Kyrgyz Republic: Preparing the Second Community-Based Early Childhood Development Project
(Financed by the Japan Special Fund)
CURRENCY EQUIVALENTS
(as of 5 May 2006)

Currency Unit – som (Som)
Som1.00 = $0.02451
$1.00 = Som40.8001

ABBREVIATIONS
ADB – Asian Development Bank
CBECDP – Community-Based Early Childhood Development Project
ECD – early childhood development
ECE – early childhood education
IDA – iron deficiency anemia
IDD – iodine deficiency disorders
IMCI – integrated management of childhood illnesses
IMR – infant mortality rate
JFPR – Japan Fund for Poverty Reduction
MCH – maternal and child health
MCN – maternal and child nutrition
MDG – Millennium Development Goal
MLSP – Ministry of Labor and Social Protection
MOE – Ministry of Education
MOH – Ministry of Health
PMO – project management office
TA – technical assistance
TOR – terms of reference
UNICEF – United Nations Children’s Fund
USMR – under-5 mortality rate

TECHNICAL ASSISTANCE CLASSIFICATION

Targeting Classification – Targeted intervention
Sector – Health, nutrition, and social protection
Subsector – Early childhood development
Theme – Inclusive social development
Subtheme – Human development

NOTE
In this report, "$" refers to US dollars.

Vice President L. Jin, Operations Group 1
Director General J. Miranda, Central and West Asia Department (CWRD)
Officer-in-Charge I. H. Keum, Social Sectors Division, CWRD
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Team member A. Chyngysheva, Project Implementation Officer, Kyrgyz Resident Mission
I. INTRODUCTION

1. The Government of the Kyrgyz Republic requested technical assistance (TA) from the Asian Development Bank (ADB) to prepare the Second Community-Based Early Childhood Development Project. The TA is included in the Kyrgyz Republic country strategy and program update for 2006–2008, and is programmed for 2006. The Community-Based Early Childhood Development Project (CBECDP) began in March 2004, with implementation progressing satisfactorily. Because the loan is small ($10.5 million equivalent), the CBECDP was restricted to the 12 poorest raions (districts). The Government and ADB agreed that a follow-on project would be included in the 2007 lending program to build on experience gained by the CBECDP and extend the coverage of CBECDP activities to other raions. Fact-finding for the TA was carried out in January–February 2006, and an understanding reached with the Government on the TA’s impact and outcome, scope, cost and financing, and implementation arrangements. The design and monitoring framework is in Appendix 1.

II. ISSUES

2. Early childhood development (ECD) refers to physical and psychosocial development during the first several years of life. Evidence is growing that ECD has long-lasting effects and is critical to human development. Children who are healthy, stimulated, and well nurtured during this period tend to do better in school and have a better chance of developing the skills required to contribute to social and economic development. Before the collapse of the former Soviet Union in 1991, young children in the Kyrgyz Republic received a comprehensive package of ECD services, comprising child health care, nutrition, and nursery and/or preschool programs. Pregnant women had access to antenatal care that helped maintain maternal health and mitigated risks associated with pregnancy. Poverty was far less prevalent than it is today. The favorable ECD situation changed dramatically in the decade after 1991, with ECD deteriorating largely as a consequence of economic contraction, increased poverty, and declines in social services. Child health and nutrition worsened, a large number of preschool institutions were closed down, and parents were left without sufficient resources or knowledge to care for children at home. The CBECDP was designed to arrest the deterioration in ECD.

3. Socioeconomic indicators have improved over the last few years. Per capita nominal GDP increased from $322 in 2002 to $430 in 2004, while poverty incidence declined from 52% in 2000 to 46% in 2004. Despite some signs of improvement, especially in the 12 raions covered by the CBECDP, significant challenges to ECD remain. Recognizing the positive effects and potential of the CBECDP, the Government proposes to expand its investment in ECD to other raions, and strengthen the sustainability of ECD activities.

4. Child Health and Nutrition. Child health and nutrition have been improving slowly but require intensified efforts to achieve the relevant Millennium Development Goals (MDGs), including reduction of the infant mortality rate (IMR) and the under-5 mortality rate (U5MR), and achievement of universal primary education. The IMR and U5MR are high for a country with (i) high education levels, (ii) universal immunization coverage, and (iii) an extensive network of

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2 The TA first appeared in ADB Business Opportunities on 2 March 2006.
3 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.
4 Since they were adopted in 2000, the MDGs have become the most widely accepted yardstick of development efforts by governments. Specifically, the targets associated with these MDGs include reduction of IMR and U5MR by two thirds from 1990 to 2015 and achievement of a 100% net enrollment rate in primary education by 2015.
health care facilities. The proportion of infant deaths occurring during the neonatal period (the first 28 days after birth) is rising. Common infectious diseases (diarrhea and respiratory infections) have been the major cause of infant deaths, but their significance has declined in recent years. The decline may be partly attributed to the integrated management of childhood illnesses (IMCI). However, IMCI is less effective in reducing neonatal mortality. To further reduce the IMR, specific measures targeted at the neonatal period are required.

