Completion Report

Project Number: 29660
Loan Number: 1645
September 2005

Kyrgyz Republic: Social Services Delivery and Finance Project

Asian Development Bank

CURRENCY EQUIVALENTS

Currency Unit – som (Som)

		At Appraisal (15 October 1998)	At Project Completion (31 May 2005)
Som1.00	=	$0.049	$0.024
$1.00	=	Som20.12	Som41.004

ABBREVIATIONS

ADB	–	Asian Development Bank
CBO	–	community-based organization
DGF	–	discretionary grant fund
ECD	–	early childhood development
ECG	–	electrocardiograph
GDP	–	gross domestic product
HMIS	–	health management information system
MCH	–	maternal and child health
MIS	–	management information system
MOE	–	Ministry of Education
MOF	–	Ministry of Finance
MOH	–	Ministry of Health
MOLSP	–	Ministry of Labor and Social Protection
NGO	–	nongovernment organization
O&M	–	operation and maintenance
OPEC Fund	–	Organization of Petroleum Exporting Countries Fund for International Development
PCH	–	provincial central hospital
PCO	–	project coordination office
PHC	–	primary healthcare
PIU	–	project implementation unit
PPMS	–	project performance and monitoring system
PSC	–	project steering committee
RPC	–	rural polyclinic
SDR	–	special drawing right
SRH	–	subrural hospital
SOE	–	statement of expenditures
SPMIS	–	social protection management information system
TA	–	technical assistance
UNDP	–	United Nations Development Programme
UNICEF	–	United Nations Children's Fund
USAID	–	United States Agency for International Development
WHO	–	World Health Organization

GLOSSARY

oblast	–	province
raion	–	district

NOTES

(i) The fiscal year of the Government ends on 31 December.

(ii) In this report, "$" refers to US dollars.

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BASIC DATA

A. Loan Identification

1.	Country	Kyrgyz Republic
2.	Loan Number	1645-KGZ[SF]
3.	Project Title	Social Services Delivery and Finance Project
4.	Borrower	Government of the Kyrgyz Republic
5.	Executing Agency	Ministry of Finance
6.	Amount of Loan	
	a. Asian Development Bank (ADB) Loan	SDR7.29 million ($10 million equivalent at appraisal)
	b. Organization of Petroleum Exporting Countries Fund for International Development (OPEC Fund) Loan	$3.58 million
7.	Project Completion Report Number	PCR:KGZ 912

B. Loan Data

1.	Appraisal	
	– Date Started	6 July 1998
	– Date Completed	24 July 1998
2.	Loan Negotiations	
	– Date Started	30 September 1998
	– Date Completed	13 October 1998
3.	Date of Board Approval	27 November 1998 (ADB Loan) 23 September 1998 (OPEC Fund Loan)
4.	Date of Loan Agreement	6 May 1999 (ADB Loan) 14 June 1999 (OPEC Fund Loan)
5.	Date of Loan Effectiveness	
	a. ADB Loan	
	– In Loan Agreement	4 August 1999
	– Actual	28 July 1999
	– Number of Extensions	0
	b. OPEC Fund Loan	
	– In Loan Agreement	27 June 2000
	– Actual	7 June 2000
	– Number of Extensions	0
6.	Closing Date	
	a. ADB Loan	
	– In Loan Agreement	30 June 2004
	– Actual	1 July 2005
	– Number of Extensions	3
	b. OPEC Fund Loan	
	– In Loan Agreement	30 June 2004
	– Actual	2 September 2005
	– Number of Extensions	3
7.	Terms of Loan	
	– Interest Rate	1% service charge

– Maturity (number of years) 40 years
– Grace Period (number of years) 10 years

8. Disbursements

a. Dates

(i) ADB Loan

Initial Disbursement	Final Disbursement	Time Interval
12 May 2000	1 July 2005	61 months
Effective Date	**Original Closing Date**	**Time Interval**
28 July 1999	30 June 2004	59 months

(ii) OPEC Fund Loan

Initial Disbursement	Final Disbursement	Time Interval
27 July 2001	2 September 2005	49 months
Effective Date	**Original Closing Date**	**Time Interval**
7 June 2000	31 December 2003	43 months

b. Amount ($ '000)

(i) ADB Loan (SDR)

Category	Original Allocation	Last Revised Allocation	Amount Canceled	Net Amount Available	Amount Disbursed	Undisbursed Balance
Civil Works	2,385	3,426	0	3,426	3,381	45
Training	241	182	0	182	182	0
Educational Equipment	627	1,000	0	1,000	999	1
Medical Equipment	1,284	1,474	0	1,474	1,474	0
Office Equipment	109	88	0	88	88	0
Vehicles	58	59	0	59	59	0
Consulting Services	503	0925	0	925	926	(1)
PIU Operations	95	0	0	0	0	0
Operating Recurrent Costs	160	17		17	13	4
Service Charge During Construction	160	120	0	120	120	0
Unallocated	1,670	1	0	1	0	1
Total	**7,292**	**7,292**	**0**	**7,292**	**7,242**	**50**[a]

PIU = project implementation unit.
[a] The undisbursed amount of SDR49,640.52 ($72,306.88 equivalent) was cancelled on 1 July 2005.

(ii) OPEC Fund Loan

Category	Original Allocation	Last Revised Allocation	Amount Canceled	Net Amount Available	Amount Disbursed	Undisbursed Balance
Civil Works	3,580	3,580	0	3,580	3,542	38
Total	**3,580**	**3,580**	**0**	**3,580**	**3,542**	**38**

10. Local Costs (Financed)
    - Amount ($ '000) 3,480
    - Percent of Local Costs 43%
    - Percent of Total Cost 21%

C. Project Data

1. Project Cost ($ million)

Cost	Appraisal Estimate	Actual
(i) ADB Loan		
Foreign Exchange Cost	5.98	6.44
Local Currency Cost	4.02	3.48
Total	**10.00**	**9.92**
(ii) OPEC Fund Loan		
Foreign Exchange Cost	1.91	1.88
Local Currency Cost	1.67	1.66
Total	**3.58**	**3.54**
(iii) Government		
Foreign Exchange Cost	0.00	0.00
Local Currency Cost	4.91	3.09
Total	**4.91**	**3.09**

2. Financing Plan ($ million)

Cost	Appraisal Estimate			Actual		
	Foreign	Local	Total	Foreign	Local	Total
Implementation Costs						
Borrower Financed	0.00	4.91	4.91	0.00	3.09	3.09
ADB Financed	5.76	4.02	9.78	6.27	3.48	9.75
OPEC Fund Financed	1.58	1.67	3.25	1.88	1.66	3.54
Total	**7.34**	**10.60**	**17.94**	**8.15**	**8.23**	**16.38**
IDC Costs						
Borrower Financed	0.00	0.00	0.00	0.00	0.00	0.00
ADB Financed	0.22	0.00	0.22	0.17	0.00	0.17
OPEC Fund Financed	0.33	0.00	0.33	0.00	0.00	0.00
Total	**0.55**	**0.00**	**0.55**	**0.17**	**0.00**	**0.17**

ADB = Asian Development Bank, IDC = interest during construction, OPEC = Organization of Petroleum Exporting Countries.

3. Cost Breakdown by Project Component ($ million)

Component	Appraisal Estimate			Actual		
	Foreign	Local	Total	Foreign	Local	Total
A. Local Government Capacity						
1. Institutional Strengthening	0.22	0.25	0.47	0.02	0.02	0.04
2. Project Implementation	0.72	0.80	1.52	0.96	0.32	1.28
Subtotal (A)	0.94	1.05	1.99	0.98	0.34	1.32
B. Delivery of Services						
1. Rehabilitation	3.63	7.08	10.68	4.23	5.85	10.08
2. Furniture and Equipment	2.42	1.97	4.39	2.55	1.03	3.58
3. Expanded Services Response	0.07	0.09	0.16	0.01	0.00	0.01
Subtotal (B)	6.90	8.32	15.22	6.78	6.81	13.59
C. Community Participation						
1. Village Governance	0.01	0.02	0.03	0.02	0.01	0.03
2. Management of Community Services	0.14	0.22	0.36	0.20	0.90	1.10
3. NGO Strengthening	0.00	0.01	0.01	0.00	0.07	0.07
4. Effective Community Organizations	0.10	0.13	0.23	0.16	0.03	0.19
5. Studies and Surveys	0.03	0.05	0.08	0.00	0.00	0.00
Subtotal (C)	0.29	0.43	0.72	0.38	1.01	1.39
Total A+B+C	7.34	10.59	17.93	8.14	8.16	16.30
D. Service Charge	0.55	0.00	0.55	0.17	0.00	0.17
Total Project Cost[a]	**7.89**	**10.60**	**18.49**	**8.32**	**8.23**	**16.55**

NGO = nongovernment organization.
[a] Contingencies are distributed among project components.

4. Project Schedule

Item	Appraisal Estimate (Quarter)	Actual (Quarter)
Date of Contract with Consultants	I Qtr 1999	II Qtr 2000
Completion of Engineering Designs	Not Applicable	Not Applicable
Civil Works Contracts	III Qtr 2003	IV Qtr 2004
Date of Award	III Qtr 1999	IV Qtr 2000
Completion of Work	III Qtr 2003	IV Qtr 2004
Equipment and Supplies		
First Procurement	IV Qtr 1993	II Qtr 2002
Last Procurement	III Qtr 2003	IV Qtr 2004
Completion of Equipment Installation	Not Applicable	Not Applicable
Start of Operations		
Completion of Tests and Commissioning	Not Applicable	Not Applicable
Beginning of Start-Up	Not Applicable	Not Applicable

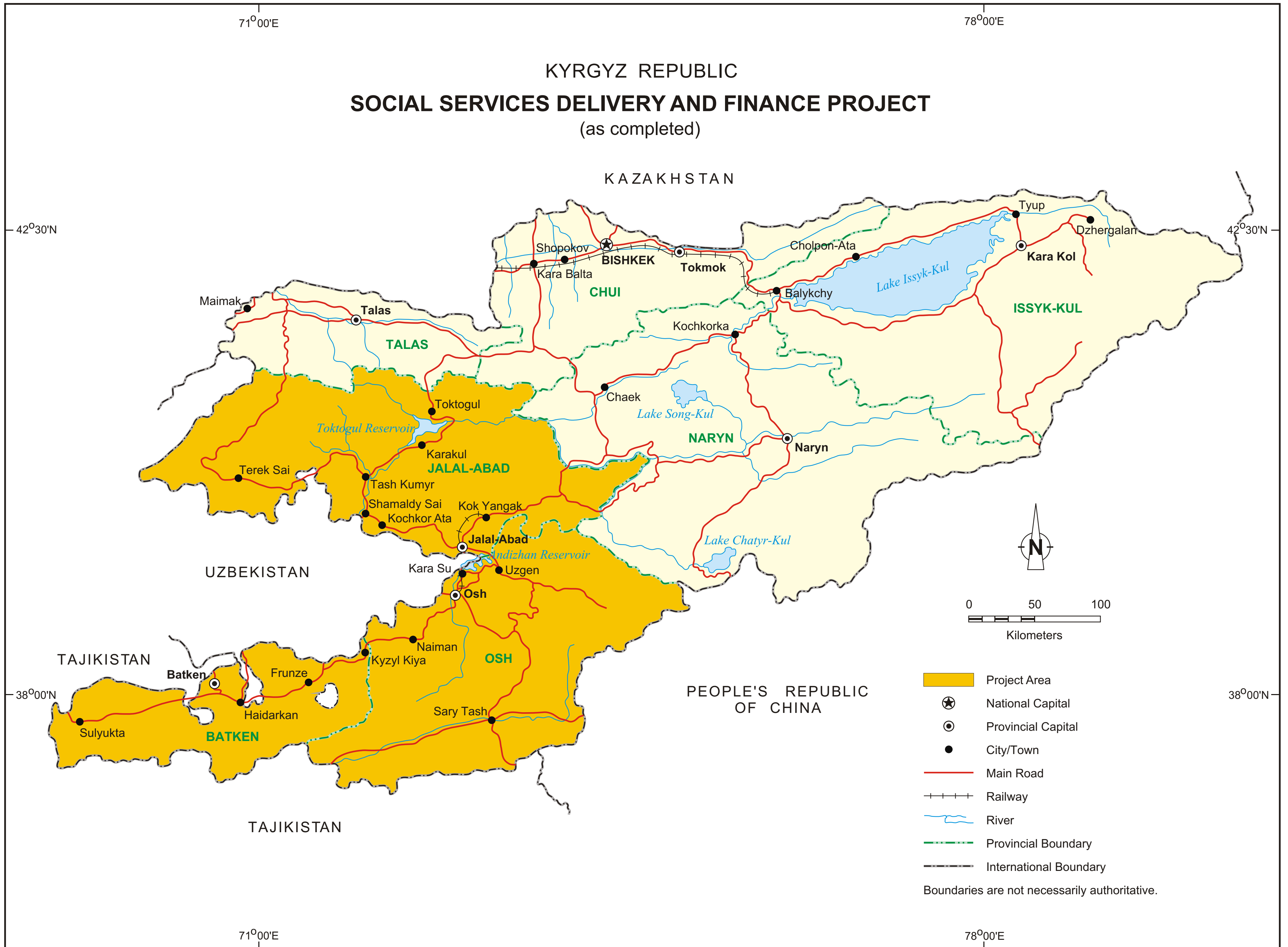
5. Project Performance Report Ratings

Implementation Period	Ratings	
	Development Objectives	**Implementation Progress**
From 27 November 1998 to 30 June 2005	Satisfactory	Satisfactory

D. Data on Asian Development Bank Missions

Name of Mission	Date	No. of Persons	No. of Person-Days	Specialization of Members[a]
Fact-Finding	13–29 April 1998	5	93	a, b
Appraisal	6–24 July 1998	3	57	a, b, c
Inception	16–31 March 2000	4	42	a, b, d, e
Review 1	1–12 November 2000	1	12	d
Review 2	2–10 July 2001	3	27	b, d, e
Review 3	9–15 December 2001	2	14	d, e
Midterm Review	13–22 June 2002	2	17	d, e
Review 4	28 August–3 September 2003	2	14	d, e
Review 5	1–7 December 2004	2	14	d, e
Project Completion Review[b]	27 April–2 May 2005	2	12	d,b,e

[a] a = economist, b = staff consultant, c = counsel, d = health specialist, e = project analyst.
[b] The project completion report was prepared by T. Yasukawa, senior health specialist, and C. Navarro, project officer.



