there is still substantial scope for improvement, including classifying anemia, and advising on nutrition for sick children.
- (iii) Ninety-five percent of households in the 12 project raions were using iodized salt in 2009, up from 92% in 2004, according to the end-line survey. The latest annual monitoring in 2008 showed that 98% of households were using iodized salt. This means that the almost universal use of iodized salt achieved during the implementation of the project for Improving Nutrition of Poor Mothers and Children financed by the Japanese Fund for Poverty Reduction (JFPR) was maintained.²⁰ However, this still raises concerns about the quality of iodized salt on the market.

46. Improved access to primary health services is also evident from the end-line survey. Health workers' house visits to young children increased. Annual monitoring conducted by social workers showed that the share of FAPs as primary providers of medical assistance rose from 52% in 2005 to 60% in 2008, while the share of Family Group Practices (FGPs) declined from 44% to 34%.

47. **Improved access of children to and quality of preschools run by the state, or based on communities or home.** The indicator for the second outcome of improving access to and quality of preschools (at least 50% of children who attended preschool enter primary school against those without any kind of preschool) was achieved. According to the monitoring data of the MOES, about 76% of children who entered grade 1 had attended state- or community-based kindergarten or the 100-hour school preparation program (see Appendix 12). In the 12 project raions, more than 13,100 children are enrolled in 324 community-based preschools and about 4,200 children are enrolled in 46 state kindergartens. This means that community-based preschools have contributed to a three-fold increase in the number of children enrolled in preschool programs.

48. **Improve the capacity of communities to plan and manage child development.** The targets of the two indicators for this outcome were also achieved.

- (i) The first indicator—at least 80% of ayil okmotus implementing projects financed by the VIF—was achieved; 119 of a total 129 ayil okmotus, including urban settlements (i.e., 92% of ayil okmotus in the project raions) implemented VIF projects. Ayil okmotus played an important role in motivating their communities to establish and sustain community programs. As a result, the participation level of communities was very high and the percentage of people who found ayil okmotus helpful in contributing to the well-being of children has more than doubled, from 16% in 2004 to 37% in 2009.
- (ii) The second indicator—at least 60% of communities organizing community- and home-based preschool activities—was also achieved, as 224 of 399 villages, or 62% of the

²⁰ ADB. 2001. *Proposed Grant Assistance (Financed from the Japan Fund for Poverty Reduction [JFPR-9005]) to Asian Countries in Transition for Improving Nutrition for Poor Mothers and Children*. Manila.

villages in the project raions, established preschools. In total, 463 of 589 VIF-supported projects were aimed at supporting education needs. The monitoring survey showed that 51% of respondents indicated that there is a preschool in their community. This figure has more than tripled since 2004, when it was as low as 15%.

C. Efficiency in Achieving Outcome and Outputs

49. The project was rated as *efficient*. The project completed most of the originally planned activities within 5 years of the effective date, even though it suffered from frequent change of director and slowed down for more than a year following the revolution in March 2005. An extension of 9 months was granted to complete additional activities, especially replicating the successful public–private partnership (PPP) rural pharmacies to the remaining raions, and finance additional VIF subprojects, taking advantage of loan savings. The project completed all planned and additional activities by March 2010.

D. Preliminary Assessment of Sustainability

50. Sustainability of the project is rated *likely*. For the last year and a half, the project worked to ensure sustainability of project activities beyond the project implementation period. For all project outputs, the government has developed, or is developing, institutional and financial sustainability measures. The government budget finances EPI vaccines and cold chains are regularly maintained, partly with UNICEF's assistance. IMCI is included in medical universities' pre-service training curriculum, and were included in feldshers' pre-service training Rural pharmacy networks run by private pharmaceutical retailers in collaboration with the government have been profitable, and some companies are planning to expand to other villages on their own.

51. Community-based kindergartens were established with the project's support for start-up investments and with communities' cash and in-kind contributions, and their entire recurrent costs have been borne by the communities and by the ayil okmotus, in some cases. Community-based kindergartens are also now officially recognized institutions, according to the new preschool law. Thus, they are likely to be sustainable even without additional support. Eager to ensure their sustainability, the MOES has agreed with the MOF on the government's financial support for preschools.

52. The project provided extensive support to increase parents' confidence and competence in enhancing their children's development and learning, advocate for early prevention and treatment of health or developmental problems, promote successful school achievement, and increase parents' involvement in their children's school experience. As evidenced by the monitoring survey, these achievements are likely to be maintained in the short run. The most successful parent education programs were mainstreamed into training programs, which some local nonformal training providers (NGOs) deliver under sponsored projects. However, to ensure the positive long-term effect of parent education, effective parent education strategies should be worked out and incorporated into the government's education policies.

53. Communities and ayil okmotus have acquired experience in designing and managing community-based projects under the VIF. This experience is likely to remain with them, as they maintain preschools and other VIF-financed projects, or apply it to other projects.

E. Impact

54. **Impact Indicators.** The project Design and Monitoring Framework (DMF) identified five impact indicators. Progress on the indicators is provided in Appendix 13. The IMR in Jalalabad, Naryn, and Osh oblasts declined by 25% on average from 2006 to 2008²¹ and the U5MR declined by 18% over the same period. Thus, there is a chance that the IMR and U5MR will have been reduced by 20% and 30% from 2004 to 2009. Government statistics, however, have been known to underestimate the IMR and U5MR as well as the prevalence of IDD and IDA; moreover, some data is incompatible due to changes in some of the definitions used.²² Therefore, the real extent of reduction is hard to determine. At any rate, with the improving quality of primary health services, women's IDA status is likely to improve and the IMR and U5MR are likely to decline steadily in the next few years in the project raions.

55. To achieve MDGs on the IMR and U5MR, neonatal mortality will have to be significantly reduced. By the project's midterm review, better data on neonatal mortality was available and showed that more than half of infant deaths occurred during the neonatal period. In 2004, ADB and the MOH developed a pilot project focusing on the reduction of neonatal mortality in four project raions in Osh oblast.²³ Under the pilot project, neonatal mortality and the IMR declined by half between 2005 and 2009.

56. The assumption of decline in IDA prevalence is based on the following: (i) the end-line survey showed that more people who have been diagnosed as anemic are taking iron tablets; and (ii) the implementation of mandatory flour fortification to help reduce IDA. It is unlikely that IDD prevalence will have declined by 30% between 2004 and 2009 mainly because its prevalence had already fallen from 2003 to 2004 among those who consumed iodized salt. Thus, the project has helped maintain the reduced level, rather than further reduced it. Also, the problem of inadequately iodized salt emerged during implementation, which the project had no control over.

57. According to studies conducted under the project, the percentage of children in grade 1 passing basic literacy, mathematics, and life skills tests increased by more than 30%. These results are in line with other indicators, all pointing to the project's very positive impact on children's preparedness for primary school. The results are likely to be sustained for the foreseeable future, as community-based preschools are likely to be sustained, as discussed earlier.

58. **Impact on institutions.** The project strengthened existing service-delivery systems. It has also brought the private sector and the communities into social services previously monopolized by the government. Essential drugs, including those for IMCI, are now accessible through for-profit private pharmacies with government support through MHIF and *ayil okmotus*. Community-based preschools, established with community contributions, are formally recognized by a new preschool law, while the previous law recognized only state kindergartens.

59. Another important institutional impact is strengthened local self-governance. The *ayil okmotus* and communities have proven capable of designing, managing, and sustaining VIF-

²¹ The 2006 data seemed to be more compatible than those for 2005. The IMR and U5MR of the Republican Medical Information Center showed increase in the IMR and U5MR as a result of the change in the definition of live births in 2006. The 2009 data will be available in late 2010.

²² The change in the definition of live births in 2004 caused data incompatibility between the beginning and the end of the project.

²³ ADB. 2004. *Grant Assistance to the Kyrgyz Republic for Reducing Neonatal Mortality in Osh*. Manila (financed by the Japan Fund for Poverty Reduction).

financed projects, and, in general, their capacity increased during project implementation. The end-line survey also showed that people's perception of the ayil okmotus improved. Compared to only 16% in 2004, 37% of respondents said that ayil okmotus are helpful during 2009 survey.

60. **Socioeconomic impact.** The project was targeted at the 12 poorest raions: those with higher than 70% poverty rates in 2003. The Kyrgyz Republic has about 490,000 children under 5 years of age, including about 101,000 infants, who benefit from the project's support for immunization, IMCI, and nationwide TV programs on child development. In the 12 project raions, about 120,000 children below 7 years of age benefit annually from better childcare by trained parents, better primary health services, and preschool programs.

61. ECD's long-lasting impact on children's well-being in general and its larger impact on economically disadvantaged children have been well documented. The World Bank confirmed that community-based preschools (kindergartens) are distributed among the poorest communities, while state kindergartens were benefiting wealthier groups. Also, an independent study conducted by the Kyrgyz Academy of Education on grade 1 schoolchildren showed major improvements in their literacy and mathematical skills.

IV. OVERALL ASSESSMENT AND RECOMMENDATIONS

A. Overall Assessment

62. On the basis of the preceding assessment, the project was found to be *relevant, effective, efficient, and likely to be sustainable*; overall the project is rated *successful*. The project was largely implemented as conceived and met the original objectives. The project's highly successful outputs include delivering EPI vaccines and cold chains and increasing the government's self reliance on EPI vaccine financing; establishing rural pharmacies through public-private partnerships; establishing the legal framework for community-based preschool services; and establishing and operating preschool programs.

B. Lessons

63. **Strong executing agency.** A multisector project requires a strong executing agency that can coordinate multiple implementing agencies. Major reforms also require strong leadership from the executing agency. The Administration of the President of the Kyrgyz Republic as the executing agency contributed enormously to the project's success despite the major regime change in the middle of project implementation.