5. Micronutrient deficiencies can cause various developmental delays and contribute to increased morbidity and mortality. Iodine deficiency disorders (IDD) and iron deficiency anemia (IDA) have been major public health problems among children and women. Progress in containing IDD and IDA is mixed. The prevalence of IDD, which increased 8–10 times in the decade after 1991, is now expected to decrease because of progress toward universal salt iodization. In 2005, about 90% of households regularly consumed iodized salt, but continuing efforts by the Government, private sector, civil society, and development agencies to achieve and sustain universal salt iodization are needed. However, IDA has not declined. According to the 1997 Demographic Health Survey, 38% of women and 50% of children under the age of 3 suffer from IDA. IDA prevention is complex, and requires a combination of (i) dietary change, (ii) promotion of fortified flour, and (iii) dietary supplementation for selected target groups such as pregnant women.

6. **Children’s Psychosocial Development.** Because data on children’s psychosocial development are scarce, the CBECDP is helping the Ministry of Education (MOE) assess children’s psychosocial development. Access to preschool programs is a serious problem, with many villages lacking access to any preschool programs. The number of state preschool institutions declined significantly from 1,696 in 1990 to 402 in 2001, and subsequently increased, reaching 440 in 2004. The number of children in preschools followed the same pattern, decreasing steadily from 151,500 in 1990 to 46,800 in 2001, and then increasing to 50,935 in 2004; the latter equaled about 8% of children 1–7 years of age. MOE estimates that alternative preschools covered about 1,500 more children. On average, about 90% of available preschool capacity is used, with substantial variations among raions.

7. In the preschool concept adopted in 2005, MOE pledges equal access to preschool programs to all children, and has initiated several new approaches to achieve this goal. Expanding the network of alternative preschools and increasing the use of existing preschools (from the present 90% to 100%) are important measures for increasing preschool program access. MOE has officially recognized alternative preschools in the new preschool standards (2005), and is working on a financing mechanism that will allow cost-sharing by the Government, local governments, and beneficiaries. MOE has also introduced the “100 hours of preschool program” to prepare children for school during the summer before they enter primary school. The CBECDP supports the establishment of alternative preschools, including community-based preschools and preparatory courses.

8. **Child Care at Home and in the Community.** The family is the primary caregiver for young children, and both the home and the community should provide a safe and nurturing environment for child development. The CBECDP baseline survey and discussions during parents’ education sessions revealed that parents were not fully aware of the importance of their roles and had limited child care knowledge. Parents have significant unmet needs and demand for ECD-related knowledge. The high community demand for financing under the CBECDP

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5 Official data underestimate IMR and U5MR because of underreporting by health care workers and delays in adjusting the definition of live births to the World Health Organization standards.

6 According to the CBECDP baseline survey, only about 25% of villages in the 12 project raions have preschool programs, of which about a quarter were community-based.
Village Initiative Fund is indicative of the willingness of and potential for communities to support ECD.

9. **The CBECDP and Emerging Needs.** The CBECDP has supported integrated health, nutrition, and psychosocial development activities. It has implemented interventions to (i) improve primary health care for children, with a focus on preventing child deaths from common infectious diseases; (ii) introduce behavioral changes to prevent micronutrient deficiencies; (iii) improve access by poor children to preschool programs, especially through the establishment of alternative preschools; (iv) improve the quality of child care at home; (v) develop the capacity of local governments and communities to plan, implement, and monitor ECD activities; and (vi) improve monitoring of development indicators for young children. These activities are highly relevant and need to be built on and further developed and refined.

10. Several important emerging issues are not adequately addressed under the CBECDP: (i) reducing neonatal deaths; (ii) establishing a viable essential-drug distribution mechanism; and (iii) capacity building of the ECD service delivery system, with a focus on accreditation, attestation, and retention of health care workers, preschool teachers and caregivers, and social workers. The Japan Fund for Poverty Reduction (JFPR) Project for Reducing Neonatal Mortality\(^7\) is helping the Ministry of Health (MOH) (i) conduct an IMR survey, (ii) improve the accuracy of IMR data, and (iii) pilot measures to reduce neonatal mortality. The CBECDP has helped improve and expand the IMCI, and plans to pilot drug distribution by a nongovernment organization in remote raions.