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I. PROJECT DESCRIPTION

1. The Kyrgyz Republic became independent from the former Soviet Union in 1991 and started the transition toward a market economy. During the 1990s, the Central Asian country experienced severe economic and fiscal difficulties that affected all sectors. The social sectors (education, health, and social protection) faced (i) severe budgetary constraints; (ii) worsened social indicators, including higher school non-enrollment and dropout rates, mortality, and morbidity; (iii) large arrears in the payment of pensions that were already worth less than the minimum food basket; (iv) a lack of equipment and consumables; and (v) severe deterioration of physical infrastructure. The southern *oblasts* (provinces) of Osh and Jalal-Abad—the country's poorest, with half the national population—were particularly hard hit. Social services are financed mostly through local governments, and their lack of capacity to plan, implement, and monitor social services resulted in inefficient use of limited funds, aggravating social conditions.

2. Against this background, the Asian Development Bank (ADB) approved the Social Services Delivery and Finance Project (the Project) on 27 November 1998. The total cost of the Project was $18.49 million, of which $10.00 million was financed by ADB, and $4.91 million by the Government. The Organization of Petroleum Exporting Countries Fund for International Development (OPEC Fund) provided cofinancing of $3.58 million for the investment cost of the rehabilitation activities. The Project was designed to build local government and community capacity to increase the equitability, efficiency, and sustainability of social services delivery. Noting the severe poverty, the Project selected Osh, Jalal-Abad, and Batken oblasts as its project areas.[1] Although direct support for national reforms was not in its scope, the Project aimed to have its components reflect social sector reform policies that have been initiated nationally. The Executing Agency was the Ministry of Finance (MOF).

3. The goal of the Project was to protect human capital and improve the quality of life by promoting vulnerable populations' access to, and utilization of, basic social services. By focusing on rural *raions* (districts) in the three oblasts, the Project was expected to contribute to reducing poverty. The project objectives were to (i) improve the capacity of local governments to effectively deliver priority social services to the rural poor and (ii) increase community and private sector participation in social services. To achieve these objectives, the Project was to (i) strengthen the capacity of local governments to manage and provide health and education services by improving administrative procedures and systems; (ii) improve the delivery of basic health and education services by rehabilitating critical social infrastructure and strengthening the technical and management capacity of providers; and (iii) increase the involvement of communities and the private sector and so mobilize community resources to improve targeting, planning, and the sustainable operation and maintenance (O&M) of social services. The project framework is in Appendix 1.

4. The Project covered health, education, and social protection sectors, with geographical focus on three oblasts. It had three components, which are summarized below:

5. **A. Strengthening Local Governments' Capacity to Manage and Provide Health and Education Services.** To this end, the Project (i) set up social protection management information systems (SPMIS) and health management information systems (HMIS); and (ii) trained oblast administrations to plan, budget, and manage social sectors, as well as to manage construction.

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[1] Batken was originally a part of Osh but became a separate province in 1999. Substantial activities started in Batken in December 2001. Prior to that, only limited assistance was provided due to security constraints.

6. **B. Improving Delivery of Basic Health and Education Services.** To this end, the Project (i) rehabilitated schools, health centers, and raion hospital facilities; (ii) provided medical and educational equipment; (iii) trained teachers and health workers; and (iv) ran public information campaigns.

7. **C. Increasing Community and Private Sector Involvement in Targeting, Planning, and Sustaining Social Services.** To this end, the Project (i) provided a discretionary grant fund (DGF) for small-scale community infrastructure strengthening; and (ii) trained staff of village administrations, nongovernment organizations (NGOs), and community-based organizations (CBOs).

II. EVALUATION OF DESIGN AND IMPLEMENTATION

A. Relevance of Design and Formulation

8. The Project was consistent with the Government's policies for the social sectors. It was prepared at a time when the Kyrgyz Republic had inadequate internal and external resources for its education, health, and social protection sectors, and assistance was urgently needed to strengthen decentralized management and the provision of social services. The Project helped the Government strengthen decentralized management in line with the Law on Local Self Administration (1993), presidential decrees on local self government (1994) and strengthening communities (1996), the national health care reform program (1993), and the Law on Education (1992). The Project also supported the Government's policy for rural development and poverty reduction by targeting the poorest and most remote oblasts. The Project was consistent with ADB's operational sstrategy for the Kyrgyz Republic,[2] which stresses the importance of (i) supporting sector policy reforms, (ii) strengthening the institutional capacity of the government agencies directly responsible for social service delivery and finance, and (iii) rehabilitating social infrastructure. The Project had associated technical assistance (TA) for institutional strengthening for social services delivery and finance, which was intended to provide capacity-building support to complement loan inputs. The TA designed standards for local governments' practice and performance and developed guidelines and training courses. The Project was highly relevant in design, scope, and modality.

9. The Project was formulated through intensive assessment and policy dialogue undertaken in two stages under the project preparatory TA. The first stage reviewed the situation in the field and the legislative and policy framework for the social sectors. During the second stage, the TA worked with national and local governments to design the Project and build initial capacity. The TA helped the national and local governments assess and understand the need to set policy and plan the social sector locally, rationalize and rehabilitate social infrastructure and services, mobilize communities, and build staff capacity. The Project was formulated through a consultative and participatory process.

B. Project Outputs

10. The Project was implemented from March 2000 to June 2005. It comprised three components: (i) strengthening local government capacity, (ii) improving social services, and (iii) increasing community self reliance. Appendix 2 compares project outputs as envisaged at appraisal and actually implemented. Most project outputs were completed as envisaged at appraisal.

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[2] ADB. 1996. *Country Operational Strategy for the Kyrgyz Republic*. Manila.

1. Part A: Strengthening Local Government Capacity

11. This component was intended to improve the capacity of local governments to plan and manage social services delivery. To do this, the Project supported improving the SPMIS and HMIS in oblasts, raions, and local facilities in pilot areas. The Project developed budget guidelines and conducted 20 workshops and training courses, training 400 participants from oblasts, raions, and local facilities, strengthening HMIS and SPMIS planning and management capacity, enabling social mobilization, and improving the business planning capacity of local governments. The Project provided a total of 50 computers to 3 oblast social protection offices, 44 raion social protection offices, and 3 project coordination offices for the SPMIS. A total of 31 computers were provided to 28 health facilities (3 raion hospitals and 25 primary healthcare facilities) under the HMIS. As planned at appraisal, the computerized HMIS and SPMIS have been established, and administrative systems and the planning and management capacity of staff have been improved. However, new planning guidelines based on population and need were not introduced during the Project, and local government staff have not yet had the opportunity to use fully the new planning skills they learned under the Project.

b. Part B: Improving Social Services

12. This component was intended to help local governments improve the availability of high-quality education and health services by rehabilitating and equipping schools and health facilities and training staff. A total of 682 facilities, including 187 schools and 495 health facilities, were rehabilitated under the Project (Appendix 3). The actual number of rehabilitated schools and health facilities was almost at the same level as planned at appraisal. The need at appraisal for rehabilitation of schools and health facilities in the Kyrgyz Republic was too great to be addressed by any single donor or project. Hence, the Project coordinated with other projects to ensure the complementarity of rehabilitation efforts.[3]

13. Several criteria were applied when selecting facilities for rehabilitation. One of the major criteria for health facilities was the oblast hospital rationalization plan that established which facilities were to be closed or merged and which would be downgraded. Sometimes, the priority of the community conflicted with that of the national and oblast plan, which led to delays in agreeing with the Ministry of Health (MOH) on facility selection. Eventually the delays proved useful, as none of the facilities rehabilitated under the Project was closed or downgraded after the rationalization plan was finally implemented. Some health facilities rehabilitated by other donors' projects were closed.

14. The Project required local governments to increase their social sector budget allocations by 2% for the operation and maintenance (O&M) of rehabilitated facilities. However, this was not implemented, and hence the sustainability of the rehabilitated facilities is at risk.

15. Procurement of school furniture is in Appendix 4. Furniture was provided to 317 schools, including 74 schools rehabilitated by communities and 56 schools not rehabilitated under the Project. At appraisal, the Project planned to provide equipment only to those schools it rehabilitated. During implementation, however, the Project supported community initiative by expanding the provision of equipment to cover schools rehabilitated by communities. In all, the

[3] For example, ADB. 1997. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the Kyrgyz Republic for the Education Sector Development Program, Manila,* rehabilitated only the heating system in some of the schools for which the Project rehabilitated walls, floors, and roofs to improve their energy efficiency.

Project distributed 19,212 school desks, 1,473 blackboards, 1,549 teachers' tables, 3,853 teachers' chairs, and 1,549 bookcases and bookshelves.

16. In the health sector, all 495 rehabilitated health facilities received basic diagnostic and treatment equipment, and 188 health facilities were provided with advanced equipment including electrocardiograms (ECGs), ultrasound scanners, clinical chemistry analyzers, hot air sterilizers, centrifuges, obstetric chairs, and basic diagnosis and treatment kits (Appendix 5). While ECGs and ultrasound scanners are well used and maintained in hospitals, some ECGs in primary healthcare (PHC) facilities were not. The Project intended at appraisal to provide basic equipment to PHC facilities, and basic and advanced equipment to hospitals. However, at the beginning of project implementation, MOH requested mostly advanced equipment. ADB and MOH discussions led to agreement to provide mainly basic equipment to PHC facilities but also ECGs to those in key locations. Suppliers provided training, but the equipment was still underutilized because PHC staff lacked skills. At ADB's request, the project implementation unit (PIU) and local governments rearranged training on the use of the equipment.

17. The Project conducted nine training courses on heath, education, and early childhood development for 150 teachers and health workers. Teachers were trained on modern teaching methods, while health workers learned about child and women's health. Training on how to monitor and evaluate benefits was not conducted because the project monitoring system was unavailable early in the Project. Public information campaigns on social sector issues were organized and conducted through mass media (journals and newspapers), brochures, and community meetings. Sector campaigns promoted hygiene and sanitation, women's health, school attendance, and social protection.

18. Developing sector reform plans was not in the Project's scope. However, the Project planed to build capacity and improve the delivery of services in line with sector reform policies and strategies. This was necessary to ensure that project outputs and impacts were effective and sustainable. However, the Government's schedule for implementing reforms did not mesh with the project schedule. The reforms were initially implemented in Bishkek and the northern oblasts, and reforms in the project oblasts started only in 2004, by which time project activities were almost completed. The Project carefully selected facilities for rehabilitation in line with the oblast rationalization plans, and none of the facilities rehabilitated under the Project was closed or merged. However, if the reforms had been implemented during project implementation, the Project could have been more instrumental in pursuing comprehensive health system rationalization. The Project's training programs addressed health insurance and health financing methods, but some of the new mechanisms have not yet been elaborated and implemented.

3. Part C: Increasing Community Self Reliance

19. The Project financed community-support activities to (i) encourage communities and beneficiaries to participate in local decision-making; (ii) increase the involvement of the private sector, NGOs, and CBOs in social services delivery; and (iii) mobilize community resources to improve and maintain community and social facilities. The Project trained three NGOs as planned at appraisal, but contracts were eventually concluded with only two NGOs to conduct workshops for CBO strengthening. The Project was not able to work with the remaining NGO due to disagreement over the contract. More than 200 CBOs were trained to assess community needs, solve problems, and plan strategically. Local government meetings were organized annually. A summary of project training activities is in Appendix 6.