64. **Community-based approach.** As the project proved, communities are powerful agents for designing and implementing projects that they themselves benefit from. Those community-developed projects are likely to be sustainable.

65. **Flexibility and transparency.** Implementing a project in a new field, especially in a dynamically changing transition economy, requires flexibility on the part of both the government and ADB. Willingness to adjust the project's design to a new environment or new findings and acceptance of extra time required for the adjustments is essential. To be successful, the project must also be transparent to receive support from local governments and communities.

66. **Sufficient time for establishing policy, and legal and institutional frameworks.** Given that the idea of community-based preschools was innovative for the country, sufficient time should

be given for a legal and regulatory framework to be established to adequately serve preschool educational services at the community level.

C. Recommendations

1. Project Related

67. **Monitoring.** To ensure that ECD indicators continue to improve and project activities are sustained, the government should continue to monitor (i) key indicators on ECD set out in the project's DMF, and (ii) the performance of public-private partnership rural pharmacies and preschools, in particular.

68. Sustainability.

- (i) To ensure free or low-cost access for rural children to affordable and flexible preschool programs, the government should promote cost-effective models by keeping the standard requirements to a minimum. While government support is important for sustainability of preschools in rural areas, communities should be given sufficient flexibility in using resources.
- (ii) Efforts should be made to upgrade the professional capacity of teachers through relevant improvements in pre-service teacher training and by promoting enhanced motivation from performance-related pay.
- (iii) Training constitutes a major component in a social sector project. For the training to have real effect, regular supervision after the training is important, and supervision costs should be factored into training costs. The MOH should (i) include supervisory visits by coordinators for child health in IMCI and any other special training plan to ensure that health workers practice newly gained skills, and (ii) improve the quality of training and trainers of state training institutes or contract training out on a competitive basis.
- (iv) The project provided extensive support to increase parents' confidence and competence in promoting their children's development. Although these achievements are likely to be maintained in the short run, to ensure the positive long-term effect of parent education, effective parent education strategies should be incorporated into the government's education policies.

2. General

69. **Project design.** The project's design was largely appropriate, but included some performance targets that were too ambitious to be achieved. For future projects, the design should be more consistent with available resources.

70. **Regulatory framework for public-private partnerships in health and education sectors.** The role of the community and the private sector in the health and education sectors is likely to increase. The government, especially the MOH and the MOES should study the situation, develop strategies, and start preparing a legal and regulatory framework to take advantage of private-sector and community involvement, but also to exercise adequate quality control.

PROJECT FRAMEWORK

Design Summary	Performance Indicators/Targets	Monitoring Mechanisms	Assumptions and Risks	Actual Outputs and Outcomes
<p>Goal</p> <p>Improve health, nutrition and psychosocial development of children between birth and 8 years of age in the 12 poorest raions</p>	<p>Infant mortality rate (IMR) in project raions (districts) reduced by 20% from 2004 levels by 2009</p> <p>Under-five mortality rate (U5MR) in project raions reduced by 30% from 2004 levels by 2009</p> <p>Prevalence of iodine deficiency disorder (IDD) in project raions reduced by 90% from 2004 levels by 2009</p> <p>Iron deficiency anemia (IDA) in project raions reduced among pregnant women by 30% from 2004 levels by 2009</p> <p>The percentage of grade 1 children who pass the basic literacy, mathematics, and life skill test in project raions increased by 30% from 2004 levels by 2009</p>	<p>Statistics of national, oblast, and raion governments</p> <p>Project baseline and evaluation survey at the last year of the project</p>	<p>The Kyrgyz Republic maintains its commitment to child development.</p> <p>Modest economic growth will continue and the poverty rate will be contained.</p>	<p>It is impossible to verify IMR and U5MR reductions because the definition of the live birth was adjusted to World Health Organization standards only in 2004, and general underreporting of child mortality in the government statistics. However, it was noted that IMR and U5MR declined faster in Jalal-abad, Naryn and Osh than the other oblasts.</p> <p>The prevalence of IDD was not reduced dramatically from 2003–2004 among the population who consumed iodized salt. Thus, the reduction of IDD from 2004 to 2009 could be modest.</p> <p>IDA prevalence is also difficult to prove due to the quality of the government statistics. But, 30% reduction by 2009 is very unlikely to have been achieved. This was too ambitious a target.</p> <p>The percentage of children who have scored more than 50% in the test increased by 42%.</p>
<p>Purpose</p> <p>Improve access of children to and quality of basic child health and nutrition services</p>	<p>Sustained universal immunization coverage</p> <p>By 2009, 50% of child illnesses, especially diarrhea and acute respiratory cases treated according to Integrated Management of Childhood Illnesses (IMCI) guidelines</p>	<p>Survey by the Ministry of Health (MOH)</p> <p>The monitoring reports by Family Group Practices (FGPs)</p> <p>Regular recording at primary health care posts (FAPs)</p> <p>Annual household survey by social workers</p>	<p>The health reform efforts will continue.</p>	<p>EPI immunization coverage has been above 95% through 2009.</p> <p>More than 70% of common child illnesses are classified and treated according to IMCI protocols by primary health workers.</p>

Design Summary	Performance Indicators/Targets	Monitoring Mechanisms	Assumptions and Risks	Actual Outputs and Outcomes
<p>Improve access of children to and quality of preschools run by the state, or based on communities or home</p> <p>Improve the capacity of communities to plan and manage child development</p>	<p>By 2009, increased to 100% of households using iodized salt</p> <p>At least 50% of children enter primary school after preschool (vs. against those without any kind of preschool)</p> <p>At least 80% of <i>ajyl okmotus</i> (village authorities) implementing projects financed by the village initiative funds (VIF)</p> <p>At least 60% of communities organizing community/home-based preschool activities</p>	<p>Annual household survey by social workers</p> <p>Survey by grade 1 teachers</p> <p>Regular reports by the project management office (PMO)</p> <p>Annual survey by social workers and monitoring reports by the project coordination office (PCO)</p>	<p>Ministry of Education and Culture (MOES) will maintain its commitment to preschool reform.</p> <p>The government maintains the decentralization efforts.</p> <p>The village authorities will not change frequently</p>	<p>According to the annual survey by social workers 98% of households were using iodized salt in 2008. According to end-line survey, it was 95%.</p> <p>76.9% of children who entered grade on had attended kindergarten or the 100-hour school preparation program.</p> <p>119 AOs out of total 129 village authorities (including urban settlements), i.e. 92% of village authorities in the project raions implemented VIF projects.</p> <p>224 out of 399, or. 62% of the villages in the project raions established preschools.</p>
<p>Outputs/Activities</p> <p>1. Child Health and Nutrition Maintained delivery of 100% of vaccine requirements to vaccines centers.</p> <p>Effectively maintained cold chain for ensuring vaccine potency</p> <p>Feldshers (primary health care workers) trained on IMCI</p> <p>Testing of salt by the community</p>	<p>Annual vaccine supplies ensured at the beginning of every year</p> <p>Nonworking refrigerators repaired and replaced</p> <p>Training plan for feldshers developed</p> <p>Feldshers and FGP doctors trained</p> <p>Testing kits supplied to all communities</p> <p>Salt testing conducted at least annually in all communities</p>	<p>Reports by the MOH Sani</p> <p>Epidemiology Services and reports by FGPs and FAPs</p> <p>Reports by FAPs and Family Medicine Center</p> <p>Annual survey by the social worker</p> <p>Report by the PCO</p>	<p>FGP doctors are trained by other sources.</p> <p>Iodized salt is available in sufficient quality in the country at affordable prices.</p>	<p>All vaccine requirements have been met.</p> <p>The national immunization center regularly maintained the cold chain</p> <p>In total, 271 primary health workers including all feldshers in the project raions and 25 FGP doctors in Nookat raion and 47 medical nurses were trained in IMCI.</p> <p>Salt test kits were procured, and salt testing was conducted annually.</p>

Design Summary	Performance Indicators/Targets	Monitoring Mechanisms	Assumptions and Risks	Actual Outputs and Outcomes
FAPs rehabilitated and provided with sufficient essential drugs and basic equipment	<p>Rehabilitation completed</p> <p>Equipment procured for FAPs</p> <p>Essential drugs purchased annually and delivered to the FAPs</p>	Report by FGP and FAPs Regular reports by the PCO and the PMO	Essential drugs will safely reach the intended FAPs.	<p>131 FAPs and 59 other health facilities were rehabilitated. All FAPs were equipped.</p> <p>Essential drugs are delivered through rural pharmacy networks established through public–private partnership. Ninety percent of people in the project raions now have access to pharmacies compared to only 30% before the project.</p>
2. Early Childhood Care and Education Community and home-based preschools established and provided with learning materials	<p>Child development committee or equivalent established at the community and a model selected with assistance of the child family coordinator (CFC)</p> <p>The training module on the community-based preschool developed.</p> <p>Community-based preschool teachers selected and trained</p>	<p>Regular report of the PCO</p> <p>Regular report of the PMO</p> <p>Regular report of the PMO</p>	<p>Communities are willing to try out a new preschool.</p> <p>Qualified candidates for preschool teachers are available.</p>	<p>325 out of 400, i.e. more than 80% of communities have established child development initiative groups or committees with CFCs' assistance</p> <p>The training module drafted by a technical assistance consultant was adjusted by the education and health specialists of the Kyrgyz Republic to suit local need.</p> <p>463 preschool teachers for over 300 preschools have been trained.</p>
A resource kindergarten per raion established	Resource kindergartens procured with learning and reference materials, and plan and conduct supervision of other preschool programs	Regular report of the PCO and the PMO	<p>The kindergarten is willing to play a supervisory role.</p> <p>The staff understands alternative models of preschools.</p>	Resource kindergartens were provided with pedagogical materials and reference books, as well as learning materials for children.
Teaching at Grade 1 improved	<p>Teacher in-service training plan developed and 750 teachers (one teacher per class) trained</p> <p>All grade 1 students have a set of textbooks</p>	<p>The plan submitted by the oblast education department and annual survey by the social workers</p> <p>Report of the oblast education department and annual survey by the social workers</p>	Existing teacher training centers have sufficient capacity.	