11. The retention and recruitment of health care workers poses a serious challenge to primary health care. Medical doctors have been emigrating for some years, and a more recent increase in emigration among paramedical workers has worsened health care staff shortages. Low pay deters new medical college graduates from taking health care jobs, and MOH has had difficulty filling vacancies and retaining staff in remote primary health care facilities. A similar situation exists for preschools. Although alternative preschools can at present take advantage of dedicated retired teachers, securing qualified teachers is a potential problem as demand for alternative preschool teachers and caregivers increases and former preschool teachers age. Systematic upgrading of teachers’ skills, starting from pre-service training, will also be required to ensure the quality of preschool programs.

12. **External Assistance.** In addition to the CBECDP and the JFPR Project for Reducing Neonatal Mortality (para. 10), ADB has supported a regional JFPR project for improving nutrition of poor mothers and children,\(^8\) and is supporting a follow-on regional JFPR project for sustainable food fortification.\(^9\) The proposed project will build on the activities, experiences, and studies of these projects. ADB is working closely with the United Nations Children’s Fund (UNICEF), which is assisting the Kyrgyz Republic in child health interventions, including IMCI, training in neonatal care, and developing ECD materials. The World Bank is financing two health sector reform projects (a loan and a grant) focusing on restructuring of the health care delivery and financing systems.

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\(^7\) ADB. 2004. *Grant Assistance to the Kyrgyz Republic funded by the Japan Fund for Poverty Reduction for Reducing Neonatal Mortality.* Manila.

\(^8\) ADB. 2001. *Grant Assistance to Azerbaijan, Kazakhstan, Kyrgyz Republic, Mongolia, Tajikistan, and Uzbekistan funded by the Japan Fund for Poverty Reduction for Improving Nutrition for Poor Mothers and Children in Asian Countries in Transition.* Manila.

\(^9\) ADB. 2004. *Grant Assistance to Kazakhstan, Kyrgyz Republic, Mongolia, Tajikistan, and Uzbekistan funded by the Japan Fund for Poverty Reduction for Sustainable Food Fortification.* Manila.
13. **Government and ADB Policies.** The Government has long recognized the importance of child development. The Law on Protection of the Kyrgyz People’s Health clearly stipulates the state’s responsibility and the obligation of citizens to provide children with the living conditions required for sound physical, cognitive, and psychosocial development. Investing in ECD is directly relevant to the basic human development needs of the Kyrgyz Republic as set out in its poverty reduction strategy and the Education Strategy for 2010. Maternal and child health is a major focus of the second MOH health reform policy. ADB also recognizes that ECD is instrumental to human development and poverty reduction. ADB’s framework policy and strategy for the education sector emphasizes that investment in ECD (i) leads to improved learning capacity and reduced dropouts from school, and (ii) gives poor children a head start in breaking out of the poverty cycle.

III. **THE TECHNICAL ASSISTANCE**

A. **Impact and Outcome**

14. The impact of the TA will be to improve the health, nutrition, and psychosocial development of children up to 8 years of age. The outcome of the TA is a project design that will achieve this impact and is compatible with ADB financing requirements. The TA outputs are (i) a needs assessment of the targeted populations, (ii) policy and sector analysis and training, and (iii) a project designed for ADB financing.

B. **Methodology and Key Activities**

15. The TA will be guided by four principles: (i) targeting the poor; (ii) participatory project development; (iii) the integrated life-cycle approach, which addresses holistic development of children of different ages; and (iv) sustainability. The TA will build on experience gained and lessons learned from the CBECDP. Investment activities under the project are expected to focus on selected poor raions that have not been covered by the CBECDP, while policy and capacity-building activities will be organized nationwide. The raions will be selected before TA inception by the Government and ADB based on poverty data, and in consideration of coverage of other similar projects and/or programs. The summary initial poverty and social analysis is in Appendix 2. The expected outputs include the following.

(i) A needs assessment that will identify the problems of young children, their families, the community, and frontline workers with regard to improving ECD, and constraints that health care workers, preschool teachers, and social workers are facing in delivering ECD services. The TA will support analysis of secondary data, surveys, and systematic qualitative research to assess (a) the ECD status and problems related to ECD of the target populations in the TA raions; (b) child care practices at home and in the community; (c) access by children and families to ECD services, which include health care, preschool education programs, and social protection; and (d) constraints faced by the families and health care, preschool, and social workers.