20. The Project included a DGF that provided grants for 453 DGF activities supporting community-based initiatives. The DGF rehabilitated schools, kindergartens, roads, bridges, water supply infrastructure, sanitation and health facilities, and other community facilities. As the DGF concept was new to the country, and there were no models to follow, the Project developed guidelines and a manual for DGF management, organized briefings to raise awareness, conducted business planning meetings for community representatives, and helped communities identify needs and develop appropriate DGF applications. As experience was gained, the number of grant applications increased. Based on the previous DGF experience in local resource mobilization, the Government introduced a similar mechanism under the name of "stimulative grants" and annually allocated the national budget of $3 million to support and finance initiatives of local administrations and communities. Eventually the Project disbursed about $470,000 under this component, considerably more than the $300,000 planned at appraisal. Subprojects funded under DGF are summarized in Appendix 7.

21. Under the DGF component, some communities received one grant and some more than one, while some communities did not participate. Project staff frequently visited communities to raise awareness and provide advice on application methods. However, the DGF's requirement of resources from the community may have discouraged poorer communities from participating in the scheme. The Project coordinated with other agencies that implemented similar funds and helped poor communities apply for the funds without having to provide counterpart resources. Despite these measures, poorer communities without strong leadership had less access to the DGF in practice.

C. Project Costs

22. The total project cost was estimated at $18.49 million equivalent at appraisal, with ADB to finance $10.00 million equivalent (SDR7.29 million), OPEC Fund to finance $3.58 million, and the Government to finance $4.91 million equivalent. The foreign exchange cost was estimated at $7.89 million, of which $5.98 million was to be financed by ADB and $1.91 million by OPEC Fund. The local currency cost was estimated at $10.60 million equivalent, of which $4.02 million equivalent was to be financed by ADB, $1.60 million equivalent by OPEC Fund, and $4.91 million equivalent by the Government.

23. The actual project cost was $16.55 million, comprising $8.32 million in foreign exchange and $8.23 million equivalent in local currency. Actual project costs were closely in line with anticipated costs at appraisal, with ADB financing at $9.92 million against the appraisal estimate of $10.00 million, OPEC Fund at $3.54 against $3.58 million, and the Government at $3.09 million (including a tax contribution of $1.72 million) against $4.91 million. A comparison of appraisal cost estimates and actual project costs by category and source of financing is in Appendix 8.

24. Expenditures financed by ADB were higher than expected under (i) civil works, which cost $4.60 million (against $3.27 million expected at appraisal); (ii) education equipment, which amounted to $1.34 million ($0.86 million); and (iii) consultants, which cost $1.26 million ($0.69 million). The estimated unit costs for civil works turned out to be too low because the degree of deterioration was underestimated at appraisal. The DGF component significantly increased awareness in communities of the importance of community initiatives, and so increased demand, resulting in more DGF activities being financed than were planned at appraisal. The consultant's contract for project management was also higher than the appraisal estimate as it covered PIU operations originally treated as a separate expenditure category.

25. ADB approved reallocation of loan proceeds as follows: (i) reallocation of $0.36 million equivalent from the unallocated category to consulting services in response to the consolidation of consulting services and PIU operations; (ii) reallocation of $2.03 million equivalent from the unallocated category to civil works, educational equipment, medical equipment and consulting services in response to requests from local governments and communities; and (iii) a final reallocation of $0.01 million equivalent from the unallocated category to civil works. By completion, originally unallocated funds were almost fully utilized.

D. Disbursements

26. The breakdown of yearly disbursements from the ADB loan is in Appendix 9. Total ADB loan disbursements were $9.92 million, equivalent to 99% of the loan amount of $10.0 million. The unutilized loan balance of $0.08 million was cancelled at the loan closing date of 1 July 2005. The loan proceeds were disbursed through the imprest account and direct payment. The Project was provided with an imprest account of $250,000, which was later increased to $500,000. The imprest account was efficiently utilized and liquidated, with an average annual turnover of 2.59, in line with the country average of 2.61.

27. Initial disbursement delays in 2000–2001 can be attributed to project start-up and the PIU's unfamiliarity with project implementation and ADB guidelines and procedures. Further delays were caused by lack of agreement between the Project and MOH on the list of facilities for rehabilitation and the equipment to be provided. Starting in 2003, project implementation was affected by expenditure caps in the public investment program, which significantly slowed project activities. After intensive discussion with MOF, the Project was provided adequate allocations for 2003, 2004, and 2005 to complete the planned activities.

28. The OPEC Fund loan disbursed $3.54 million, equivalent to 99% of the loan amount of $3.58 million. The loan account was closed on 2 September 2005, and the unutilized loan balance of $0.02 million was cancelled. The disbursement of loan proceeds was done through an imprest account. Initially, $250,000 was provided, and this was later increased to $500,000. Disbursements were delayed due to the factors mentioned in paragraph 27. In addition, disbursement of OPEC Fund loan proceeds was delayed by 3–4 weeks by (i) the internal procedures of the OPEC Fund, (ii) delays in processing withdrawal applications by MOF, (iii) the time required for delivery of withdrawal applications by post, and (iv) ADB processing of withdrawal applications.

29. The Government disbursed a total of $3.09 million equivalent, including tax exemptions of $1.72 million, in local currency costs incurred for facilities development, local training, and domestic consultants.

E. Project Schedule

30. Appendix 8 compares the appraisal and actual implementation schedule. The Project was approved on 27 November 1998, the loan agreement was signed on 6 May 1999, and the loan promptly became effective on 28 July 1999. However, the commencement of the Project was delayed until March 2000 because of security problems in the project oblasts.

31. The Project was to be implemented over 5 years, with the loan closing on 30 June 2004. The closing date was extended three times to 30 June 2005 for a cumulative extension of 12 months to allow for the completion of project activities. Initially, civil works were slowed by (i) delays in the payment of Government counterpart funds, (ii) delays in reaching agreement with

MOH on the list of health facilities for rehabilitation, and (iii) a larger-than-expected need for staff monitoring of civil works and the DGF. In addition, overall implementation of project activities was constrained by (i) the public investment program's external funding caps, which put limits on the Project's annual expenditure and prevented the Project from accelerating activities to meet the original loan closing date, and (ii) the political unrest in March 2005, which further delayed the handover of project facilities. The OPEC Fund loan closing was also extended by 12 months from 30 June 2004 to 30 June 2005.

F. Implementation Arrangements

32. The Project was implemented in accordance with the arrangements envisaged at appraisal. The project director was the first deputy minister of MOF. A national project steering committee (PSC) was established to direct the project activities and budget and to coordinate policy reforms of relevance to the Project. The PSC comprised representatives of MOF, Ministry of Education (MOE), MOH, Ministry of Labor and Social Protection (MOLSP), the administrations of the project oblasts, and the project manager. PSC meetings were held regularly, but in-depth discussions on sector issues were held at informal meetings. The PSC's coordination of line ministries and maintenance of policy dialogue on sector issues was weak and insufficient. High turnover of government counterpart staff, in particular at MOE and MOLSP, contributed to coordination difficulties. Due to the multisector nature of the Project and its focus on activities in the oblasts, the Project was not able to gain strong support and ownership from line ministries.

33. The Project contracted the management consulting firm EPOS to help MOF implement the Project. EPOS established the project implementation unit (PIU) in March 2000 in Jalal-Abad oblast administration with a sub-PIU office in Osh oblast administration. The PIU consisted of a project manager, eight officers, and 3 support personnel. The PIU took responsibility for overall project implementation and supervision and in general functioned as envisaged at appraisal. The sub-PIU office had a community development officer and strengthened community support in Osh oblast. Each project oblast established a project coordination office (PCO) composed of representatives of the oblast administration and the education and health sectors of local governments. The PCOs worked as counterparts on the local government side, provided orientation to the PIU and sub-PIU on project-related issues, discussed detailed components, and monitored project implementation with the PIU and sub-PIU.

34. Initial training was provided to PIU staff on ADB procedures and operations. PIU staff salaries were financed by loan proceeds. As PIU staff were contracted through EPOS, their salaries were paid without delay. As staff of a foreign firm, the government ceiling on PIU staff salaries did not apply. These conditions helped ensure PIU staff stability. During the initial year of implementation, EPOS provided a long-term international consultant at PIU, but subsequently project management was handled by local PIU staff, who were monitored and supervised through regular visits by international consultants. Project management was generally satisfactory.

35. In line with the implementation arrangements envisaged at appraisal, all project staff were located in the project oblasts. However, in 2002, a liaison office was established in Bishkek to improve coordination with line ministries on policy and implementation issues and to help prepare withdrawal applications.

G. Conditions and Covenants

36. Compliance with covenants, as detailed in Appendix 11, was satisfactory overall. The covenants for implementing health sector reforms (hospital rationalization and the introduction of family group practice and user fees) were complied with, but implementation of reforms in the project oblasts was delayed and ineffective.

37. Covenants on a project performance and monitoring system (PPMS) were partly complied with. The PIU failed to set up the PPMS implementation plan during the initial phase due to the Government's reluctance to hire international consultants as originally planned. Consequently, initial data inputs were lacking, and the system lapsed. The system was completed through additional inputs from a local firm in the middle of project implementation. No covenant was modified, suspended, or waived during implementation.

H. Related Technical Assistance

38. The Project included associated TA to support institutional strengthening for social services delivery and finance. The TA objective was to help the Government develop appropriate programs for strengthening management of local governments to improve the efficiency and effectiveness of public services. TA focused on capacity building in local governments for (i) capital planning and budgeting, (ii) the O&M of facilities, (iii) strengthening public–private partnerships, and (iv) targeting public subsidies to appropriate service clients. To do this, TA provided (i) international and domestic consulting services; (ii) national workshops and symposia on strategic planning and social sector budget planning and management; and (iii) training of local government staff in oblasts, raions, and villages.

39. TA was successful. The TA consultants worked professionally and adjusted well to local situations, contributed to building local government capacity, and provided a technical basis for the loan project activities, particularly for the training component and activities related to the O&M of facilities. TA was implemented in close consultation and coordination with the PIU, which allowed TA personnel to play a significant advisory and supporting role to the loan project. The TA completion report is in Appendix 12.

I. Consultant Recruitment and Procurement

40. Under the Project, consulting services for project management were provided for 17.7 international consultant person-months and 755 domestic consultant person-months, somewhat more than the appraisal estimates of 15.4 international person-months and 720 domestic person-months. Consultants were recruited for management, accounting, general social sector coordination, engineering, procurement, training, and community development. The consultants were recruited and contracted in accordance with ADB's *Guidelines on the Use of Consultants.* The breakdown of consulting services is in Appendix 13. Two NGOs were recruited to provided training to CBOs.

41. The indicative procurement plan at appraisal included procurement of (i) medical equipment through international competitive bidding, (ii) educational and office equipment and civil works through local competitive bidding, and (iii) vehicles through international shopping. Actual procurement was carried out as envisaged at appraisal and in line with ADB's *Guidelines for Procurement*.

J. Performance of Consultants, Contractors, and Suppliers

42. The performance of consultants was satisfactory. Project management consultants' performance was effective, their relationship with national and local governments was satisfactory, and they played a key role in ensuring the effective implementation of project activities and the capacity building of counterpart staff.

43. The performance of the civil works contractors and equipment suppliers was generally satisfactory. Initially, low quality of works was observed, which was attributed to the weak monitoring capacity of the PIU. Subsequently, the PIU engaged a group of raion civil works engineers to oversee contractors' work and ensure effective monitoring. This significantly improved the quality of rehabilitation works. The equipment procured under the Project met the technical specifications and complied with the delivery requirements.

K. Performance of the Borrower and the Executing Agency

44. The performance of the Borrower and Executing Agency was satisfactory. The Project was considered a key government intervention to build local governments' capacity in the social sectors and respond to the needs of communities. The performance of the PIU was satisfactory on the whole. It was established promptly within a month of loan effectiveness and satisfactorily set up reporting procedures. It submitted quarterly progress reports, audited financial statements and project accounts, and the Government's project completion report on time. The utilization of loan proceeds was efficient and effective. Delays occurred in providing counterpart funds, but the Borrower met its commitment to settle outstanding obligations before loan closing.

L. Performance of the Asian Development Bank

45. ADB maintained a good working relationship with MOF and the oblast administrations throughout implementation; cooperated closely with MOF, the PIU, and the oblast administrations to address implementation problems; and was responsive to needs that arose during implementation. ADB strengthened the link between the Project and line ministries by visiting ministries during missions. ADB carried out a total of seven review missions including project inception and a comprehensive midterm review in June 2002. The performance of ADB was satisfactory.