Design Summary	Performance Indicators/Targets	Monitoring Mechanisms	Assumptions and Risks	Actual Outputs and Outcomes
Parents trained on better child care at home	Parents education materials developed and 50,000 parents trained	Regular report of the PMO and report by the AO	Parents are interested in better child caring and have time to attend training.	The entire number of target parents, 43,000,(50,000 was an overestimate) were trained and 25,000 parents received materials that were developed in the latter part of the project. Other parents have access to the materials provided at resource kindergartens and preschools.
Strategy and standard for preschool developed	A task force constituted and the strategy and standard drafted and approved by MOEC	The report of the task force and submission of the final approved strategy and the standard solution to the president's office	The task force will comprise capable professionals, able to think creatively.	The preschool standards were approved by the government in Jan 2007.
Selected kindergartens and grade one classrooms rehabilitated	A rehabilitation list developed and planned Rehabilitation completed	Report of the PCO (prepared by the project architect)		23 state kindergartens were rehabilitated.
3. Capacity Building Village initiative fund (VIF) established.	The resolution for the VIF passed by the government	A copy of the resolution	The community is able to cofinance a project.	The regulation on VIF was approved by MOF's order No.57-11 on 23 March 2005 and registered by the Ministry of Justice on 20 April 2005.
	Village authorities and community leaders trained on the mechanism and application for the VIF	Report of the PCO		Heads of all village authorities were trained in 2005, and after a 2005 election, newly elected village authorities were trained in 2006.
CFC's appointed at each village authority	Village authorities completing the selection and contracting of the CFC according to the agreed-upon criteria and terms of reference. CFCs trained on child development and their role.	A copy of contracts for CFCs Report of the PCO.	Qualified candidates for the CFCs are available in each AO.	Recruitment for CFCs were advertised at each village authority, and 116 CFCs were selected on a competitive basis based on criteria agreed between village authorities and the PMO. All CFCs were trained.
Child development questionnaire developed and added to the social passport survey	Child development module modified and endorsed by the steering committee and added to the social passport survey, at least in the project raions	Copy of the questionnaire endorsed by the steering committee submitted		An ECD module was discussed with all implementing agencies, and approved by the government and added to the social passport survey. As the survey was no longer annually conducted, social workers

Design Summary	Performance Indicators/Targets	Monitoring Mechanisms	Assumptions and Risks	Actual Outputs and Outcomes
Social workers trained	116 social workers trained along with CFCs	Annual social passport survey reports Report of the PCO.	Turnover of social workers will be minimal.	conducted the ECD survey as an independent exercise annually. 128 social workers were trained together with CFCs.
Raion Ministry of Labor and Social Protection (MLSP) staffers trained on data social passport data management	Computer program for the social passport data management developed and staff trained on data management.	Report of the PCO	MLSP should bear recurrent cost for the computer.	MLSP raion offices were provided with computer and software, and managed ECD data.
Inputs	Base Cost (\$)			
1. Child Health and Nutrition	3,308,000	Quarterly progress reports submitted by the President's office and PMO	PMO and MLSP personnel are proficient in collection, interpretation, and analysis of data and trends.	
2. Early Childhood Care and Education	2,739,000	MOH and MOES reports	Quality of data and information are transparent and impartial	
3. Capacity Building	2,315,000	Supervisory missions by Government and ADB	Reporting activities are carried out in a timely manner within the agreed-upon time frame.	
4. Project Implementation	1,311,000	Field surveys and studies		

AO = Ail Okmotu, CFC = child and family coordinator, ECD = Early Childhood Development, FAP = feldshers accoucheur (midwife) post, FGP = Family Group Practice, IDD = iodine deficiency disorder, IMR = infant mortality rate, MOES = Ministry of Education and Science, MOF = Ministry of Finance, MOH = Ministry of Health, MLSP = Ministry of Labor and Social Protection, PCO = project coordination office, PMO = Project Management Office, U5MR = under-five mortality rate, VIF = Village Initiative Fund.

Source: ADB. 2003. *Report and Recommendation of the President to the Board of Directors: Proposed Loan and Technical Assistance Grant to the Kyrgyz Republic for the Community-Based Early Childhood Development Project*. Manila.

VACCINE PROCUREMENT FINANCING

Table A2.1: Vaccine Procurement Financing
(\\$)

Item	2004	2005	2006	2007	2008
	Amount	Amount	Amount	Amount	Amount
ADB	177,976	356,122	394,602	298,901	205,345
Government	78,000	250,000	263,158	285,000	411,168

ADB = Asian Development Bank

Sources: Community-Based Early Childhood Development Project Completion Report of the Administration of the President of the Kyrgyz Republic. Bishkek. 2010; Republican Immunoprophylaxis Center, the Ministry of Health of the Kyrgyz Republic .

Table A2.2: Vaccine Procurement Financing
(%)

Item	2004	2005	2006	2007	2008
Government	30	30	40	50	60
ADB (Project)	70	70	60	50	40

ADB = Asian Development Bank.

Source: Community-Based Early Childhood Development Project Completion Report of the Administration of the President of the Kyrgyz Republic. Bishkek. 2010; Republican Immunoprophylaxis Center, the Ministry of Health of the Kyrgyz Republic .

PUBLIC–PRIVATE PARTNERSHIP FOR SUSTAINABLE DRUG SUPPLY

1. The availability of essential drugs in remote rural areas was considered to be a major constraint to achieving quality care. The pharmaceutical network was privatized during the mid-nineties, except for hospital pharmacies. Since the privatization of all outpatient pharmacies in 1990s, most of remote villages have been left with no pharmacy. At the time of appraisal, the Mandatory Health Insurance Fund (MHIF) of the Kyrgyz Republic had just started introducing an additional drug package (ADP) to subsidize essential drugs based on doctors' prescriptions. The ADP included Naryn in 2002, and Osh and Jalal-Abad in the end of 2003. It was expanded to all oblasts in 2002. The co-payment mechanism of the ADP formed a part of the state benefits package. In this scheme, pharmacies contract with the MHIF to sell an approved list of drugs to enrolled patients at a reduced cost. Children under 5 years and women were the priority categories for financial assistance in purchasing medicines.

2. However, the financial assistance provided through the MHIF was limited by the absence of pharmacies in the remote villages and the reduced availability of the assistance at the primary healthcare level. Although children and pregnant women were covered by MHIF, few children and women in rural areas could benefit from it. First, the essential drug list did not include the drugs required for implementing IMCI, or iron tablets for treating anemia, and secondly, there were no pharmacies in remote villages. One reason for the lack of rural pharmacies was that establishing a pharmacy in a rural area was simply not viewed as a good investment by the private sector. As a result, MHIF's ADP was unintentionally benefiting more of urban and adult patients, neglecting rural patients and children. Establishing a reliable and affordable essential drug distribution system for remote villages throughout the entire country was therefore a critical task.

3. In 2004, the MHIF of the Kyrgyz Republic and the Kyrgyz-Swiss Health Reform Support Project began a pilot project to establish a not-for-profit pharmacy network in the remote villages of Jumgal raion in Naryn oblast. "Makzat," a newly established nongovernment organization (NGO), opened one central warehouse in Jumgal raion centre and 13 pharmacies on the premises of existing FGPs and FAPs in 13 Jumgal villages. Funds from the Kyrgyz–Swiss Health Reform Support Project were used to purchase an initial supply of medicines. These medicines are replenished through a revolving fund mechanism. Nurses and feldshers manage the pharmacies after successful completion of a certified training program. The objectives of the pilot were to provide accessible and affordable high-quality, safe drugs; increase access to medicines supplied through the ADP; and increase the effectiveness of primary health care in rural areas. The donors created and financed the organization and financed the equipment and furniture in the pharmacies and the salaries of the pharmacists. An evaluation in November 2005 of the Jumgal pilot model by ZdravPlus and Boston University and the World Health Organization–Department for International Development of the United Kingdom Health Policy Analysis Project was positive.

4. The project convinced MOH of adding drugs required for implementing IMCI to the essential drug list. In 2002 MOH also allowed health workers to act as dispensers, after training. The latter scheme itself did not effectively help increase access to essential drugs in rural areas, but later contributed to public–private rural pharmacy networks. In 2006, MOH, MHIF, and ADB agreed to modify the model piloted in Jumgal raion and to create village pharmacy networks by giving incentives to the private pharmaceutical retailers to open pharmacies in remote villages. The government provided a premise for a pharmacy, and the project financed an initial supply of essential drugs, minimum equipment furniture, training of health workers to be dispensers. A private company had to establish and run a net work of rural pharmacies, with a head pharmacy

in or near a raion center and branches in remote villages that did not have pharmacies. The pharmacies had to have drugs on the government's essential drug list including IMCI drugs. MOH and the project enforced price regulation for IMCI drugs, but allowed pharmacies to sell any other registered drug or toiletry to make profits. Private companies were selected through a competitive bidding.