(ii) Policy and sector analysis and training will identify technical measures and policy developments required to improve ECD and to address problems identified by the needs assessment. The TA will support an ECD sector analysis comprising subsector analyses in child health, early child education, social protection for children, and child care at home and in the community. The analysis will include identification of (a) problems and issues in improving quality, effectiveness, and efficiency of service delivery, budgetary systems, human resources, and related policies; and (b) cost-effective and feasible solutions. Ongoing activities supported by the Government and other development agencies will be thoroughly reviewed. The TA consultants will conduct short training
and/or seminars for government staff on international best practices in key aspects of ECD.

(iii) A project suitable for ADB financing will be designed. The TA will prepare a project feasibility study that will build on the design, implementation experience, and lessons learned from the CBECEDP. Best practice from other countries as well as innovations will be introduced as appropriate. Project preparation will include detailed formulation of project components, cost estimates, implementation arrangements, economic analysis, financial sustainability analysis, a plan for institutional and financial sustainability of the ECD program, poverty and social impact assessments, and monitoring and evaluation framework.

C. Cost and Financing

16. The total cost of the TA is estimated at $471,000; $400,000 will be financed on a grant basis by the Japan Special Fund, funded by the Government of Japan. The remaining $71,000 equivalent will be financed by the Government and will cover office accommodation (including basic utilities), counterpart staff, data collection, and logistics support (Appendix 3). The Government has been informed that approval of the TA does not commit ADB to finance any ensuing project.

D. Implementation Arrangements

17. The Executing Agency will be the Office of the President, which is also the Executing Agency for the CBECEDP. The CBECEDP project director will also be the project director for the TA. A steering committee will be established by expanding the CBECEDP steering committee to include representatives from the oblasts (provinces) covered by the TA. The Steering Committee will provide overall policy guidance. The TA will be implemented over 7 months, from September 2006 to April 2007. ADB will engage an international consulting firm, in accordance with the Guidelines on the Use of Consultants by ADB and its Borrowers, which will provide 10 person-months of international consultants and 36 person-months of domestic consultants with expertise in team leadership, child health, maternal and child nutrition and early child education, economic and financial analysis, social analysis, and coordination of oblast activities (Appendix 4). Simplified technical proposals will be required, and the quality- and cost-based selection method used. Consultants will procure equipment in accordance with ADB’s Procurement Guidelines.

18. The CBECEDP project management office (PMO) will be closely involved with TA implementation to take full advantage of knowledge and experience gained under the CBCEDP. The PMO project manager will act as the local team leader for the TA. TA consultants should (i) consult with the PMO in finalizing the TA implementation schedule, and organizing working group meetings and workshops; and (ii) regularly report to the PMO and the Office of the President and submit all reports to ADB, the PMO and the Office of the President. ADB will review TA implementation jointly with the PMO and the Office of the President.

IV. THE PRESIDENT’S DECISION

19. The President, acting under the authority delegated by the Board, has approved the provision of technical assistance not exceeding the equivalent of $400,000 on a grant basis to the Government of the Kyrgyz Republic for preparing the Second Community-Based Early Childhood Development Project, and hereby reports this action to the Board.
## DESIGN AND MONITORING FRAMEWORK

<table>
<thead>
<tr>
<th>Design Summary</th>
<th>Performance Targets/Indicators</th>
<th>Data Sources/Reporting Mechanisms</th>
<th>Assumptions and Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Impact</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improved health, nutrition, and psychosocial development of children from birth to 8 years of age</td>
<td>IMR in project raions (districts) reduced by 20% from 2008 levels by 2012</td>
<td>Statistics of national, oblast (provincial), and raion governments</td>
<td>Assumptions: The Kyrgyz Republic will maintain its commitment to ECD.</td>
</tr>
<tr>
<td></td>
<td>U5MR in project raions reduced by 30% from 2008 levels by 2012</td>
<td>Project baseline and evaluation surveys</td>
<td>Modest economic growth will continue and the poverty rate will not increase.</td>
</tr>
<tr>
<td></td>
<td>Psychosocial development status measured by basic language, numeracy, and life skills of children entering primary school improved by 30% from the 2008 level by 2012</td>
<td></td>
<td>The political situation will be stable.</td>
</tr>
<tr>
<td><strong>Outcome</strong></td>
<td></td>
<td></td>
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<tr>
<td>Project design suitable for ADB financing, and agreed to by the Government and ADB</td>
<td>MOU or appraisal signed by the Government and ADB</td>
<td>MOU</td>
<td>Assumptions: Various stakeholders will actively participate in the project design.</td>
</tr>
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<td></td>
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<td>Policy changes initiated under the CBECDP will have been adopted.</td>
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<td></td>
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<td></td>
<td>Risk: Frequent changes in senior government officials may delay decision-making.</td>
</tr>
<tr>
<td><strong>Outputs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Completed needs assessment</td>
<td>Needs assessment report, sector reports, and feasibility study discussed with and disseminated among stakeholders, and positive feedback received</td>
<td>Workshop and training reports</td>
<td>Assumption: The political situation will be stable and geographical access will remain free.</td>
</tr>
<tr>
<td>2. Completed sector analysis and training</td>
<td>Training conducted</td>
<td>Comments received from stakeholders</td>
<td></td>
</tr>
<tr>
<td>3. Completed feasibility study report</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Activities with Milestones</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 Complete a needs assessment within 6 weeks of the TA inception.</td>
<td></td>
<td></td>
<td>Inputs: ADB: $400,000</td>
</tr>
<tr>
<td>2.1 Complete a sector analysis within 12 weeks of the TA inception.</td>
<td></td>
<td></td>
<td>Government: $71,000</td>
</tr>
<tr>
<td>3.1 Prepare a draft final report for review by the Government and ADB within 16 weeks of the TA inception.</td>
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<tr>
<td>3.2 Conduct a tripartite meeting and agree on the feasibility study within 20 weeks of the TA inception.</td>
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</tbody>
</table>