III. EVALUATION OF PERFORMANCE

A. Relevance

46. The Project is rated relevant overall, but its relevance varied by objective. The Project achieved its objectives of strengthening local government capacity and community participation in the social sectors and was highly relevant to the Government objective of decentralizing management and improving the delivery of social services. The Project also supported the Government's policy reforms in the social sectors and its efforts to reduce poverty. The Project was consistent with ADB's operational strategy for the Kyrgyz Republic (footnote 2) in the social sectors and responded to the need for policy reforms in the social sectors, institutional capacity building in oblasts and raions, and the rehabilitation of social infrastructure. The project design was considered highly relevant as it was tailored to the needs of a country with limited capacity, severe economic and social challenges, and the need for urgent reforms. The Project was designed with community and beneficiary participation.

47. During project implementation, several minor adjustments were made in its scope, with related reallocations of loan proceeds. A minor increase in the allocation to the DGF was necessary to accommodate increased requests from communities. The PIU successfully raised awareness and demand and strengthened the capacity of communities to apply for DGF grants. The change enhanced the Project's relevance. The project design as a multisector intervention implemented in oblasts detracted from its ability to secure concerned line ministries' commitment and participation, which limited the Project's role in developing sector policies and approaches. This shortcoming was addressed during implementation by establishing a liaison office in MOF in Bishkek but was never fully corrected. Overall, the Project is rated relevant.

B. Efficacy in Achievement of Purpose

48. The Project is rated efficacious. It laid a foundation for capacity building in local governments and communities in project oblasts. The computerization of oblast administration offices improved the efficiency of social sector management. Information in the HMIS has been regularly monitored and analyzed in oblasts and used for decision making. The SPMIS helped local governments and communities obtain a clear picture of poverty and target and monitor support to the poor. It helped other projects plan and target activities for the poor, including the ADB-supported community-based Early Child Development Project.[4] The SPMIS was adapted to the needs of, and used for, MOLSP's social passport program, which targets support to the neediest people.

49. Local government staff were trained to plan and monitor programs and budgets, manage civil works, and procure civil works and equipment. The quality and availability of health services has improved at PHC facilities. The Project's rehabilitation of schools, the increased availability of equipment, and the improved knowledge and skills of school staff have improved education. The Project helped empower communities to make decisions on community issues and mobilized community resources for identified priorities. The Project successfully developed a model for community support and established necessary policies, procedures, and guidelines.

C. Efficiency in Achievement of Outputs and Purpose

50. The Project is rated efficient in investment and process. Investments were made in (i) civil works, (ii) equipment, (iii) training, and (iv) minor community projects and related civil works. In the health sector, both equipment and civil works targeted the PHC and first referral level, which is considered more cost-effective than investing in the tertiary level.[5] In the education sector, the Project provided an enabling physical environment for learning by rehabilitating buildings and providing basic furniture. In social protection, the SPMIS helped establish a basis for planning and targeting activities for vulnerable groups. MOF and the PIU also provided timely and appropriate supervision. Local governments and communities demonstrated strong commitment to and ownership of project activities throughout project planning and implementation. During the initial phase, ADB provided extensive support to the PIU to strengthen its project management capacity. Throughout the Project, the PIU was managed efficiently.

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[4] ADB. 2003. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the Kyrgyz Republic for the Community-Based Early Childhood Development Project*. Manila.

[5] The cost-effectiveness of investing in PHC was advocated in the World Bank. 1993. *World Development Report*, Investing in Health. Washington, DC..

D. Preliminary Assessment of Sustainability

51. The sustainability of the project components on government capacity building and social services improvement is rated less likely because of (i) stagnating and low public expenditure for social sectors, in particular the health sector; (ii) stagnating and low local O&M budgets for education and health facilities; and (iii) limited sector reform. During the project period, government expenditure for health declined in real terms and as a percentage of gross domestic product (GDP), from 2.76% of GDP in 1997 to 2.02% in 2003. Meanwhile, expenditure for education increased somewhat in real terms but remained stable at about 4% of GDP (Appendix 14). Budgeting in the health sector is still norm-based and has not shifted to a more efficient mechanism. Hence, most of the health budget is still used to pay for staff salaries and utilities, and so keep hospitals open, while funding for actual services and PHC remain inadequate.

52. The Project rehabilitated facilities and provided equipment. For the physical sustainability of this investment, the Project developed O&M guidelines and repeatedly asked MOF and local governments to allocate incremental O&M cost. However, local governments have not allocated sufficient budgets and service staff to implement O&M in accordance with the established guidelines. This puts the sustainability of project benefits at risk. Parents contributed to O&M budgets for schools to make up for local government budget shortfalls. The Project Completion Review Mission was advised of specific instances where project facilities required repairs for which funds were lacking.

53. On the other hand, the Project's support to local communities is rated highly sustainable. Based on experience gained under the Project, the Government expanded the DGF program nationwide as the "stimulating grant scheme" to help communities mobilize resources to address local needs. Other externally funded projects, including the ADB-supported Community-Based Early Childhood Development Project (footnote 3), have adopted the DGF modality. The capacity of communities to mobilize resources and respond to community problems was strengthened. Communities that were supported by the Project continue to apply the skills and problem-solving abilities learned under the Project. Despite this success in the communities, the overall sustainability of the Project is less likely.

E. Environmental, Sociocultural, and Other Impacts

54. The Project included minor civil works for the rehabilitation of health facilities and school buildings. These civil works were confined to the construction sites, and the environment category was C. No adverse impact on the environment was observed during implementation. The Project did not require any land acquisition or resettlement, and no ethnic minority issues arose during project implementation.

55. The Project had positive social impacts. Basic health care and schooling became more available. Local governments' abilities to target vulnerable rural populations with basic health and education services are strengthened. Community participation through parent and teacher associations, health committees, and other groups served as a bridge to local administrations and allowed the most vulnerable to be represented. Through these CBOs, communities participated in local decisions affecting services and helped make the services more responsive to their needs. However, insufficient national policy reforms to improve the delivery of basic health services resulted in limited project benefits for the poor, and hence the overall impact of the Project is moderate.

IV. OVERALL ASSESSMENT AND RECOMMENDATIONS

A. Overall Assessment

56. The Project is rated successful (Appendix 15). Its objectives were generally achieved (i) to improve the capacity of local governments to effectively deliver priority social services to the rural poor and (ii) to increase community and private sector participation in social services. In particular, the Project's support to communities set a precedent and a model for the Government and other development agencies, and hence was considered highly relevant. Implementation was delayed, but this was due to the shortage of counterpart funds and their limited availability owing to ceilings on disbursements set by the public investment program, which was instituted as part of the Government's macroeconomic stabilization program. The Project's effectiveness in supporting policy reforms was hampered by the limited and delayed social sector reforms being implemented in the project oblasts only in 2004, close to project completion. The Project succeeded in meeting the immediate needs of the Kyrgyz Republic in the social sectors by rehabilitating schools and health facilities, providing furniture and equipment, establishing an operational HMIS and SPMIS, and strengthening the capacity and skills of staff working in the social sectors. The Project was efficacious in achieving its objectives, and the project outcomes are likely to lead to the project goal.

B. Lessons Learned

57. The DGF successfully responded to community social infrastructure needs and mobilized community support. However, poor communities without strong leadership had difficulty preparing proposals and needed significant support in accessing the DGF. To ensure the full participation of the most disadvantaged communities, similar schemes should ensure that adequate support is provided.

58. During preparation, the Project had two options regarding scope. One was to reform policies and set standards nationally, and the other to strengthen decentralized management and service provision by local government and communities. The Project took the second option on the assumption that other donors and the national Government would pursue reforms and standard setting nationally. The Project achieved its objectives and produced the intended outputs. However, technical effectiveness, impacts on the poor, and the sustainability of investments were undermined by the limited scope of reform nationally, particularly regarding budget planning and allocation, and by the failure of reforms to proceed at the same pace as project investments locally. It is important to ensure that appropriate national policies and strategies are at an advanced stage of preparation when planning local capacity building. Although national policy reforms were not in the project scope, the Project could have worked more closely with other donors to help the Government accelerate the planning and implementation of reforms.

59. The PIU was located in Jalal-Abad, which made monitoring the development of national policies and initiatives difficult. The cost of implementation arrangements was minimized by establishing a project presence only at the project sites and by recruiting only civil engineers, administrators, training specialist, and DGF coordinators. The PIU did not have either education or health specialists who could have been effective interlocutors with line ministries. The project manager discussed sector issues with line ministries only when problems arose. The implementation arrangements ensured the quality and timely implementation of civil works and equipment provision. The PIU was also able to provide strong support to communities. However, disbursements, consultation with MOF, and coordination with line ministries suffered.

The Project established a liaison office in Bishkek to resolve these issues, but this proved insufficient. The experience highlighted the need for significant project contact with the national Government even when the targets are local governments and communities.

60. The Project provided computers and training for the SPMIS in the project oblasts but did not provide technical support nationally toward designing the system. At appraisal, it was envisaged that other agencies would help MOLSP design the system, but this support did not materialize. Eventually, MOLSP technicians developed the system, but they pointed out that designing it was difficult and time consuming and were uncertain of the quality of the network. This component could have been implemented more promptly and efficiently if the Project had provided a comprehensive package including hardware, software, and technical support.

C. Recommendations

1. Project-Related

61. Both national and local governments should have ensured adequate budgets for sustaining the benefits of donor investment. Incremental budget allocation for O&M was one of the indicators for measuring the achievement of objectives. However, under the Project, local governments did not allocate enough for O&M, which risks undermining project investments in facilities and equipment. It is recommended that the Government ensure that oblast governments provide adequate budgets to cover the O&M costs of project facilities and qualified technicians to maintain the project facilities. It is further recommended that the Government ensure that oblast governments provide necessary training for the technicians who handle the advanced medical equipment procured under the Project.

62. As the Project has started delivering outcomes, MOF should continue to monitor progress toward achieving project objectives through the PPMS developed under the Project. Particular attention should be paid to the progress of the other national reforms including the National Health Reform Program[6] and the HMIS, which were integrated with the PPMS. The PPMS is expected to serve as a national model for data collection and analysis and to be operated by policymakers on a continuous basis.

2. General

63. The Project highlighted both the advantages and disadvantages of a multisector project. It was designed and implemented by local governments and communities and responsive to local needs and problems. The Project successfully addressed local needs, strengthened local service provision, and mobilized community support. However, it faced difficulties in obtaining commitment and ownership from line ministries, whose participation was weak and whose recognition of project outputs was lacking. The Project was often neglected in the Government's matrix of sector assistance, despite the significant size of the investment.

64. To coordinate activities, the Project intended that MOF would work closely with the PSC nationally. The PSC, comprising representatives of MOF, MOE, MOH, MOLSP, and project oblast representatives, was supposed to bridge national sector policies and programs, on the one hand, and project activities in oblasts and raions on the other. However, the PSC did not play this role effectively. The multisector nature of the Project posed more disadvantages than advantages under conditions prevailing in the Kyrgyz Republic, given the difficulty of

[6] Ministry of Health, Kygyz Republic. 1994. *MANAS Health Care Reform Program.* Bishkek.

coordinating sectors and mobilizing sector commitment. A lack of sector commitment was a major shortcoming in a country where sector reforms were a high priority. Under similar conditions, sector-based projects, rather than multisector projects, are likely to be more appropriate.

65. For future projects, investment and O&M should be planned together to ensure sustainability. When planning investments, external agencies should obtain a firm commitment that the Government will budget sufficient resources. It is also important to ensure the presence of qualified technicians to maintain the rehabilitated infrastructure.

PROJECT FRAMEWORK

Design Summary	Performance Targets	Monitoring Mechanisms	Assumptions and Risks
1. Goals			
Protect human capital by improving utilization of basic health and education services for vulnerable populations in Jalal-Abad and Osh provinces	Utilization by rural populations of primary healthcare (PHC) services outside of hospitals increased vis-à-vis use of hospital-based services Increased primary school promotion and graduation rates Reduced primary school absenteeism rate and missed days due to facility closures	Baseline data in household survey conducted under project preparatory technical assistance Comparator data from monitoring and evaluation Household surveys/routine statistics at midterm and final reviews 1998 district data used as baseline; annual comparator from routine data incorporated into education sector management information system (MIS) Baseline to be calculated on data from project preparatory household survey and 1998 facility data. Comparators from monitoring and evaluation facility and household surveys Project MIS	Rural poverty reduction and decentralization remain key objectives of the Government. Macroeconomic conditions nationally and in the selected provinces are stable or improved, increasing affordability. Greater use of less expensive primary services and better targeting of public subsidies will ensure the affordability of services to the poor. Jala-Abad and Osh continue support for national health and education reform. Additional income increases affordability of health and education services.
2. Purpose			
2.1 Increased capacity of local government to deliver priority social services to the rural poor	79% of health and 20% of primary education facilities rehabilitated to a functional state in rural districts 100% of formal user fees and health insurance payments retained by collecting facility; mobilization of community resources for social services equivalent to $530,000 (over the 5 years of the Project)	Project monitoring and evaluation Problem analysis established from facility costs study Baseline data and comparators for individual facilities determined by monitoring and evaluation facility survey and project documents Annual expenditure analysis	The decentralization of Government responsibilities continues. Budgets increase for health and education. A policy for retaining user fees and insurance payments is implemented. Rationalization of social facilities occurs.