5. The model was piloted in three raions first starting 2007, and very closely monitored. After the success, it was rolled out to six more raions. In 2005, less than 100 pharmacies (including illegal operations) existed in raion centers of the 12 raions. As of March 2009, two private firms are running an additional 123 pharmacies (including three pharmacies opened by the private firm's own initiative) in 9 out of the 12 raions.¹ Now 90% of the people in the nine raions have access to pharmacies compared to only 30% before the rural pharmacy networks were established. A monitoring report of the first three raions² (Alay, Kochkor, and Toktogul) showed that majority of populations now have access to drugs, and drugs have become cheaper, and perceived as of better quality. Each pharmacy network became profitable within a year.

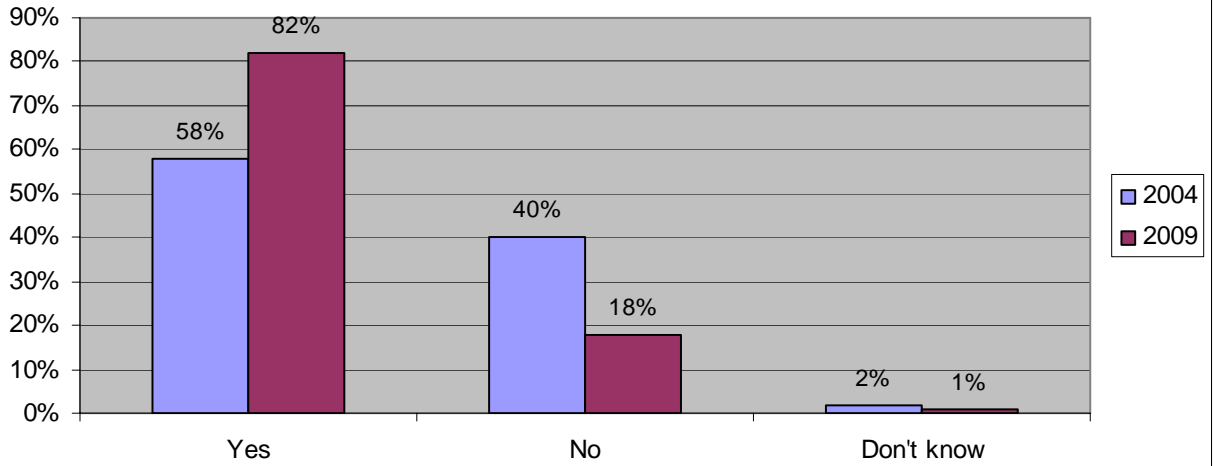
6. The project and MHIF have now improved access of rural populations to essential drugs, and to some extent to MHIF ADP. The next step is to ensure equitable access among the insured rural populations to ADP. The project found doctors tend to use MHIF prescription forms for elder patients, not for children and women. A reason seems to be that doctors prioritized MOH's priority diseases. MOH monitors the prevalence of four diseases (hypertension, asthma, anemia, and stomach ulcers), which are common among pensioners who are also covered by MHIF.

¹ Chon-Alay will be covered by Aga Khan, Chatkal will be covered by a local private pharmacy, and Jumgal has been covered by NGO Maksat.

² Health Care Institute. 2009. *Monitoring of Pilot Projects on the Establishment of Pharmacy Nets in Toktokgu, Alay, and Kochkor Raions under the Community-Based Early Childhood Development Project*. Bishkek.

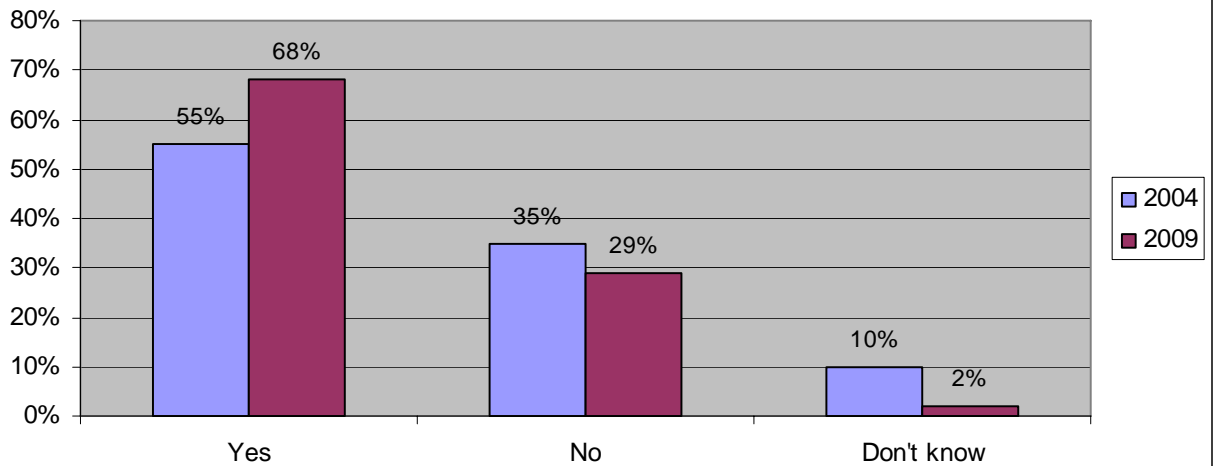
PUBLIC AWARENESS OF IODINE DEFICIENCY DISORDER AND IODINE DEFICIENCY ANEMIA

Figure A4.1: Women with Goiter or Iron Dificiency Disorder Taking Iodine Tablets



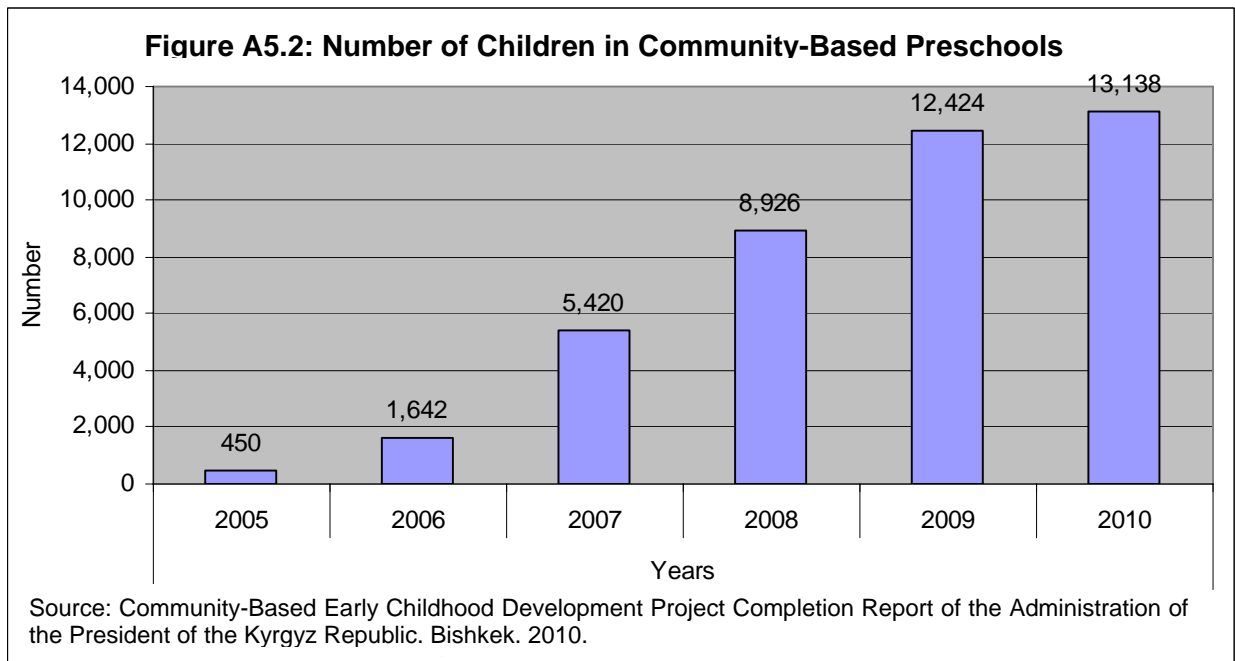
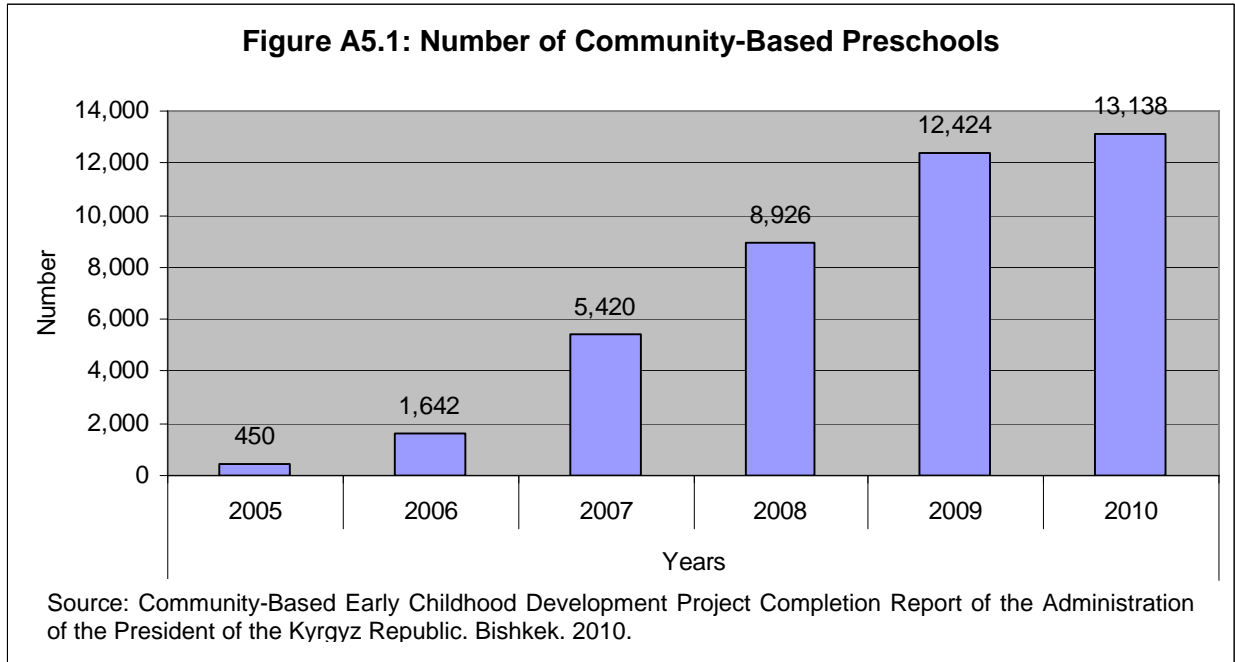
Source: End of Project Survey Evaluation Report 2009. Community-Based Early Childhood Development Project Completion Report of the Administration of the President of the Kyrgyz Republic. Bishkek. 2010.