ADB = Asian Development Bank, CBECDP = Community-Based Early Childhood Development Project, ECD = early childhood development, IMR = infant mortality rate, MOU = memorandum of understanding, TA = technical assistance, U5MR = under-5 mortality rate.
INITIAL POVERTY AND SOCIAL ANALYSIS

A. Linkages to the Country Poverty Analysis

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the sector identified as a national priority in country poverty analysis?</td>
<td>☑</td>
<td></td>
</tr>
<tr>
<td>Is the sector identified as a national priority in country poverty partnership agreement?</td>
<td></td>
<td>☑</td>
</tr>
</tbody>
</table>

Contribution of the sector or subsector to reduce poverty in the Kyrgyz Republic:
The project will help reduce poverty by enhancing the physical and psychosocial development of young children. Investments in early childhood development (i) yield high returns to individuals and the society; and (ii) have long-lasting effects on people’s educational attainment, productivity, and social behaviors. These effects will contribute to (i) people’s income-earning capacity, and (ii) the reduction of health care and education expenditures.

B. Poverty Analysis

<table>
<thead>
<tr>
<th>Targeting Classification: Targeted intervention</th>
</tr>
</thead>
</table>

What type of poverty analysis is needed?
The project will help achieve key Millennium Development Goals: reducing child mortality and achieving and sustaining a 100% primary school enrolment rate. It will also help children from underserved areas. The technical assistance should expedite feasible and cost-effective means to target poverty. Geographical targeting was effective for the Community-Based Early Childhood Development Project (CBECDP). It covered those raions (districts) where the poverty rates were above 70%. If the second CBECDP includes raions where the poverty rate is less than 50%, it may require other targeting mechanisms, as well.

C. Participation Process

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there a stakeholder analysis?</td>
<td>☑</td>
<td></td>
</tr>
<tr>
<td>Is there a participation strategy?</td>
<td>☑</td>
<td></td>
</tr>
</tbody>
</table>

The CBECDP experience suggests that stakeholders include children, families, Ayil Okumotus (village authorities), raion and oblast (provincial) governments, health workers, preschool workers, social workers, ministries, and the Government. All these agencies and people will be involved in the project design, through needs assessments and consultation workshops.

D. Gender Development

| Strategy to maximize impacts on women: There are no tangible gender-based differences in children’s access to child health, nutrition, or preschool programs. By increasing children’s access to preschool programs outside the home, the project may encourage women to join the labor force. |
| Has an output been prepared?                                             | Yes | No |

E. Social Safeguards and Other Social Risks

<table>
<thead>
<tr>
<th>Item</th>
<th>Significant/ Not Significant/ None</th>
<th>Strategy to Address Issues</th>
<th>Plan Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resettlement</td>
<td>☐ Significant</td>
<td></td>
<td>☑ Full</td>
</tr>
<tr>
<td></td>
<td>☑ Not significant</td>
<td></td>
<td>☑ Short</td>
</tr>
<tr>
<td></td>
<td>☑ None</td>
<td></td>
<td>☑ None</td>
</tr>
<tr>
<td>Affordability</td>
<td>☐ Significant</td>
<td></td>
<td>☑ Yes</td>
</tr>
<tr>
<td></td>
<td>☑ Not significant</td>
<td></td>
<td>☑ No</td>
</tr>
<tr>
<td></td>
<td>☑ None</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Item</td>
<td>Significant/ Not Significant/ None</td>
<td>Strategy to Address Issues</td>
<td>Plan Required</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-----------------------------------</td>
<td>----------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Labor</td>
<td>□ Significant □ Not significant □ None</td>
<td></td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Indigenous Peoples</td>
<td>□ Significant □ Not significant □ None</td>
<td></td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Other Risks and/or Vulnerabilities</td>
<td>□ Significant □ Not significant □ None</td>
<td></td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>
### COST ESTIMATES AND FINANCING PLAN
($'000)