Design Summary	Performance Targets	Monitoring Mechanisms	Assumptions and Risks
	Repairs and maintenance spending for health and education rises incrementally, meeting project needs		Local governments' debts and arrears affecting social sectors are reduced. Province expenditure data is available.
2.2 Increased participation of local communities through partnerships with local governments	Functioning community-based organizations (CBOs) support social services Mobilization of community resources to cover 40% of estimated maintenance costs for rehabilitated infrastructures ($530,000 over the 5 years of Project)	Baseline and comparators to be decided during implementation from monitoring and evaluation facility and household sample surveys	Government continues to support and promote private CBOs and nongovernment organizations (NGOs). Poor rural communities can mobilize adequate cash or in-kind contributions.
3. Project outputs			
3.1 Strengthening local government capability to finance and manage priority maternal and child health (MCH) and education services 3.1.1Project management 3.1.2 Institutional strengthening 3.1.2.1 Improved province and district administrative systems and procedures	Implementation of Social Services Delivery and Finance Project By month 3: (i) PIU and 2 PCOs staffed and operational (ii) procedures for civil works, CBO support, procurement and training established (iii) financing arrangements established Timely accomplishment of project targets Improved capital planning system linked to budget process; revised systems and procedures for the operation and maintenance of social infrastructure implemented in provinces, districts and village	Periodic review, progress reports, and evaluations Annual expenditure reviews Progress reports First Review Mission Steering committee and PCO reports Project MIS Midterm and final evaluations Budget guidelines; maintenance systems manuals and guidelines; Project MIS and evaluations Legally approved contracts implemented between public and	Project financing is additional to current and planned provincial budgets; local governments implement the Project as designed; and activity selection criteria are correctly applied. Provision of project and Counterpart financing from government budgets is timely. The impress fund is successful negotiated. Provinces assign appropriately skilled staff to the PCOs. Internal and external audit capacities are developed by Government as planned.

Design Summary	Performance Targets	Monitoring Mechanisms	Assumptions and Risks
	clusters in both provinces by end of year 3 Leasing and contracting arrangements formalized for private delivery or use of public services and facilities	private sectors for delivery of social services or use of facilities	The norm calculation method for social sector budgets is revised. An adequate legal framework for public–private collaboration is put in place.
3.1.2.2 Management training for institutional and service delivery managers	Revised MIS for province, district, and village social protection departments; 58 professionals trained Computerized health management information system (HMIS) established in Osh; computerized MIS for social protection in Osh and Jalal-Abad. Training for 223 Jalal-Abad and 272 Osh healthcare administrators and 100 Jalal-Abad and 100 Osh school administrators	Project monitoring and evaluation Project reports Project reports and evaluations Training evaluations Project MIS Progress reports	Appropriate staff made available, and counterpart financing is provided for training.
3.2 Improved delivery of basic education and MCH services 3.2.1 Rehabilitated health and education physical infrastructure 3.2.2 Basic equipment and materials provided to priority health facilities and schools	Rehabilitated primary facilities with standard equipment and supplies and trained personnel providing services and being maintained Rehabilitation of 187 rural schools, 352 health posts, 86 rural polyclinics (RPCs), rural health centers, 42 subrural hospitals, 15 central district hospitals, and all provided with basic equipment, furniture, and other supplies. All participating local contractors trained in cost estimation, tendering, and quality control	Baseline and comparators to be decided through monitoring and evaluation facility surveys Project MIS, progress reports, and site visits Project MIS and training evaluations Monitoring and evaluation facility and household surveys 1998 district expenditure analysis to set baselines (1997 equivalent to less than 0.6%); annual analysis of expenditures as comparators	Project inputs are additional to current and planned resources, and trained personnel remain in social services. Construction materials, skilled labor, and fuel are available. Local contractors are motivated to participate and make use of training opportunities. Adequate systems of inventory and control are in place.

Design Summary	Performance Targets	Monitoring Mechanisms	Assumptions and Risks
	Most patients and pupils satisfied with facilities	Project MIS, progress reports, and monitoring and evaluation facility survey	
	Increase to 2% of sector budget resources provided for maintenance of rural district social infrastructure		
3.2.3 Expanded technical services response			Staff and courses are available for training.
3.2.3.1 Technically strengthened services	Continuing education for rural health providers on PHC management of MCH priorities; 500 professionals trained on women's health, 100 professionals trained on early childhood development (ECD)	Project MIS Monitoring and evaluation facility surveys Project reports Project MIS and facility surveys	Standardized national education curricula, training programs, and materials are available. The National Health Reform Program continues. National reform programs and related local capacity building are valued and supported by local governments.
	Clinicians retrained as family health practitioners for each district; rehabilitated RPCs converted to family group practices	Target to be set in at project startup in discussion with the National Health Reform Program, which issues certificates for practice; contracts between local governments and family group practices for RPCs	Ministries of Finance; Health; Labor and Social Protection; and Education, Science, and Culture coordinate targeting.
	Training for service managers in cross-sector approaches focusing on targeting, monitoring and evaluation, and ECD	Project MIS, progress reports, and facility surveys	
	Pilot ECD programs established in Jalal-Abad and Osh	Project MIS and pilot evaluation	
3.2.3.2 Public and professional information and education	Successful public information and education campaigns for priority health and education topics implemented	Project MIS, household surveys, and social marketing evaluations Progress reports	Public information increases the appropriate demand for, and utilization of, health and education services.
	Workshops for professional associations on child education and PHC topics	Project MIS, progress reports, and workshop evaluations	Professional association members are interested and motivated.

Design Summary	Performance Targets	Monitoring Mechanisms	Assumptions and Risks
	Community health education programs established	Project MIS, household surveys, and social marketing evaluations	NGOs and CBOs have adequate capacity for social marketing
3.2.3.3 Linkages with other programs	National Health Reform Program and Bilim (Knowledge) policies, priorities and standards incorporated into the Project Technical coordination established with other international funding organization programs	Progress reports	
3.3 Increased community self-reliance in MCH and education services 3.3.1 Improved local responsiveness of government to community needs in target villages	895 village, district, and province staff trained in facility maintenance, planning, community assessment, social services delivery, and cooperative resource management Village authorities and CBOs establish working relationships Annual village authority meetings held	Project MIS, facility surveys, and training evaluations Progress reports	Local government personnel are interested, available, and motivated to participate. Village staff are able and encouraged to utilize skills developed through training. Village authorities show good leadership on sector reforms.
3.3.2 Improved management of community facilities and services	Discretionary grants ($300,000) to village authorities and communities for social infrastructure improvement successfully implemented	Project MIS, community studies, and household surveys	Village authorities exercise legal and administrative authority over, and ownership of, local infrastructure.
3.3.3 NGOs strengthened to support development of CBOs	Six NGOs trained to support CBOs through consultation and administrative support	Project MIS, progress reports, and project evaluations	Local governments accept the role of NGOs and CBOs in supporting service delivery and maintenance.
3.3.4 Functional CBOs established to support health and education services	200 CBOs trained by NGOs in cooperative resource management, community promotion, and problem solving CBOs work with schools and health facilities to secure resources and maintain facilities	Project MIS and progress reports Progress reports and facility surveys Project MIS Progress reports and household surveys	CBOs not effective in all localities. Communities are supportive and cohesiveness.

Design Summary	Performance Targets	Monitoring Mechanisms	Assumptions and Risks
	Community health campaigns developed by CBOs		
3.3.5 Community studies and surveys of needs and benefits	CBO fact-finding and problem-solving teams established	Progress reports	
	Household survey (year 4)	Survey	
4. Project Inputs			
Civil Works	Rehabilitation of health and education facilities:	Progress reports.	Sufficient quality contractors are available.
Equipment and furniture	Procurement and distribution of school furniture, medical equipment and furniture, and computer equipment for health and social protection sectors	Progress reports Government statistics.	Government's understanding of tendering works exists.
Training and Workshops	Training of teachers, health workers, local government's staff, and village representatives	Progress reports	Trainers and participants are motivated to participate actively.
Consultant Services	Recruitment and deployment of consultants.	Progress reports	The Government is agreeable with the salary level of international consultants
Public Information Campaigns	Health, education, and social protection information campaigns.	Progress reports Government statistics.	Campaigns are relevant to sector issues
Discretionary Grant Funds	Support and finance of rehabilitation of community and small social infrastructure		Mechanisms developed are effective. Communities are interested in the scheme.
Project Support	Establishment of the steering committee.	Progress reports.	Competent and committed staff are available for PIU.
	PIU Establishment and equipping		Security is ensured for PIU operation
	PPMS development		

CBO = community-based organization, ECD = early childhood development, HMIS = health management information system, MCH = maternal and child health, MIS = management information system, NGO = nongovernment organization, PIU = project implementation unit, PCO = project coordination office, RPC = rural polyclinics.

Source: Asian Development Bank.

ACHIEVEMENT OF OUTPUTS AND TARGETS

Project Component	Project Inputs		Project Outputs	
	Appraisal	Actual	Appraisal	Actual
A. Strengthening the capability of local government to finance and manage priority maternal and child health (MCH) and education services				
1. Project management	Consulting services for 15.4 international person-months and 720 domestic person-months Training on civil works and procurement procedures and community-based organization (CBO) support	Consulting services for 17.7 international person-months and 755 domestic person-months utilized 132 persons (contractors and CBO representatives) provided with training on bidding procedures	Project is successfully implemented and monitored with functioning project implementation unit (PIU) and province project coordinating offices (PCOs)	PIU and two PCOs staffed and operational Procedures for civil works, CBO support, procurement and training established Financing arrangements established
2. Institutional strengthening (i) Improved province and district administrative systems and procedures	Training of village authorities on budgeting, operations, and maintenance of social infrastructure projects	3,173 village authorities trained to implement community development projects, budgeting, business planning, maintenance of facilities, preparation of project proposals, etc. 123 people representing health and education departments and nongovernment organizations (NGOs) received training on budgeting	Improved monitoring of, and planning for, social infrastructure and maintenance needs Formalized interactions with private sector	An improved capital planning system linked to budget process; systems and procedures for the operation and maintenance of social infrastructure revised in provinces, districts, and villages in three provinces Leasing and contracting arrangements formalized for private delivery or use of public services and facilities
(ii) Management training for institutional and service delivery managers	Provision of computer equipment for management information system (MIS) and health management information system (HMIS)	50 computers provided to 3 provincial social protection offices, 44 district social protection offices, 3 project coordination offices for MIS	Effective data collection on service utilization by the poor More accurate and timely social sector data utilized	Revised MIS for province, district, and village social protection department; 57 professionals trained

Project Component	Project Inputs		Project Outputs	
	Appraisal	Actual	Appraisal	Actual
		31 computers provided to 28 health facilities (3 district hospitals and 25 primary healthcare facilities) for HMIS.	in provinces, districts, and villages Increased skills in social services areas	Computerized HMIS established in Osh
	Training of 58 staff of social protection department	57 staff were trained on information system for social passport of family program of Ministry of Labor and Social Protection.		Computerized MIS for social protection established in Osh and Jalal-Abad
	Computer specialist on a part-time basis	Procurement specialist acting as computer specialist during initial period of project implementation		
	Training of 223 Jalal-Abad and 27 Osh healthcare administrators and 200 Jalal-Abad and 100 Osh school administrators	Training provided to health and education representatives, but areas of training provided were for health reform, budgeting, strategic planning, and project implementation		
B. Improving delivery of basic education and MCH services				
1. Rehabilitated health and education physical infrastructure	Rehabilitation of 187 rural schools, 352 health posts, 86 rural polyclinics (PPCs), rural health centers, 42 subrural hospitals (SRHs) and 15 central district Hospitals	187 rural school facilities and 495 health facilities rehabilitated	PHC and education facilities upgraded	Rehabilitation of 190 rural schools and 495 health facilities