Figure A4.2: Children under 5 with Goiter or Iodine Dificiency Disorder Taking Iodine Tablets



Source: End of Project Survey Evaluation Report 2009. Community-Based Early Childhood Development Project Completion Report of the Administration of the President of the Kyrgyz Republic. Bishkek. 2010.

ESTABLISHMENT OF COMMUNITY-BASED PRESCHOOLS



MAJOR REGULATIONS AND GUIDELINES, TRAINING MATERIALS, AND MODULES TO SUPPORT CHILD CARE AND EDUCATION COMPONENT

Objective	Outcome	Major Documents Developed with Project Support
Promote early childhood development (ECD)	Improved legal and regulatory framework	<ul style="list-style-type: none"> • Preschool education concept (approved by the government in 2005) • Preschool standards (approved by the government in 2005) • Preschool Law (approved by the Parliament in April 2009)
Promote ECD at community level	Improved parental awareness of ECD	<ul style="list-style-type: none"> • The parental 10-days training program based on the “Resource Book for Parents” • Training aids (brochures in Kyrgyz language) distributed to 25,000 parents • Learning materials developed, bulletin “Baldar Uchun” issued, “Tushoo Kesuu” TV program on ECD importance
	Effectively Operating Child and Family Coordinators (CFCs)	<ul style="list-style-type: none"> • A module for 10-day trainings of CFC based on the “Resource Book for Parents”
Establishment of resource centers based on resource kindergartens (RKs)	Qualified methodological support to preschool teachers	<ul style="list-style-type: none"> • Methodology on establishment and operation of RKs • Draft regulation on RKs (to be approved by the Ministry of Education and Science [MOES]) • Order of MOES on establishing the selected 12 RKs • The Guidebook on Training of Teachers of Preschools (approved by MOES) • The Mechanism of Interaction of RKs and Community-Based Kindergartens (approved by MOES)
	Learning and training materials to create library fund and for learning activities	<ul style="list-style-type: none"> • List of manuals, learning materials, and books approved by MOES for use at libraries at RKs and community-based preschools • Series of child literature comprised of 15 items under the title “Trip to the world of books” (approved by MOES)

Source: Community- Based Early Childhood Development Project Completion Report of the Administration of the President of the Kyrgyz Republic. Bishkek. 2010

VILLAGE INITIATIVE FUND

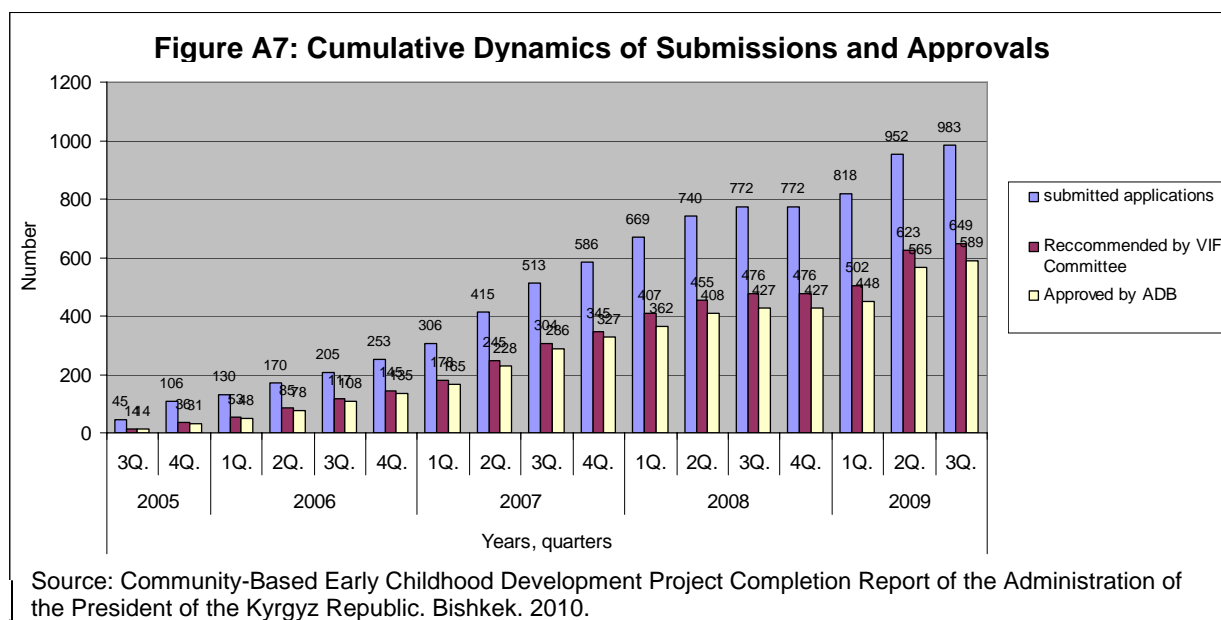


Table A7: Approvals for Health and Education

Oblast	Approved VIF Projects in Education			Approved VIF Projects in Health			Approved Total		
	Qty	Amount (KGS)	Actually disbursed (KGS)	Qty	Amount (KGS)	Actually disbursed (KGS)	Qty	Amount (KGS)	Actually disbursed (KGS)
Naryn oblast	185	35,06,793	32,045,010	55	11,160,959	10,839,325	240	46,222,752	42,884,335
Djalal-Abad oblast	175	36,255,354	36,065,644	36	7,419,785	7,419,785	211	43,675,139	43,485,429
Osh oblast	103	22,233,550	20,259,206	35	6,399,182	5,022,831	138	28,632,732	25,282,037
Total	463	93,550,697	88,369,860	126	24,979,926	23,281,941	589	118,530,623	111,651,801

Qty = quantity, KGS = Kyrgyz Republic Som.

Source: Community-Based Early Childhood Development Project Completion Report of the Administration of the President of the Kyrgyz Republic. Bishkek. 2010.

COMPARISON OF APPRAISAL AND ACTUAL PROJECT COST

Project Cost Estimates and Financing Plan by Source at Appraisal and Actual
(\$ '000)

Item	Appraisal Estimates						Actual					
	ADB		Total Cost	Government and Communities		Total Project Cost	ADB		Total Cost	Government and Communities		Total Project Cost
	Foreign Exchange	Local Currency		Local Currency	Local Currency		Foreign Exchange	Local Currency		Local Currency	Local Currency	
Investment Costs												
A. Rehabilitation of												
Facilities	190	629	819	181	810	1,000	163	539	702	154	693	856
B. Furniture	143	527	670	130	656	800	610	0	610	0	0	610
C. Equipment	506	38	544	9	47	554	536	195	731	59	254	790
D. Supplies	2,390	712	3,103	113	826	3,216	1,851	485	2,336	80	565	2,416
E. Training	168	426	597	109	538	706	11	606	617	156	762	773
F. Community and IEC												
Campaigns	60	86	145	25	111	170	3	84	87	27	111	114
G. Village Initiative Fund	548	1,073	1,621	400	1,473	2,021	2,871	0	2,871	500	500	3,371
H. Surveys	15	15	30	0	15	30	0	42	42	0	42	42
I. Consultancies	418	88	506	27	115	533	18	254	272	101	355	373
J. Monitoring and Data Acquisition	10	28	38	7	35	45	0	18	18	5	23	23
PMO Operation	41	379	420	98	477	518	147	351	498	68	419	566
Account Audit	54	5	59	1	6	60	29	0	29	0	0	29
Recurrent Costs	110	86	196	14	101	210	0	0	0	0	0	0
Duties and Taxes	0	0	0	1,700	1,700	1,700	0	0	0	52	52	52
Total Investment	4,649	4,095	8,748	2,815	6,913	11,563	6,239	2,574	8,813	1,202	3,776	10,015
Contingencies	504	1,022	1,526	154	1,176	1,680	0	0	0	0	0	0
Interest Charge	226	0	226	0	0	226	245	0	245	0	0	245
Total Project Cost	5,383	5,117	10,500	2,970	8,087	13,470	6,484	2,574	9,058	1,202	3,776	10,260

ADB = Asian Development Bank, IEC = information, education, and communication, PMO = project management office

Sources: Asian Development Bank and project management office

YEARLY DISBURSEMENT OF LOAN PROCEEDS
(\$ '000)