<table>
<thead>
<tr>
<th>Item</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Asian Development Bank (ADB) Financing</strong>&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>1. Consultants</td>
<td></td>
</tr>
<tr>
<td>a. Remuneration and Per Diem</td>
<td></td>
</tr>
<tr>
<td>i. International Consultants</td>
<td>215.0</td>
</tr>
<tr>
<td>ii. Domestic Consultants</td>
<td>37.0</td>
</tr>
<tr>
<td>2. Equipment&lt;sup&gt;b&lt;/sup&gt;</td>
<td>5.0</td>
</tr>
<tr>
<td>3. Training, Seminars, and Conferences</td>
<td></td>
</tr>
<tr>
<td>a. Facilitators</td>
<td>3.0</td>
</tr>
<tr>
<td>b. Training Program</td>
<td>27.0</td>
</tr>
<tr>
<td>4. Surveys</td>
<td>15.0</td>
</tr>
<tr>
<td>5. Miscellaneous Administration and Support Costs&lt;sup&gt;c&lt;/sup&gt;</td>
<td>10.0</td>
</tr>
<tr>
<td>6. Representative for Contract Negotiations</td>
<td>5.0</td>
</tr>
<tr>
<td>7. Contingencies</td>
<td>55.0</td>
</tr>
<tr>
<td><strong>Subtotal (A)</strong></td>
<td>400.0</td>
</tr>
</tbody>
</table>

| B. Government Financing                                              |            |
| 1. Office Accommodation and Transport                                | 30.0       |
| 2. Remuneration and Per Diem of Counterpart Staff                    | 35.0       |
| 3. Others                                                           | 6.0        |
| **Subtotal (B)**                                                     | 71.0       |

| **Total**                                                           | 471.0      |

<sup>a</sup> Financed by the Japan Special Fund, funded by the Government of Japan.

<sup>b</sup> Computers, a printer, a photo copier, and a fax machine. Upon completion of the technical assistance, the equipment will be transferred to the Government.

<sup>c</sup> Including translation costs.

Source: ADB estimates.
OUTLINE TERMS OF REFERENCE FOR CONSULTANTS

1. The technical assistance (TA) will be implemented by a team of international (10 person-months) and domestic (36 person-months) consultants engaged through an international consulting firm. The consultant team will also appoint coordinators for selected oblasts (provinces), who will work closely with the governor’s office and communities. The TA will be guided by four principles: (i) targeting of the poor, (ii) participatory project development, (iii) the integrated life-cycle approach that addresses holistic development of children of different ages, and (iv) sustainability. The TA will build on experience gained and lessons learned from the Community-Based Early Childhood Development Project (CBECDP).

2. The CBECDP project management office (PMO) will be fully involved with the TA and project development. The PMO project manager will (i) be a local team leader for the TA team, (ii) ensure that experience and lessons learned from the CBECDP are fully reflected in the project design, and (iii) be responsible for quality control of the TA consultants’ work, especially by advising the TA consultants on the ECD situation and the roles of different stakeholders, and reviewing TA consultants’ outputs.

A. Meetings, Workshops, and Training

3. The TA team will meet with the Office of the President (the Executing Agency), the Ministry of Health (MOH), the Ministry of Education (MOE), and the Ministry of Labor and Social Protection (MLSP) at least once a month to discuss the TA’s progress. The TA team should maintain weekly contact with the PMO, which will be the TA team’s daily counterpart in designing the project. The PMO will (i) render necessary support by facilitating meetings between the TA team and the Government and steering committee meetings, (ii) advise on the TA team’s work plan and implementation schedule, and (iii) discuss the TA team’s proposals relating to the project design and activities.

4. The team will also meet with the governors of the project oblasts and raions (districts) at least 1 or 2 times during the TA. There will be at least three national consultative workshops: (i) the inception workshop to explain the objective of the TA and the ensuing project, and to initiate awareness building; (ii) the midterm review workshop to present the findings of each sector and policy review, a general strategy for early childhood development (ECD) in the Kyrgyz Republic, and a preliminary package of project interventions; and (iii) the final workshop to present and discuss the strategy and final project design. Oblast or raion workshops should be held as appropriate. The plan for the local workshops and other methodologies and a concrete action plan for involving stakeholders in project development should be included in the technical proposal.