Project Component	Project Inputs		Project Outputs	
	Appraisal	Actual	Appraisal	Actual
	Training of 80 local coordinators in cost estimation, tendering and quality control	132 contractors and CBO representatives provided with training on bidding procedures	Improved maintenance of rehabilitated facilities	All participating local contractors trained in cost estimation, tendering, and quality control Most patients and pupils satisfied with facilities Increase to 2% of sector budget resources provided for maintenance of district social infrastructure in rural areas
2. Basic equipment and materials provided to priority health facilities and schools	Provision of basic equipment, furniture and supplies to 187 rural schools, 352 health posts, 86 RPCs, 42 SRHs, and 15 central district hospitals	190 rural schools, 495 health facilities provided basic equipment, furniture, and other supplies	Priority facilities functioning	Optimal utilization noted
3. Expanded technical service response (i) Technically strengthened services	Training on managing women's health for 500 participants (250 from Jalal-Abad and 250 from Osh)	Not conducted	Accelerated improvements in local teaching and health delivery	Continuing education for rural health providers on PHC management of MCH priorities; 500 professionals trained on women's health, and 100 professionals trained on ECD
	Training on early childhood development (ECD) for 100 participants (50 from Jalal-Abad and 50 from Osh)	Workshop on ECD conducted in April 2003 in two pilot raions in Jalal-Abad and Osh (number of participants is unknown)		
	Training of rural health providers	Training provided to health and education representatives, but areas of training provided were	Increased rural health access to family practitioners	Clinicians retrained as family health practitioners for each district; rehabilitated RPCs

Project Component	Project Inputs		Project Outputs	
	Appraisal	Actual	Appraisal	Actual
		health reform, budgeting, strategic planning, and project implementation		converted to family group practices
	Training of community Benefit Monitoring and Evaluation (BME) approach for 170 participants (85 from Jalal-Abad and 85 from Osh)	Not conducted	Integrated (cross-sectoral) approaches to targeting vulnerable families improves health and education access of rural poor	Training for service managers in cross-sector approaches focusing on targeting, monitoring and evaluation, and Early Childhood Education (ECD)
(ii) Public and professional information and education	Workshops on public information		Increased community interest and support for schools and basic health concerns	Pilot ECD programs established in Jalal-Abad and Osh Successful public information and education campaigns for priority health and education topics implemented Workshops for professional associations on child education and PHC topics
(iii) Linkages with other programs			Expanded technical coordination and resource base for implementing sector reforms	Community health education programs established National Health Reform Program and Bilim (Knowledge) policies, priorities and standards incorporated into Project

Project Component	Project Inputs		Project Outputs	
	Appraisal	Actual	Appraisal	Actual
				Technical coordination established with other international funding organization programs
C. Increasing community self-reliance in MCH and education services				
1. Improved local responsiveness of government to community needs in target villages	Training on village government responsibilities for village, district, and province staff (450 from Jalal-Abad and 445 from Osh)	3,173 village authorities trained on implementing community development projects, budgeting, business planning, maintenance of facilities, preparation of project proposals, etc.	Village authorities effectively represent community health and education issues Health and education services better meet community needs	Village, raion, and oblast staff trained in facility maintenance, planning, community assessment, social services delivery, and cooperative resource management Village authorities and CBOs establish working relationships Annual village authority meeting held
2. Improved management of community facilities and services	Management of community services through discretionary grant funds	More than 400 activities financed through the discretionary grant funds	Improved effectiveness of local services Community outreach efforts established by health and school facilities	Discretionary grants (roughly $500,000) to village authorities and communities for social infrastructure improvement successfully implemented
3. NGOs strengthened to support development of CBOs	Training of three NGOs	26 representatives from 3 NGOs trained on training trainers	Partnerships and community goal-sharing fostered between NGOs and CBOs, and between CBOs	Three NGOs trained to support CBOs through consultation and administrative support

Project Component	Project Inputs		Project Outputs	
	Appraisal	Actual	Appraisal	Actual
4. Functional CBOs established to support health and education services	Training of 200 CBOs on resource management, community promotion, and problem solving	283 CBOs trained on resource management, community promotion, and problem solving.	Increased mobilization of community resources Local facilities better maintained Improved access to basic services for vulnerable populations	283 CBOs trained by NGOs in cooperative resource management, community promotion, and problem solving CBOs with schools and health facilities to secure resources and maintain facilities Community health campaigns developed by CBOs
5. Community studies and surveys of needs and benefits	One household survey ECD pilot study		More effective targeting of services Increased community involvement targeting and delivery	CBO fact-finding and problem-solving teams established Household survey

CBO = community-based organization, ECD = early childhood development, HMIS = health management information system, MCH = maternal and child health, MIS = management information system, MOLSP = Ministry of Labor and Social Protection, NGO = nongovernment organization, PIU = project implementation unit, PCO = project coordination office, RPC = rural polyclinics, SRH = subrural hospital
Sources: ADB and Project Implementation Unit of the Executing Agency.

CIVIL WORKS REHABILITATED BY THE PROJECT

Province	Medical Facilities		School Facilities[a]		Total	
	Appraisal	Actual	Appraisal	Actual	Appraisal	Actual
Osh[b]	270	204	93	72	363	276
Batken		68		23		91
Jalal-Abad	223	223	92	92	315	315
Total	**493**	**495**	**185**	**187**	**678**	**682**

[a] Medical facilities consist of 436 primary health care facilities and 59 hospitals.
[b] Appraisal figures for Osh include Batken.
Sources: Project Implementation Unit of the Executing Agency.

PROCUREMENT OF SCHOOL FURNITURE

Province	Number of Schools Provided with Furniture		Type of Furniture Provided				
	Appraisal	Actual	School Desks	Blackboards	Teachers' Tables	Teachers' Chairs	Bookshelves
Osh[a]	93	120	7,335	575	635	1,169	680
Batken		47	2,542	171	171	387	161
Jalal-Abad	92	150	9,335	727	743	2,297	708
Total	**185**	**317**	**19,212**	**1,473**	**1,549**	**3,853**	**1,549**

[a] Appraisal figures for Osh include Batken.
Source: Project Implementation Unit of the Executing Agency.

EQUIPMENT PROCUREMENT FOR HEALTH FACILITIES

Health Facilities	Medical Equipment (Number)					
	Ultrasound	Electrocardiograph	Defibrilator	Biomedical Analyzer	Sterilizer	Surgical Tools
Family Group Practice	0	28	0	0	6	21
Family Group Practice Center	24	29	36	10	8	7
Rural hospital	5	8	0	3	2	4
Reference hospital[a]	16	30	0	4	1	0
Total	**45**	**95**	**36**	**17**	**17**	**32**

[a] Reference hospitals include central district, city, provincial, and sector hospitals.
Source: Project Implementation Unit of the Executing Agency.

TRAINING

Component	Target Participants	Subject	No. of Training Programs	No. of Participants
A. Local Government Capacity	• Representatives of ministries of Kyrgyz Republic and international organizations • *Raion* (district) and *oblast* (provincial) architects in Osh and Jalal-Abad oblasts • Village authority leaders of Osh and Jalal-Abad oblasts • Representatives of health and education departments in Osh and Jalal-Abad oblasts • Deputies of both chambers of Parliament; representatives of Ministries of Finance and Health and oblast, raion and town hospitals from Osh and Batken oblasts	• Health reform II • Annual village authority meeting • Policy and strategy of health system financing • Bidding procedures • Preparation of bidding documents • Drawings and estimation documentation • Budgeting • Contract signing • Coordination of project activities • Discretionary grant activities • Business planning • Community development project activities • Survey of facilities for rehabilitation during the 5 years • Operation and maintenance of rehabilitated facilities • Training activities	19	1,334
B. Delivery of Services	• Contractors of construction companies in Osh and Jalal-Abad oblasts • Heads and accountants of contractors and oblast and raion tax inspectors in Osh, Batken, and Jalal-Abad oblasts • Representatives of social protection departments in Osh, Batken, and Jalal-Abad oblasts	• Preparation of bidding documents and financial proposals • Review of objectives for rehabilitation of health and education facilities • Coordination of works with project implementation unit and project coordination offices • Prequalification process • Maintenance of rehabilitated facilities • Information system for "social passport" program of the Ministry of Labor and Social Protection	10	279

Component	Target Participants	Subject	No. of Training Programs	No. of Participants
C. Community Participation	• Representatives of 6 nongovernment organizations from Osh, Batken and Jalal-Abad oblasts • Representatives of public unions and community-based organizations	• Budgeting • Project coordination • Strategic planning • Decision making • Project planning and reporting • Training of trainers • Knowledge and practical skills in the organization and conduct of independent workshops and trainings • Strengthening of community-based organizations • nongovernment organizations and society • Social partnerships • Microbusiness • Fund sourcing • Advocacy	8	3,173
Total			**37**	**4,786**

Source: Project Implementation Unit of the Executing Agency.

INFRASTRUCTURE REHABILITATED THROUGH THE DISCRETIONARY GRANT FUND

Province	Jalal-Abad	Osh/Batken	Total
Schools (including kindergartens, boarding schools, lyceums, playgrounds, and an education center)	141	73	214
Health facilities	10	17	27
Sports facilities	2	1	3
Children's homes	22	0	22
Cultural and public facilities	8	10	18
Electrical power facilities	2	1	3
Roads and bridges	55	8	63
Water supply and sanitation facilities (bathhouses and public lavatories)	29	13	42
Parks	8	0	8
Total	**277**	**123**	**400**
Percent (%)	60.7	39.3	100.0

Source: Project Implementation Unit of the Executing Agency.

COMPARISON OF APPRAISAL AND ACTUAL PROJECT COSTS

Table A8.1: Project Cost at Appraisal
($ million)

Item		Appraisal Estimates									
		ADB			OPEC Fund			Government	Total		
		Foreign	Local	Total	Foreign	Local	Total	Local	Foreign	Local	Project Cost
A.	Investment Costs										
	1. Investment										
	a. Civil Works	1.83	1.44	3.27	1.38	0.94	2.32	2.43	3.21	4.81	8.02
	b. Vehicles	0.08	0.00	0.08	0.00	0.00	0.00	0.00	0.08	0.00	0.08
	c. Training	0.24	0.09	0.33	0.00	0.00	0.00	0.21	0.24	0.30	0.54
	d. Consultancies										
	(i) International	0.44	0.00	0.44	0.00	0.00	0.00	0.00	0.44	0.00	0.44
	(ii) Domestic	0.00	0.25	0.25	0.00	0.00	0.00	0.18	0.00	0.43	0.43
	e. Equipment										
	(i) Educational	0.22	0.64	0.86	0.00	0.00	0.00	0.11	0.22	0.75	0.97
	(ii) Medical	1.76	0.00	1.76	0.00	0.00	0.00	0.22	1.76	0.22	1.98
	(iii) Office	0.10	0.05	0.15	0.00	0.00	0.00	0.02	0.10	0.07	0.17
	2. PIU Operations	0.10	0.03	0.13	0.00	0.00	0.00	0.08	0.10	0.11	0.21
	a. Recurrent Costs	0.22	0.00	0.13	0.00	0.00	0.00	0.98	0.22	0.98	1.20
	Subtotal (A)	**4.99**	**2.50**	**7.49**	**1.38**	**0.94**	**2.32**	**4.23**	**6.37**	**7.67**	**14.04**
B.	Contingencies										
	1. Physical	0.42	0.30	0.72	0.10	0.13	0.23	0.15	0.52	0.58	1.10
	2. Price	0.35	1.22	1.57	0.10	0.59	0.69	0.53	0.45	2.34	2.79
	Subtotal (B)	**0.77**	**1.52**	**2.29**	**0.20**	**0.72**	**0.92**	**0.68**	**0.97**	**2.92**	**3.89**
C.	Service Charge	0.22	0.00	0.22	0.33	0.00	0.33	0.00	0.55	0.00	0.55
	Total	**5.98**	**4.02**	**10.00**	**1.91**	**1.66**	**3.57**	**4.91**	**7.89**	**10.59**	**18.48**

OPEC = Organization of Petroleum Exporting Countries, PIU = project implementation unit
Sources: Asian Development Bank and Project Implementation Unit of the Executing Agency.