Category	2004	2005	2006	2007	2008	2009	2010	Total
01 Civil Works	279	423	0	0	0	0	0	702
02A Furniture	7	0	75	115	116	227	70	610
02B Equipment	43	49	294	34	127	169	16	732
02C Supplies	203	429	388	581	371	315	49	2,336
03 Training	69	243	19	48	124	114	0	617
04 Community and Information, Education and Communication Campaigns	0	12	10	14	39	11	0	86
05 Village Initiative Fund	0	146	285	419	1,167	854	0	2,871
06 Surveys	34	8	0	0	0	0	0	42
07 Consulting Services	18	76	16	11	76	101	3	301
08 Monitoring and Data Acquisition	0	16	0	0	0	2	0	18
09 Project Management	49	163	29	40	117	100	0	498
10 Interest Charge	2	9	24	36	54	74	46	245
Total	704	1,574	1,140	1,298	2,191	1,967	184	9,058
Percentage to Total	7.77	17.38	12.59	14.33	24.19	21.72	2.03	100.00

Source: Asian Development Bank estimates

STATUS OF COMPLIANCE WITH LOAN COVENANTS

Covenant	Reference in Loan Agreement	Status of Compliance
The Borrower shall ensure that the State Medical Institute for Continuous Training provides IMCI training to the FGP doctors and feldshers, based on the IMCI training module developed by MOH in collaboration with UNICEF and WHO, in accordance with a training program to be agreed between MOH and the Bank.	Schedule 6, para. 7a	Complied with. As planned training of 24 FGPs and 190 feldshers completed under contract with IMCI. Monitoring conducted after the training found the training to be successful.
The Borrower shall also ensure that, by the end of the third year of the Project implementation period, MOH develops a plan, satisfactory to the Bank, for continued IMCI training of the relevant health personnel, sustaining the universal immunization coverage and continued supply of essential drugs to the FAPs.	Schedule 6, para. 7b	Complied with. From 2009, the government is financing vaccines requirements without project support. A covenant on supply of drugs to FAPs is irrelevant now, as the project introduced a PPP pharmacy nets model.
The Borrower shall ensure that community preschool, preparatory preschool and kindergarten teachers and their assistants are trained in subjects agreed between the Borrower and the Bank, in accordance with a set of training guidelines to be developed under the Technical Assistance project.	Schedule 6, para. 7c	Complied with. A resource book on community-based preschool programs, and training book on parents education was developed by the TA consultants. All training modules for teachers have been successfully completed.
The Borrower shall cause the FAPs to dispose of any medical waste that may be produced at such posts in accordance with a waste management system acceptable to the Bank. The Borrower shall review, in consultation with the Bank, the medical waste disposal practices of the FAPs by the end of the second year of the Project implementation period and, when needed, introduce corrective measures immediately.	Schedule 6, para. 14	Complied with. Government decree (MOH Decree #43 dated 7 October 2003) on disposal of syringes and needles is satisfactory.
The Borrower shall ensure that the AOs in the Project area recruit CFCs to provide assistance in planning, implementing and monitoring of the Project activities at the AO and community level. In particular, the principal tasks of the CFCs shall be to (i) assist the respective AOs to develop workplans for the Project activities at the AO and community levels; (ii) assist and mobilize the communities involved to establish a child development committee and identify the needs of their children; (iii) initiate new preschool and childcare activities; (iv) manage the implementation of the information, education and communication campaign; (v) review the Project activities conducted at the AO or community levels; (vi) monitor performance indicators and prepare Project progress reports and other reports as may be needed by the PCOs.	Schedule 6, para. 5a	Complied with. CFCs have been selected and capacity of village authorities have been strengthened through round of trainings.
The CFCs shall be selected through a competitive selection process and recruited on a contractual basis for the next two years of the Project implementation from amongst candidates who shall (i) be members of their respective communities and demonstrate solid understanding of issues related to children and parents; (ii) be respected leaders in the communities involved; (ii) possess strong organizational and communication skills; and (iv) be independent and willing to travel extensively.	Schedule 6, para 5b	Complied with.

Covenant	Reference in Loan Agreement	Status of Compliance
The CFCs shall work under the supervision of the respective AOs and report to the PCO of the oblast concerned.	Schedule 6, para. 5c	Complied with.
The Borrower shall ensure that within 18 months of the CFCs' recruitment, MLSP and the AO with which the CFCs are associated jointly develop a plan with respect to how the work of the CFCs will be sustained without the financial support under the Project, and submit it for the Bank's consideration.	Schedule 6, para. 5d	Not complied with. CFCs were not absorbed in the government system as promised by the government during project designing. However, most of CFCs continued to work in the community, sometimes as community-based kindergarten teachers.
The Borrower shall ensure that CFCs and social workers are provided with pre-service and on-site in-service training in community mobilization, child development, project administration and other essential subjects relevant to their line of work.	Schedule 6, para. 7d	Complied with. Orientation training was conducted in October 2005. Further training was provided by a training institute in 2005.
The training of teachers, CFCs and social workers shall be conducted by appropriate training institutions, selected by the Borrower, that shall: (i) be registered in the Borrower's territory; (ii) have adequate financial and management capacity; (iii) have relevant prior experience; (iv) be able to provide adequate references for prior work; (v) have the key personnel and expertise to carry out the work; (vi) be familiar with the local communities and the oblast involved; and (vii) have prior experience in community mobilization, in the case of training of CFCs and social workers.	Schedule 6, para. 7e	Complied with. All training modules for preschool teachers were completed on time.
The Borrower through MOF shall, within three months of the Effective Date, take all necessary measures to make the village initiative fund (VIF) operational. This shall involve, among other things, the promulgation of regulations covering the management, scope, operations and reporting requirements of the VIF.	Schedule 6, para. 6a	Complied with. VIF regulation was ratified by the MOF decree dated 18 February 2004.
Without limiting the generality of the foregoing, the VIF shall finance small-scale community subprojects that have positive impacts on child development. The VIF-funded subprojects shall assist in (i) building local capacity to identify children's needs and opportunities for improving child development; (ii) promoting participation and ownership of local communities in ECD processes; and (iii) supporting implementation of decentralization policies of the Borrower and building capacity of the local administrations. Applications for grants from the VIF may originate from either and individual AO, or from a raion administration on behalf of two or more AOs.	Schedule 6, para. 6b	Complied with. VIF regulation defines the purpose and the intended beneficiaries of the VIF.
Subprojects eligible for VIF financing shall include (i) minor rehabilitation of FAPs, preschools and grade one classrooms (with maximum grant for any one community from the VIF for these purposes being \$2,500 equivalent); and (ii) small-scale community projects having a plausible positive impact on the development of poor children between birth and 8 years of age (with a maximum grant from the VIF for these purposes being \$5,000 equivalent).	Schedule 6, para. 6c	Complied with. On 10 May 2006, an order increasing the VIF ceiling from \$2,500 to \$5,000 for facility repair was approved.

Covenant	Reference in Loan Agreement	Status of Compliance
<p>The communities in the Project area shall develop subproject proposals for VIF financing and submit them to the respective AO for review and consideration. Following their review, the AO shall submit the endorsed proposals for evaluation to the respective PCOs who shall consult with officials from raion administrations and local representatives of MOEC, MOH, and MLSP, when needed. Individual raion administrations shall also be eligible to apply for grants from the VIF to finance subprojects that will benefit poor children coming under the responsibility of more than one AO in that particular raion provided, however, that no application submitted by a raion administration shall exceed \$15,000 equivalent. Raion administrations shall consult with the AOs concerned in developing such subproject proposals. Final decisions on the award of funds from the VIF shall be made by the PMO, with the assistance of the PSCs VIF Evaluation Subcommittee in accordance with criteria agreed between the Borrower and the Bank.</p>	Schedule 6, para 6d	Complied with. The procedures are set out in the instructions of the VIF regulations.
<p>The Borrower shall enter into an agreement, with terms and conditions acceptable to the Bank, with the recipient communities prior to the disbursement of funds from the VIF for the financing of the subprojects. The Borrower shall ensure that not less than 20 percent cash and 10 percent in-kind contributions.</p>	Schedule 6, para. 6e	Complied with.
<p>The Borrower shall ensure that all the raions in the Project area are covered under the MHIF.</p>	Schedule 6, para. 8a	Complied with. All raions in KR are covered under MHIF.
<p>The Borrower shall promptly allocate and transfer to the MHIF the budgetary resources needed for the MHIFs child health insurance scheme to ensure effective health insurance coverage of children under 16 years of age.</p>	Schedule 6, para. 8b	Complied with. The Ministry of Finance has allocated and transferred to the MHIF budgetary resources needed for the MHIF's child health insurance under 16 years of age on timely manner and in full.
<p>For the purpose of complying with the requirements of the Loan Agreement with respect to annual submission of audited financial statements, proceeds of the Loan may be used to finance expenditure for private sector auditors and translation of auditors' reports into English, provided that: (i) such auditors have qualifications, expertise and terms of reference acceptable to the Bank; and (ii) the recruitment process is acceptable to the Bank.</p>	Schedule 6, para. 15	Complied with.
<p>Established, Staffed, and Operating PMU/PIU</p> <p>The President's Office, as the Project Executing Agency, shall have overall responsibility for the carrying out of the Project.</p>	Schedule 6, para. 1a	Complied with. After major government restructuring in 2005, the Department of Strategic and Expertise took over as the new executing agency. (change of the name of the EA)
<p>The services of individual consultants shall be utilized in the carrying out of the Project, particularly with regard to: (i) early childhood care and education; (ii) primary healthcare; (iii) community planning and mobilization; (iv) project management and implementation; (v) evaluation; (vi) information</p>	Schedule 5, para. 1	Complied with.