5. Knowledge transfer from the consultant team will be an important part of the TA, as the country has limited exposure to international ECD practice because of language barriers and financial constraints. Following the sector analysis, the TA consultants will hold discussions with the Government and the Asian Development Bank (ADB) to choose specific topics and set the training schedule.

B. Reports

6. The team will submit (i) an inception report, including a detailed work plan to develop project ownership by central and local governments, and communities (due the third week after inception); (ii) a needs assessment report (by the sixth week); (iii) a draft sector technical review
and strategies (by the twelfth week); (iv) the draft final project proposal, including final sector technical papers (within 20 weeks); (v) a short workshop report (5–10 pages) for each workshop and training (within 2 weeks after the workshop or training); and (vi) the final report (within 3 weeks of a tripartite meeting). The final project proposal will be a project feasibility study and will cover all aspects required by ADB, including costing for each component with assumed unit costs, the project schedule, procurement arrangements and packaging in accordance with ADB’s *Procurement Guidelines*, consulting arrangements and terms of reference (TOR), the project design and monitoring framework and guidelines, and a sustainability plan. Sector technical reports will be prepared for the needs assessment; the poverty assessment; early childhood education (ECE), maternal and child nutrition (MCN), maternal and child health (MCH), and the economic, financial and institutional analyses. The TA team will submit reports to the Office of the President, the steering committee members, ADB, and the PMO. All reports will be in English and Russian.

C. Consultants’ Tasks

7. **Team Leader** (international, 3 person-months). The team leader should have extensive experience in designing and managing social sector and/or human development projects financed by multilateral development banks. Expertise in public finance or human development (health, education, or social protection) sector reform will be desirable. The consultant should be a strategic thinker and good communicator. Knowledge of ECD will be preferable. If the consultant lacks firsthand experience in ECD, the consultant should read the basic literature on ECD before starting the contract. The team leader will coordinate with other experts and consult with the PMO project manager in undertaking the following tasks:

(i) Supervise the team, ensure timely and quality outputs and reports, and ensure logical and editorial consistency in compiled reports.

(ii) Coordinate with the Office of the President, MOH, MOE, MLSP, the steering committee, working groups, local governments and other aid agencies, including the United Nations Children’s Fund (UNICEF).

(iii) Organize consultative workshops, meetings, and training.

(iv) Assess the institutional and financial sustainability of the project, and design a sustainability action plan, including measures for capacity building and financing plans for the next 5 years.

(v) Examine the feasibility and desirability of private sector participation and public and private sector partnership in management, financing, and service delivery of ECD services.

(vi) Develop a monitoring and evaluation framework for the project with clear measurable indicators, and an identified counterfactual, and allow for rigorous post-project evaluation. Prepare a monitoring and evaluation manual similar to that for the CBECDP.

(vii) Analyze the present institutional arrangements and capacity of different stakeholders for making policy and technical decisions related to ECD and delivering ECD services in the Kyrgyz Republic, and suggest ways to improve institutional and stakeholder capacity.

(viii) Be responsible for all reports submitted to ADB.

8. **Child Health Specialists** (international, 3 person-months; domestic, 6 person-months). The child health specialists will work closely with MOH, its working group, the JFPR 9056 for
Reducing Neonatal Mortality, and UNICEF. The international and domestic specialists should have advanced degrees in a relevant field, extensive international experience in child health interventions, and knowledge of the latest child health programs, especially in integrated management of childhood illnesses (IMCI), and prevention of neonatal mortality. The specialists will undertake the following tasks:

(i) Review the Government’s child survival and child health policies and programs, and their implementation.
(ii) Conduct a needs assessment in collaboration with the social-scientist team.
(iii) Assess and identify shortcomings and improvement strategies related to (a) the quality and quantity of child health care at the primary health care level in particular, and referral systems for high-risk cases; (b) appropriateness of preservice and in-service training of health workers; (c) accreditation and attestation systems; and (d) human resource management including retention and performance of health workers.
(iv) Develop a viable system for distributing essential drugs in remote rural areas.
(v) Based on the review in (i), develop a strategy and an action plan for improving the child health care system. If alternative means to achieve a specific improvement exist, compare their cost-effectiveness and feasibility.
(vi) Design a monitoring and evaluation framework and methodologies relating to MCH.
(vii) Participate in the working group on child health and nutrition and contribute to the development of the child health strategy as part of the overall ECD strategy for the Kyrgyz Republic.
(viii) Produce the child health sector technical paper.
(ix) Design a detailed MCH component for the project, including implementation arrangements, costing, and clear TOR for each involved agency.