Table A8.2: Project Cost at Completion
($ million)

Item	Actual									
	ADB			**OPEC Fund**			**Government**	**Total**		
	Foreign	**Local**	**Total**	**Foreign**	**Local**	**Total**	**Local**	**Foreign**	**Local**	**Project Cost**
A. Investment Costs										
1. Investment										
a. Civil Works	2.55	2.05	4.60	1.88	1.66	3.46	3.04	4.43	6.75	11.18
b. Vehicles	0.07	0.00	0.07	0.00	0.00	0.00	0.00	0.07	0.00	0.07
c. Training	0.12	0.12	0.24	0.00	0.00	0.00	0.00	0.12	0.12	0.24
d. Consultancies										
(i) International	0.96	0.00	0.96	0.00	0.00	0.00	0.00	0.96	0.00	0.96
(ii) Domestic	0.00	0.30	0.30	0.00	0.00	0.00	0.02	0.00	0.32	0.32
e. Equipment										
(i) Educational	0.35	0.99	1.34	0.00	0.00	0.00	0.03	0.35	1.01	1.37
(ii) Medical	2.11	0.00	2.11	0.00	0.00	0.00	0.00	2.11	0.00	2.11
(iii) Office	0.09	0.02	0.11	0.00	0.00	0.00	0.00	0.09	0.02	0.11
2. PIU Operations										
a. Recurrent Costs	0.02	0.00	0.02	0.00	0.00	0.00	0.00	0.02	0.00	0.02
Subtotal (A)	**6.27**	**3.48**	**9.75**	**1.88**	**1.66**	**3.54**	**3.09**	**8.15**	**8.23**	**16.38**
B. Contingencies										
1. Physical	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2. Price	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Subtotal (B)	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
C. Service Charge	0.17	0.00	0.17	0.00	0.00	0.00	0.00	0.17	0.00	0.17
Total	**6.44**	**3.48**	**9.92**	**1.88**	**1.66**	**3.54**	**3.09**	**8.32**	**8.23**	**16.55**

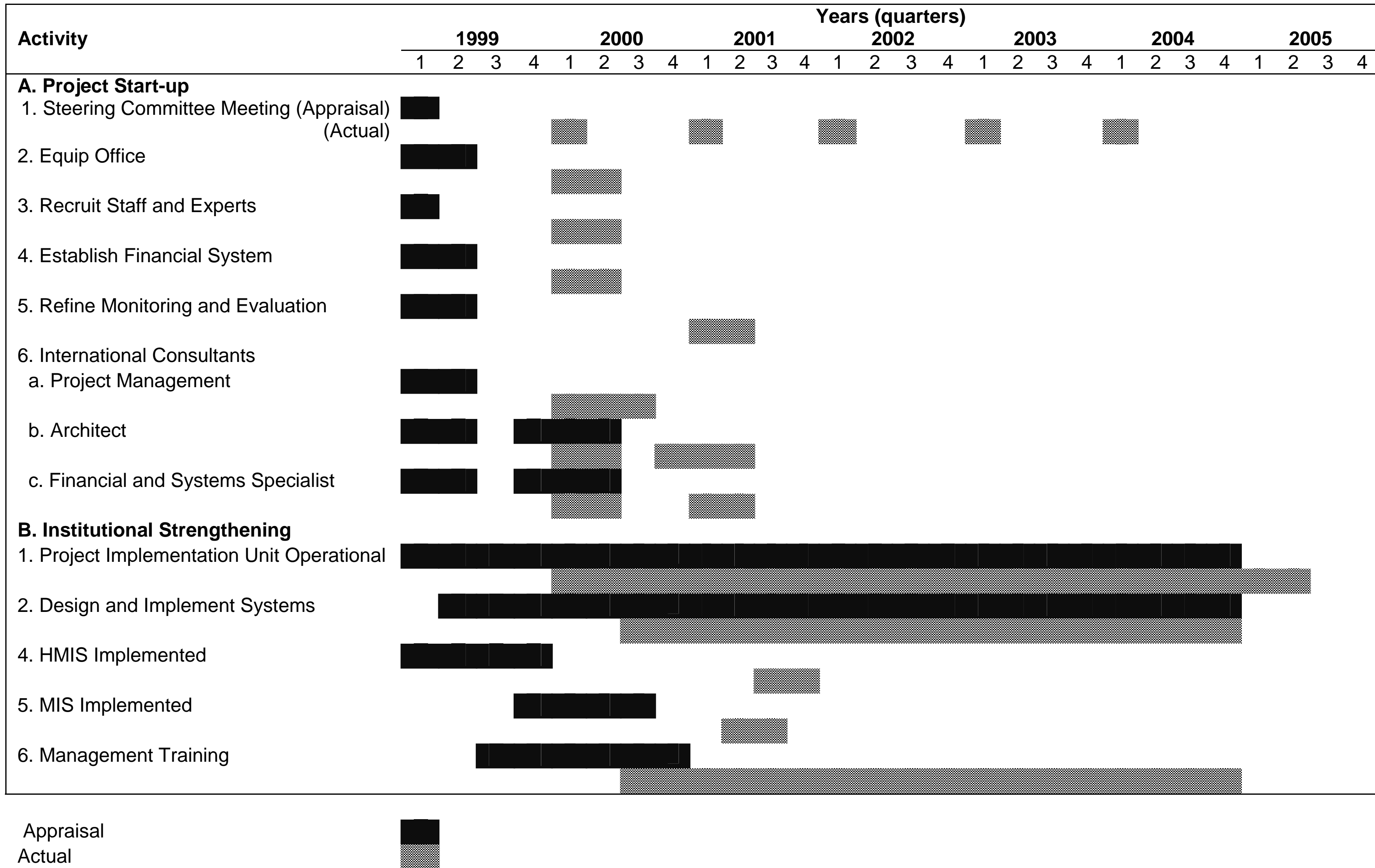
OPEC = Organization of Petroleum Exporting Countries, PIU = project implementation unit
Sources: Asian Development Bank and Project Implementation Unit of the Executing Agency

DISBURSEMENTS

Year	Quarter	Quarterly Disbursement ($ '000)	Cumulative Disbursement ($ '000)	Cumulative Disbursement (%)
1999	I	0.00	0.00	0.00
	II	0.00	0.00	0.00
	III	0.00	0.00	0.00
	IV	0.00	0.00	0.00
2000	I	0.00	0.00	0.00
	II	0.19	0.19	1.91
	III	0.11	0.30	3.02
	IV	0.30	0.60	6.05
2001	I	0.07	0.67	6.75
	II	0.03	0.70	7.06
	III	0.85	1,55	15.63
	IV	0.87	2.42	24.40
2002	I	0.17	2.59	26.11
	II	0.10	2.69	27.12
	III	1.00	3.69	37.19
	IV	0.94	4.63	46.67
2003	I	0.17	4.80	48.39
	II	0.36	5.16	52.02
	III	0.88	6.04	60.89
	IV	0.75	6.79	68.44
2004	I	0.06	6.85	69.05
	II	0.75	7.60	76.61
	III	0.82	8.43	84.88
	IV	1,40	9.82	98.99
2005	I	0.04	9.86	99.40
	II	0.06	9.92	100.00
	Total	**9.92**		

I = first quarter, II = second quarter, III = third quarter, IV = fourth quarter.
Source: Asian Development Bank.

PROJECT IMPLEMENTATION SCHEDULE



Activity	Years (quarters)																											
	1999				2000				2001				2002				2003				2004				2005			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
C. Improved Delivery of Services																												
1. Survey/Proposals																												
2. Bidding Documents																												
3. Tendering Procedures																												
4. Construction																												
5. Bidding for and Supply of Equipment and Materials																												
6. Technical Training																												
7. Service Managers Training																												
8. Training Specialist																												
9. Linkages with Other Programs																												
D. Community Participation																												
1. Survey and Studies																												
2. Strengthening CBOs																												
3. Community Planning																												
4. Monitoring and Evaluation																												

CBO = community-based organization, HMIS = health management information system, MIS = management information system
Sources: Asian Development Bank and Project Implementation Unit of the Executing Agency.

COMPLIANCE WITH LOAN COVENANTS

Covenant	Reference in Loan Agreement	Compliance
A. Standard Covenant		
1. Maintenance and audit of separate accounts for the Bank-financed components of the Project; audited Project accounts to be furnished not later than six (6) months after the end of each fiscal year.	LA, Section 4.06(b)	Complied with. All audited financial statements submitted.
2. The Borrower shall furnish to the Bank quarterly reports on the carrying out of the Project and on the operation and management of the Project facilities.	LA, Section 4.07(b)	Complied with. All quarterly progress reports submitted.
3. PCR to be prepared and furnished not later than three (3) months after physical completion of the Project.	LA Section 4.07(c)	The project completion report (PCR) was submitted to the Asian Development Bank in April 2005.
B. Project-Specific Covenants		
Project Implementation		
Project Executing Agency		
4. MOF, as the Project Executing Agency, shall have overall responsibility for the management and supervision of the Project. The Oblast Administrations of the Project Oblasts shall have the primary responsibility for the implementation of the Project.	LA, Schedule 6, para.1	Complied with.
Project Implementation Unit		
5. The Project Implementation Unit (PIU) shall be established within the Jalal-Abad Oblast Finance Department and staffed by (i) a Project Manager, (ii) two accountants, (iii) two engineers and/or architects supported by two additional engineers and/or architects during the years 2001-2003, (iv) a procurement specialist, (v) a social sector specialist, (vi) a training specialist, (vii) a computer specialist, and (viii) a community development specialist. The Borrower shall provide by the Effective Date adequate office space, either within the Jalal-Abad Oblast Finance Department or the Oblast Administration, and support staff to the PIU, and continue to provide the same throughout the Project implementation period.	LA, Schedule 6, para.2	Complied with. The PIU was established in March 2001. The office space was provided in Jalal-Abad oblast administration.

Covenant	Reference in Loan Agreement	Compliance
Project Coordinating Offices		
6. The Borrower shall establish, within one month after the Effective Date, Project Coordinating Offices (PCOs) in each Project Oblast Administration, each comprising a core staff of not less than three, representing the respective Oblast Administration and health and education sectors. The PIU shall work closely with the PCOs and, to the extent possible, shall devolve the implementation of Project activities to the Oblast administrations through the PCOs. The PIU shall also provide technical support to the PCOs and ensure coordination of Project activities. The PCOs shall work with health and education sector counterparts at the raion administration level who, in turn, shall work directly with the AOs participating in the Project. The Borrower shall maintain the PCOs throughout the Project implementation period.	LA, Schedule 6, para.3	Complied with. Established with experienced staff from the oblast administrations and the health and education sector.
7. The National Project Steering Committee, comprised of representatives of MOF, MOH, MESC, MLSP and the State Committee of the Kyrgyz Republic on Foreign Investments and Economic Development (Goskominvest) shall provide policy guidance and overall supervision.	LA, Schedule 6, para.4	Partly complied with. Meetings of the steering committee were held regularly but sector issues were discussed at informal meetings.
Other Matters		
Project Performance Monitoring and Evaluation		
8. (a) The Borrower shall ensure that an integrated system of data collection and analysis for project performance monitoring and evaluation will be designed and implemented to monitor the progress in achieving the Project objectives. (b) The PIU shall submit a detailed implementation plan for monitoring benefits and preparing benchmark information for review and concurrence of the Bank within six months after the Effective Date.	LA, Schedule 6, para.5	Partly complied with. The project performance and monitoring system was not set up due to the Government's reluctance to engage international consultants for the full duration. The system was designed only during the middle part of project implementation with additional inputs from a local consultant.
Project Reviews		
9. The Borrower shall carry out, jointly with the Bank, (i) a comprehensive review at the end of the first year of the Project implementation period, and (ii) a mid-term review within two years after the Effective Date.	LA, Schedule 6, para.6	Complied with. A comprehensive review was carried out in July 2001 and a midterm review was carried out in June 2002.

Covenant	Reference in Loan Agreement	Compliance
Counterpart Funds		
10. Without limiting the generality of Section 4.02 of this Loan Agreement, the Borrower shall ensure that (i) a supplementary amount of budgetary resources shall be allocated to cover the incremental recurrent costs of the Project, and (ii) allocations for the Project shall not displace annual budget allocations for the capital expenditures and the operations and maintenance expenditures in the health and education sectors in the Project Oblasts, and that such expenditures shall not be less, in inflation adjusted terms, than the actual expenditures for the fiscal year 1998.	LA, Schedule 6, para.7	Complied with. There were delays in providing the counterpart funding during project implementation, but the issue was resolved prior to completion.
Community-Based Organizations		
11. The Borrower shall ensure that community based organizations, such as the parent teacher associations, are included in the process of determining needs and solutions at the local levels with regard to health and education related issues and are actively involved in the operation and maintenance of the community health and education facilities.	LA, Schedule 6, para.8	Complied with. Consultations were carried out and training were provided. Community-based organizations were created and participated substantially in the implementation of discretionary grant fund activities.
Health Services Plan		
12. The Borrower shall complete, to the satisfaction of the Bank, a plan to rationalize health services in the Project Oblasts by 31 December 1999.	LA, Schedule 6, para.9	Complied with but with a delay. Initially, the Ministry of Health prepared a temporary restructuring plan for healthcare sector reforms in Chui and Issy-Kul oblasts, and similar plans were subsequently implemented in the healthcare facilities in the project oblasts.
Representation of Associations		
13. The Borrower shall ensure that the Hospital Association and the Association of Family Doctors are fully established and operating in the Project Oblasts by 31 December 2003.	LA, Schedule 3, para. 10	Partly complied with. By Decree No. 10 dated 1 January 2000 on Improvement of Local Government Structure Under Administrative Reform, the oblast health department was abolished and its duties were delegated to oblast hospitals.