Covenant	Reference in Loan Agreement	Status of Compliance
systems; (vii) financial management; (viii) procurement; and (ix) architecture/civil engineering		
The consultants shall be selected and engaged by the Borrower in accordance with the following procedures: (a) a list of the candidates together with their qualifications and a draft contract shall be furnished to the Bank for approval before the selection of consultants, (b) promptly after the contract is signed, the Bank shall be furnished with the evaluation of the candidates and a brief justification for the selection, together with three copies of the signed contract, and (c) if any substantial amendment of the contract is proposed after its execution, the proposed changes shall be submitted to the Bank for prior approval.	Schedule 5, para. 3	Complied with.
MOH shall be responsible for implementing Part A, MOEC for Part B, ad MLSP for Part C(iii) of the Project in accordance with arrangements acceptable to the Bank. MOEC with assistance from MOH will carry out the part of the Project that deals with improving childcare practice at home.	Schedule 6, para. 1b	Complied with. Decree of the President issued on 31 January 2004 defined the responsibilities of the implementing agencies.
MOF shall be responsible for establishing the VIF under Part C(i) of the Project and making it operational. MOF shall also be responsible for preparing an operational manual, in form and content satisfactory to the Bank, describing how the VIF will operate.	Schedule 6, para. 1c	Complied with. Decree of the President issued on 31 January 2004 defined the responsibility of MOF as the implementing agency for the VIF.
The Borrower shall ensure that the Project Executing Agency is supported by the Project Steering Committee (PSC) that has already been established by the Borrower in accordance with the President's Order of 18 April 2003. The PSC shall provide policy guidance and advice, facilitate inter-ministerial coordination on Project implementation at the central level, take decisions on policy-related matters and monitor the Project's activities and outputs. The PSC shall be chaired by the Project director, and shall include representatives from MOF, MOH, MOEC, MLSP, the Ministry of Local and Self Government and the oblast administrations in the Project area. The PSC shall meet at least once every three months and as often as necessary.	Schedule 6, para 2a	Complied with.
The PSC shall be assisted by a VIF Evaluation Subcommittee, comprising representatives of MOF, MOH, MOEC, MLSP, the PMO and the PCOs.	Schedule 6, para 2b	Complied with.
The PMO shall be responsible for the day-to-day implementation and management of the Project. The main functions of the PMO shall be to (i) coordinate Project activities, (ii) prepare by 1 September of each year, annual Project implementation plans, including a timetable and related budget for all tasks and a list of projected contract awards and related disbursements, (iii) undertake procurement of goods and services, disbursement of funds, preparation of accounts,	Schedule 6, para. 3	Complied with. Quarterly progress reports were submitted on time.

Covenant	Reference in Loan Agreement	Status of Compliance
auditing, monitoring and evaluation, and reporting on Project performance, and (iv) coordinate training and Technical Assistance inputs. The PMO shall be headed by a Project manager and shall include a procurement officer, a finance officer, a primary health care/IMCI specialist, and early childhood care and education specialist, a community planning and mobilization specialist, evaluation specialist, information system specialist, and an assistant.		
The Borrower shall ensure that a PCO is established, within one month after the Effective date, in each of the Naryn, Jalalabad and Osh oblast administrations, in the Project area. The main function of the PCOs shall be to (i) assist the raion administrations and the Aiyl Okmotus (AO) concerned in the preparation of work programs, and in the planning and monitoring of the Project activities at the local level; (ii) assist those same raion administrations and AOs in the supervision of construction works and in the carrying out of quality control, (iii) identify implementation constraints and report to the PMO, (iv) facilitate the work of CFCs, (v) supervise subprojects financed by the VIF, and (vi) prepare progress reports and Project data required for monitoring and evaluation, Each of the PCOs shall be headed by a Project coordinator and shall include a part-time architect or civil engineer and an assistant.	Schedule 6, para 4a	Complied with. The PCO has been established at each oblast. Project coordinators and architects have been appointed and office premises provided by the oblast administrations.
The Borrower shall ensure that the PMO and the PCOs are provided with adequate staff, office premises and resources during Project implementation.	Schedule 6, para. 4b	Complied with. The PCO has been established at each oblast. Project coordinators and architects have been appointed and office premises provided by the oblast administrations.
The Borrower shall take into account the recommendations of the Technical Assistance and take all necessary actions so as to enable its agencies to pursue effective ECD programs and strategies.	Schedule 6, para. 9	Complied with.
The Borrower shall ensure that standards for preschools, acceptable to the Bank, are developed and approved by MOE within a year after the Effective Date.	Schedule 6, para. 10	Complied with.
The Borrower shall ensure that the computers to be provided under the Project to the raions and oblasts in the Project area are used primarily for the purpose of compiling and analyzing the data gathered for the Social Passport Survey of the Borrower, which includes information on ECD. Without prejudice to Section 4.09 of the Loan Agreement, the Borrower shall also ensure that such computers are appropriately operated and maintained, and necessary allocations are made in a timely manner for the recurrent costs.	Schedule 6, para. 11	Complied with. Computers have been procured for MLSP and well maintained.
The Borrower and the Bank shall jointly undertake a midterm review of the Project in the third year of the Project implementation period to (i) examine the	Schedule 6, para. 12	Complied with.

Covenant	Reference in Loan Agreement	Status of Compliance
scope, design, implementation arrangements and relevant issues in light of the ECD strategies and policies developed by the Borrower, (ii) assess the Project's progress and achievements against its objectives, (iii) identify any problems and constraints, and (iv) recommend remedial action, if and where required.		
Within four months after the Effective Date, the Borrower shall cause the Project Executing Agency to adopt a project monitoring and evaluation plan acceptable to the Bank.	Schedule 6, para. 13a	Complied with. The monitoring and evaluation sheet has been prepared for use by the PMO.
The Borrower shall cause a baseline survey to be carried out in the Project area within a year after the Effective Date. The findings of such survey shall be used to confirm or modify, in consultation with the Bank, the base values and the target values for the key indicators of the Project. A final survey shall be carried out six months prior to the end of the Project implementation period for the purpose of evaluating the achievements and impact of the Project.	Schedule 6, para. 13 b	Complied with. The baseline survey questionnaire was tested in October 2004. The baseline survey report was submitted to ADB in 2005. Annual monitoring report was submitted on time and with increasingly good quality.
An independent monitoring and evaluation shall be conducted for the subprojects funded by the VIF. At the end of the second, third and fourth year of the Project implementation period, a review of at least 10 percent of the subprojects shall be carried out on a random sampling basis.	Schedule 6, para. 13c	Complied with. Due to a delay in starting VIF activities, the first independent monitoring took place in 2007. The monitoring found that VIF activities were implemented according to the agreed plan.

AO = Ail Okmotu, CFC = child and family coordinator, ECD = Early Childhood Development, FAP = feldshers accoucheur (midwife) post, FGP = Family Group Practice, IDD = iodine deficiency disorder, IMR = infant mortality rate, MOES = Ministry of Education and Science, MOF = Ministry of Finance, MOH = Ministry of Health, MLSP = Ministry of Labor and Social Protection, PCO = project coordination office, PMO = Project Management Office, PSC = Project Steering Committee, U5MR = under-five mortality rate, VIF = Village Initiative Fund

Source: Asian Development Bank

EXTENDED PROGRAM FOR IMMUNIZATION COVERAGE

Table A11.1: Extended Program for Immunization Coverage
(%)

Type of Vaccine	Year					
	2004	2005	2006	2007	2008	2009
TB (BCG)	98.5	97.5	98.6	97.7	98.8	97.9
Diphtheria-tetanus-pertussis for children under 1	99.3	98.5	92.6	94.1	95.4	95.7
Diphtheria-tetanus-pertussis for children under 2	98.6	98.5	98.5	98.6	98.4	98.7
Oral Polio	98.4	98.7	92.8	94	95.3	95.7
Measles-mumps-rubella combination, first dose	99.3	98.9	97.3	98.8	99.1	98.9
Measles-rubella combination, second dose	98.1	97.9	97.4	95	96.7	98.5

Source: Republican Immunization Center of the Kyrgyz Republic.

Table A11.2: Percentage of Correct Assessment of Child's Illnesses by a Medical Worker
(%)

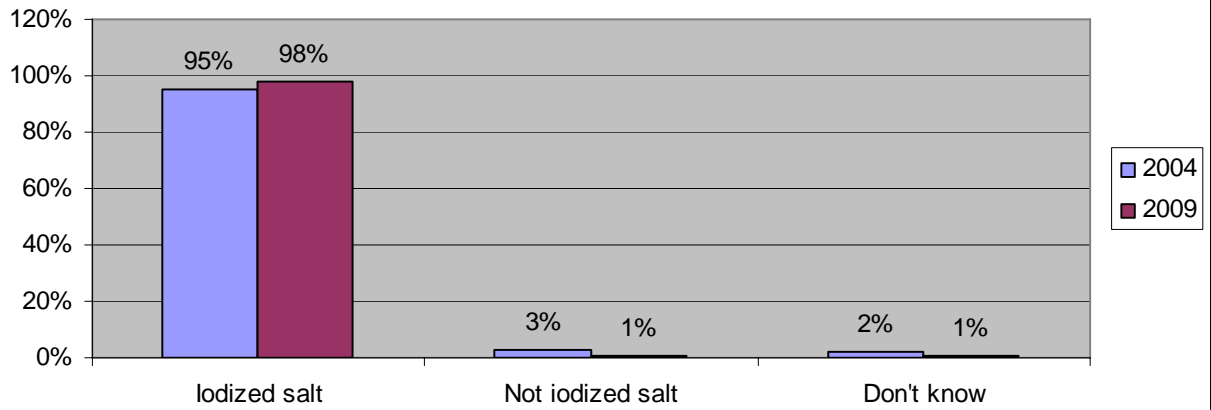
Signs	Total
If a child can take breastfeeding	67.7
If he or she has vomiting after taking any meals or drink	61.6
If he or she had spasms	50.5
If he or she had coughing or labored breathing	97.0
If a child has pneumonia	74.0
If a child has no pneumonia	89.0
If a child has diarrhea	82.8
Of a child has fever	89.9
If a child has sore throat	81.8
If a child has ear ache	70.7
Signs of severe under nourishing	25.3
If he or she has pale palms	60.6
If he or she has feet edema	14.1
Correspondence of weight to age group	52.5
Vaccination map	40.4

Source: Republican Medical Information Center, Ministry of Healthcare of the Kyrgyz Republic.