Covenant	Reference in Loan Agreement	Compliance
User Fees		
14. The Borrower shall ensure that user-fees received by the public institutions for health and education are retained by such institutions for unrestricted use in operation and maintenance of their facilities. The Borrower shall have introduced a system of user charges in primary and secondary schools in a minimum of two raions per oblast.	LA, Schedule 3, para.11	Complied with. Copayment funds for health and education facilities are used to increase salaries of staff, subsidize disadvantaged groups, and finance operation and maintenance-related expenditures.
Computer Specialists		
15. The Borrower shall appoint by the Effective Date, and make available throughout the Project implementation period, part-time computer specialists to the oblast departments where HMIS and MIS will be implemented.	LA Schedule 3, para.12	Complied with. Computer specialists were recruited and training was conducted. Computer equipment was provided and a data transmission network for family medicine centers was established.
Decentralization		
16. The Borrower shall ensure that the decentralization process is sustained and devolution of powers to the local governments is not reversed.	LA Schedule 3, para.13	Complied with. The health management information system was introduced in the raion information centers of the oblast health facilities to assist in budget planning, financial management and reporting. Training was also provided to heads and staff of oblast administrations and facilities on social mobilization; local and international bidding; design estimating, monitoring, evaluation, and supervision of civil works; and attracting investments to the social sectors.

TECHNICAL ASSISTANCE COMPLETION REPORT

Division: ECSS

TA No. and Name: 3106-KGZ: Institutional Strengthening for Social Services Delivery and Finance			Amount Approved: $634,000 Revised Amount: –	
Executing Agency: Ministry of Finance	Source of Funding: JSF		TA Amount Undisbursed $150,850	TA Amount Utilized $483,150
Date			Closing Date	
Approval 27 Nov 1998	Signing 14 Feb 1999	Fielding of Consultants 20 Sep 2000	Original 20 May 2001	Actual 31 Dec 2001

Description

The Kyrgyz Republic is undertaking comprehensive reforms in the structure of governance and social services aiming for decentralized management and efficient budget and activity planning. To support these reforms, the Asian Development Bank is providing support for education, health and social protection under the Social Services Delivery and Finance Project (the Project),[7] with which technical assistance (TA) is associated. For the system of local governments, many of the tasks and responsibilities inherent in these reforms represent new functions. TA was intended to assist the Government to refine, pilot, and implement management systems for social services delivery by local governments in provinces, districts, and villages.

Objectives and Scope

The objective of TA was to help the Government develop appropriate programs for strengthening management of local governments to increase the efficiency and effectiveness of public services. TA focused on capacity building in local governments in (i) capital planning and budgeting, (ii) the operation and maintenance of facilities, (iii) strengthening public–private partnerships, and (iv) targeting public subsidies to appropriate service clients. TA targeted each of the three levels of local government: province, district, and village. TA was also intended to reinforce the World Bank's Public Sector Resource Management Adjustment Credit recommendations made in 1998 to move from norm-based budgeting to program budgeting through capacity-building activities. The services provided under TA would encompass (i) international and domestic consulting services; (ii) national workshops and symposia on strategic planning and social sector budget planning and management; and (iii) training of local government staff in provinces, districts, and villages.

Evaluation of Inputs

TA was provided for 39 person-months of consulting services (17 international and 22 domestic). Implementation of TA was contracted to the International Management and Communications Corp. (IMCC) of the United States. The terms of reference were appropriate, and the performance of the consultant was fully satisfactory. IMCC provided international and domestic consultants in line with the terms of reference. At the initial phase, the consultants' inputs were delayed by 2 months due to instability in the project area and the sudden illness of the TA team leader. Once an alternative team leader was identified, the consultants' inputs were provided on time and fully in line with the established terms of reference.

Initially the Government's counterpart inputs, particularly the provision of office space, were not adequate. These shortcomings were fully compensated by the TA team. Office space was shared with the project implementation unit (PIU) of the Project.

Evaluation of Outputs

The TA undertook surveys and organized a national strategic planning workshop in Bishkek, a series of consultation meetings on strategic planning in project provinces (Jalal-Abad and Osh), and pilot training courses for provincial government offices. Based on these activities, TA produced the following reports in close consultation with local governments and the PIU: inception report, physical facility inventory report, benchmark report, training needs assessment, strategic planning manual, budget planning manual, policy agenda, pilot project design proposal, and final report.

[7] Loan No. 1645-KGZ(SF): *Social Services Delivery and Finance*, for $10.0 million, approved on 27 November 1998.

The reports were submitted on time, covered issues comprehensively, and were of a high professional standard. The reports and the pilot training were followed up by the PIU and reflected in project activities. TA contributed to building local government capacity and provided a technical basis for project activities, particularly for the training component and activities related to facilities maintenance. The Project organized training courses using guidelines developed through TA.

Overall Assessment and Rating

TA is considered successful. It was implemented in close consultation and coordination with the PIU of the Project, which allowed TA to play a significant advisory and supporting role.

TA proposals related to (i) capital planning and budgeting, and (ii) maintenance of facilities were fully reflected and implemented through project activities. Discussions initiated through TA have raised awareness among local government officials at all levels on the importance of (iii) private and public partnership, and (iv) targeting subsidies. TA succeeded in raising awareness among local governments of the need for strategic planning and prepared training modules to improve the capacity of local governments in planning, managing, monitoring, and evaluating the social sectors. Eight provincial and national workshops were organized with a total of about 150 participants. In addition, more than 50 meetings and interviews took place with stakeholders. Positive feedback was obtained from participants indicating that the content of the programs was appropriate and that the training materials provided were well prepared.

Major Lessons Learned

The implementation of TA highlighted the importance of having an appropriate team leader. It took time to identify a good replacement after the original TA team leader left due to illness, and during the transition few activities took place. The implementation experience also highlighted the importance of Government ownership. The Government was not able to participate in TA contract negotiations and was therefore not a full party to the discussions on Government inputs. Consequently, when the TA team arrived, no office space had been provided. In the event, the TA team was able to share the office of the PIU, and the lack of office space did not have a negative impact on the start of their activities. It is important to communicate closely with the Government and ensure that the counterpart input requirements are fully understood, even when the requirement was spelled out clearly in the TA memorandum of understanding.

Recommendations and Follow-Up Actions

The outputs of TA should continue to be reflected in Project activities, in particular, to build the capacity of local governments to maintain and operate social service facilities (schools and health facilities), conduct budget planning, and administer and manage the social sectors.

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CONSULTING SERVICES

Expertise	Planned (total months)	Actual (total months)
A. International Consultants		
1. Project Management	5.0	5.0
2. Architect/Engineer	7.0	7.0
3. Systems and Financial Specialist	3.4	0.0
4. Project Director	-	5.7
Subtotal (A)	**15.4**	**17.7**
B. Domestic Consultants		
1. Project Implementation Unit Manager	60.0	56.0
2. Senior Accountant	60.0	58.0
3. Assistant Accountant	60.0	48.0
4. Social Sector Specialist	60.0	54.0
5. Architects/Engineers	216.0	217.0
6. Procurement Specialist	48.0	57.0
7. Community Development Specialist	60.0	63.0
8. Training Specialist	18.0	26.0
9. Computer Specialist	18.0	0.0
10 Support Staff	120.0	176.0
Subtotal (B)	**720.0**	**755.0**
Total	**735.4**	**772.7**

Sources: Asian Develoment Bank and Project Implementation Unit of the Executing Agency.

GOVERNMENT EXPENDITURE FOR HEALTH AND EDUCATION

Table A14.1: Health Expenditure

Item	1997	1998	1999	2000	2001	2002	2003
A. Total Government Health Expenditure (percentage of gross domestic product)							
1. Total	2.76	2.80	2.40	2.04	1.95	2.17	2.02
2. Budget	2.74	2.68	2.20	1.84	1.75	1.87	1.70
3. Health Insurance	0.02	0.12	0.20	0.21	0.20	0.31	0.33
B. Total Government Health Expenditure (Som million)							
1. Health Insurance	0.8	5.3	19.2	11.0	11.3	17.5	20.8
2. Budget	122.6	116.2	106.8	98.0	99.3	106.1	107.2
Subtotal (B)	123.4	121.5	126.0	108.9	110.6	123.7	129.7
C. Health Expenditure (percentage of total government budget)							
1. Total	11.6	11.7	10.8	10.1	9.9	9.0	8.8
2. Republican	5.4	5.3	4.8	4.5	4.3	3.7	2.7
3. Local	28.0	27.7	27.6	25.8	23.7	23.4	19.9
D. Distribution of Government Health Expenditure by Level of Care (%)							
1. Hospitals	69.9	72.3	72.0	74.3	71.7	65.1	56.8
2. PHC	9.7	9.7	11.6	10.2	11.2	18.4	24.8
3. Public Health	6.5	5.5	5.6	5.2	5.1	5.0	5.6
4. Education	1.8	1.4	1.3	1.0	1.2	1.1	1.2
5. Research	0.6	0.7	0.7	0.5	0.6	0.5	0.0
6. Investment	3.4	1.6	1.4	1.4	2.0	0.7	0.0
7. Administration	8.7	8.4	7.4	7.4	8.2	9.0	11.6
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

PHC = primary healthcare
Source: Central Treasury under the Ministry of Finance.

Table A14.2: Education Expenditure

Expenditure	1999	2000	2001	2002	2003	2004
Total Government Education Expenditure (percentage of gross domestic product)						
	4.1	3.5	3.9	4.5	4.3	4.2
Education Expenditure (percentage of total government budget)						
	20.8	19.8	22.7	23.3	22.0	17.4
Distribution of Government Education Expenditure by Level of School (%)						
Preschool		8.6	9.4	8.9	9.1	
General		76.7	76.5	74.6	73.6	
Vocational		3.3	3.3	3.3	3.5	
Higher		11.3	10.8	13.1	13.8	
Total		**100.0**	**100.0**	**100.0**	**100.0**	

Source: Education Expenditure, Ministry of Finance.

Table A14.3: Breakdown of Government Expenditure for Health

Year	Total (Som)	Personnel-Related (%)	Travel (%)	Equipment (%)	Drugs and Supplies (%)	Food (%)	Utilities (%)	Transport (%)	Miscellaneous (%)	Capital Repair (%)
Republic										
1997	749,006	54.4	0.3	2.0	13.3	8.4	14.2	2.0	2.7	2.9
2000	1,061,603	49.9	0.3	1.1	9.7	9.4	22.4	2.4	1.3	2.7
2003	1,410,680	54.1	0.4	2.7	12.1	9.5	15.0	2.3	1.4	2.5
Osh										
1997	157,878	65.1	0.4	1.2	6.9	10.2	11.0	1.8	2.2	1.3
2000	178,349	58.3	0.5	0.6	4.6	8.3	19.5	1.6	1.8	4.8
2003	253,226	57.7	0.3	4.3	6.8	11.3	11.6	1.8	3.1	3.2
Jalal-Abad										
1997	82,927	75.9	0.3	0.5	2.9	8.6	8.3	1.6	1.4	0.7
2000	135,798	65.0	0.5	0.2	5.1	8.6	18.3	1.7	0.4	0.2
2003	170,416	69.1	0.6	0.3	6.2	8.4	12.9	1.8	0.7	0.1
Batken										
2000	54,139	53.3	0.3	0.5	5.8	7.7	18.4	1.8	1.3	1.0
2003	78,594	72.3	1.3	0.7	4.9	5.8	12.5	1.4	1.0	0.1

Sources: Ministry of Health.

PROJECT PERFORMANCE RATING ASSESSMENT

Criterion (a)	Weight (%) (b)	Assessment (c)	Rating Value (d)	Weighted Rating[a] (b) x (d)	Comments
A. Project Outcome Assessment					
1. Relevance	20	Relevant	2	0.40	The Project was relevant to government efforts to decentralize management and improve the delivery of social services.
2. Efficacy	25	Efficacious	2	0.50	The Project laid a foundation for capacity building of local governments and communities in project provinces.
3. Efficiency	20	Efficient	2	0.40	Project investment is rated efficient and cost-effective, with most of the project inputs going into civil works, equipment, training, and the discretionary grant fund.
B. Sustainability	20	Less Likely	1	0.20	Sustainability is less likely because of (i) stagnating and low public expenditures for social sectors, in particular the health sector; (ii) stagnating and low O&M budgets; and (iii) limited reforms.
C. Institutional Development	15	Moderate	1	0.15	The Project had positive institutional impact by improving the capacity of local administrations and communities to plan and manage services and ensure their availability.
Total				**1.65**	

O&M = operation and maintenance.
[a]: Weighted rating is determined as follows: highly successful = overall weighted average > 2.5 and no criterion less than 2, successful = overall weighted average 1.6–2.5 and no criterion less than 1, partly successful = overall weighted average 0.6–1.6 and no criterion less than 1, unsuccessful = overall weighted average < less than 0.6.
Source: Asian Development Bank.