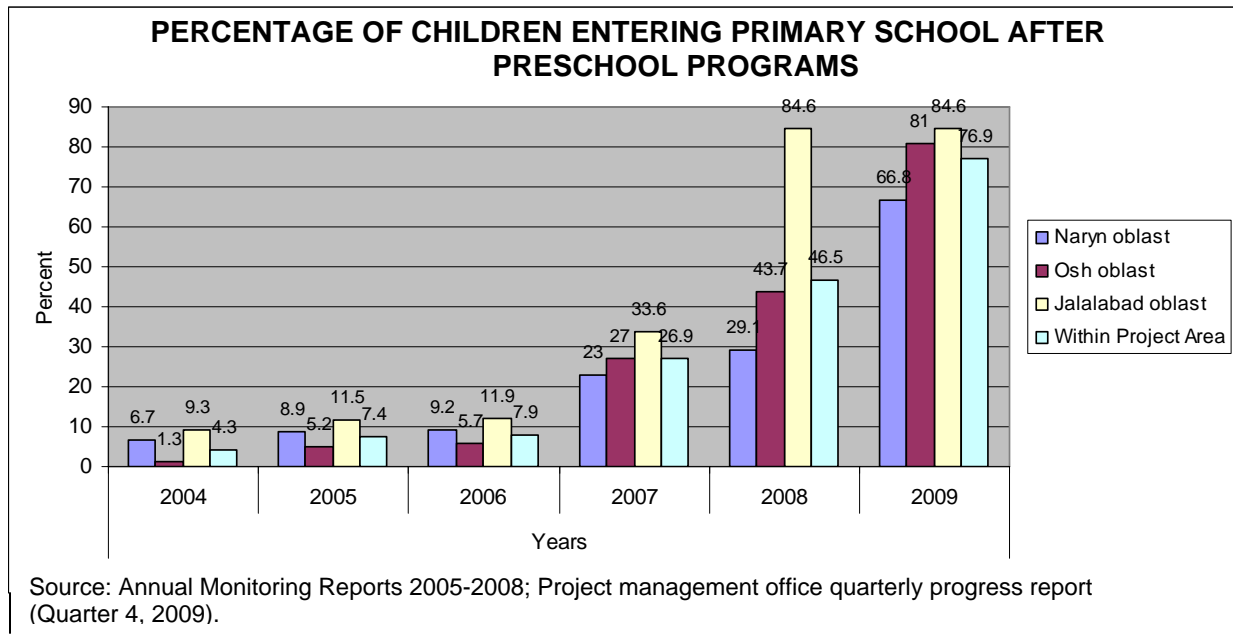
Table A11.3: Frequency of Explanations of Medical Workers to Mothers/Caregivers How to Give Prescribed Drugs to Children

Item	Kochkor		Naryn		Nookat		Toktogul		Total	
	Number	%	Number	%	Number	%	Number	%	Number	%
Antibiotics	8	94.8	2	85.4	8	86.7	7	73.3	25	85.1
Bronchial spasmolytic	-	-	-	-	-	-	-	-	-	-
Oral rehydration	-	-	-	-	2	100	-	-	2	100
Iron tablets	3	100	-	-	3	75	1	100	7	91.6

Source: Rapid Assessment of IMCI Implementation. Office of the President of the Kyrgyz Republic. 2009. Bishkek.

Figure A11: Type of Edible Salt Used in the Households

Source: End-of-Project Survey Evaluation Report, Administration of the President of the Kyrgyz Republic. February 2009



INFANT MORTALITY RATE

Table A13.1: Infant Mortality Rate
(Infant Deaths per 1,000 Live Births)

Year	2004	2005	2006	2007	2008	Reduction from 2005 to 2008 (%)	Reduction from 2006 to 2008 (%)
Kyrgyz Republic	25.7	29.7	29.2	30.6	27.1	9	7
Batken oblast	28.5	31.9	34.6	33.6	31.4	2	9
Jalalabat oblast	21.9	25.5	25.4	26	22.3	13	12
Issykul oblast	22.1	28.2	26.1	25.8	25.2	11	3
Naryn oblast	24.7	28.2	31.8	27.4	24.5	13	23
Osh oblast	23.1	27.5	38.2	27	23	16	40
Talas oblast	34.3	40.2	32.8	39.9	33.1	18	(1)
Chui oblast	23.4	28.2	26	28.8	25.2	11	3
Bishkek city	29.4	32.2	31.9	35	33.4	(4)	(5)
Osh city	45.4	46.8	42.7	59.6	50.5	(8)	(18)
UNICEF			38				100

() = negative, UNICEF = United Nations Children's Fund.

Note: The Kyrgyz Republic adjusted the definition of the live birth in 2004 to the World Health Organization Standards. However, a complete transition to the new definition took time and probably 2005 data may be still unreliable.

Source: Republican Medical Information Center, Ministry of Healthcare of the Kyrgyz Republic

Table A13.2: Causes of Infant Mortality

Causes of Mortality	2001	2002	2003	2004	2005	2006	2007	2008
Infectious diseases	12.5	8.2	6.7	5.3	5.2	5.7	6.8	5.8
Neurology and organs of senses	2.6	2.7	2.4	2	1.4	1.6	2.2	2.1
Respiratory diseases	31.2	27.1	29.2	18.6	17.8	17.5	16.7	14
Digestion diseases	0.7	0.6	0.3	0.6	0.5	0.3	0.4	0.4
Congenital defects and diseases	10.3	10.2	11.8	11.7	10.6	11.2	11.3	11.1
Perinatal complications	38.2	46.5	44.9	58.4	61.2	60.9	60.0	63.5
Traumata and poisoning	2.8	3.3	3	2.3	2.5	1.8	1.7	2.3

Source: Republican Medical Information Center, Ministry of Healthcare of the Kyrgyz Republic.

Table A13.3: Under-5 Mortality Rate
(Number of deaths of children under 5 per 1,000 live birth)

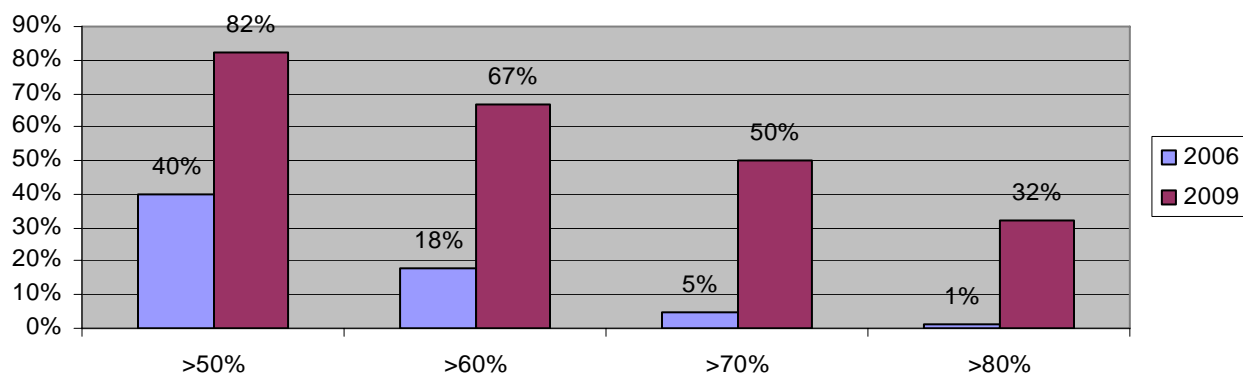
Region	2004	2005	2006	2007	2008	Reduction from 2005 to 2008 (%)	Reduction from 2006 to 2008 (%)
Kyrgyz Republic	31.8	35.2	34.6	35.3	31.5	11	9
Batken oblast	38.3	42.1	44.0	40.3	39.6	6	10
Jalalabat oblast	27.1	30.3	30.9	30.8	26.1	14	16
Issykul oblast	27.0	32.8	30.4	28.9	28.0	15	8
Naryn oblast	33.0	34.2	39.3	33.9	30.1	12	23
Osh oblast	32.0	36.2	35.6	34.7	29.9	17	16
Talas oblast	39.0	44.4	39.7	43.8	38.3	14	4
Chui oblast	27.6	31.2	29.3	31.6	27.4	12	6
Bishkek city	31.2	33.5	33.3	36.3	34.6	(3)	(4)
Osh city	50.0	51.2	47.1	63.7	52.9	(3)	(12)
UNICEF			44.0				100

() = negative, UNICEF = United Nations Children's Fund.

Note: The Kyrgyz Republic adjusted the definition of the live birth in 2004 to the World Health Organization Standards. However, a complete transition to the new definition took time and probably 2005 data may be still unreliable.

Source: Republican Medical Information Center, Ministry of Healthcare of the Kyrgyz Republic.

Figure A13: Percentage of Students Passing the Test



Source: End-of-Project Survey Evaluation Report, Administration of the President of the Kyrgyz Republic, February 2009