9. **Maternal and Child Nutrition Specialists** (international, 2 person-months; domestic, 6 person-months). The MCN specialists will work closely with MOH, JFPR 9052 for Sustainable Food Fortification, nutrition institutions, UNICEF, and the World Health Organization. The international specialist should have an advanced degree in a relevant field, and extensive international experience in and knowledge of child nutrition interventions, and anemia prevention programs. The MCN specialists will work closely with the MCH specialists and develop a strategy and an action plan for improving MCN, in particular to mitigate iron deficiency anemia and other key micronutrient deficiencies. Specific tasks include the following.

(i) Review policies and norms (clinical protocols) regarding nutrition, nutrition supplement programs, and food fortification, and identify measures for improvement based on international experience and the Kyrgyz Republic’s situation.
(ii) Conduct a needs assessment in collaboration with the social-scientist.
(iii) Assess the nutrition knowledge of families, health care workers, teachers, and nutrition specialists; review nutrition education given at schools, and during preservice training for medical doctors, paramedics, preschool and school

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1 ADB. 2004. *Grant Assistance to the Kyrgyz Republic funded by the Japan Fund for Poverty Reduction for Reducing Neonatal Mortality*. Manila.
2 ADB. 2004. *Grant Assistance to Kazakhstan, Kyrgyz Republic, Mongolia, Tajikistan, and Uzbekistan funded by the Japan Fund for Poverty Reduction for Sustainable Food Fortification*. Manila.
teachers; and suggest ways to improve the nutrition knowledge of the general public and workers who deliver ECD services.

(iv) Review the information developed for women and children, and nutrition counseling given by health practitioners and functionaries, and by preschool and primary-school teachers.

(v) Design a monitoring and evaluation framework and methodologies for MCN and establish a baseline for MCN indicators.

(vi) Examine the capacity of the sani-epidemiology department and other nutrition institutions to impart effective regulations and conduct nutrition surveillance.

(vii) Produce the MCN sector technical paper.

(viii) Design a detailed MCN component for the project, including implementation arrangements, costing, and clear TOR for each involved agency.

10. **Early Childhood Education Specialists** (international, 3 person-months; domestic, 6 person-months). The team of international and domestic ECE consultants will work closely with MOE, the working group, preschool teachers, and UNICEF. The international specialist should have an advanced degree in a relevant field, extensive international experience in ECE projects, and international knowledge of innovative ECE activities. The ECE specialists will undertake the following tasks:

(i) Review policies and norms regarding preschool programs (nurseries and kindergartens), and identify ways to improve them based on international experience and the Kyrgyz Republic’s situation.

(ii) Conduct a needs assessment in collaboration with the social scientist team.

(iii) Evaluate different preschool program models from various aspects, including pedagogy, timing, children’s involvement, facilities, materials, teacher’s education, and curriculum, and recommend ways to improve them.

(iv) Assess (a) the appropriateness of preservice and in-service training of preschool teachers; (b) accreditation and attestation systems; and (c) retention and performance of preschool workers. Suggest ways to ensure in the long run that preschool programs will have qualified teachers/caregivers as preschool enrollment increases. More than one action should be presented, with an analysis of cost-effectiveness and feasibility.

(v) Examine options for preschool program financing and management and suggest a sustainable financing mechanism based on private, public, and civil-society participation in providing preschool programs.

(vi) Produce the ECE sector technical paper.

(vii) Design a detailed ECE component for the project, including implementation arrangements, costing, and clear TOR for those involved (e.g., parents, communities, preschools, government departments, and local governments).

11. **Economist/Financial Analyst** (international, 1 person-months; domestic, 4 person-months). The economist should have an advanced degree in economics, and extensive experience in the economic analysis of projects, especially in the social sector, and public expenditure. The financial analyst should have experience in reviewing financial management. It is up to the consulting firm to divide the following tasks between the international and domestic consultants:

(i) Prepare a comprehensive economic rationale for the project, including data on key indicators in the country and the raions under consideration.
(ii) Assess the cost-effectiveness of the project on the basis of its objectives by suggesting two or more feasible approaches for achieving the objectives, along with estimated economic costs. Using a least-cost approach and a 12% real discount rate, identify the least-cost option.

(iii) Identify, quantify, and value the economic benefits of the project.

(iv) Calculate an economic internal rate of return for the project; economic benefits and costs should be appropriately shadow-priced.

(v) Review public expenditures in the health and education sectors; identify trends in the level of public expenditure and the share of the budget allocated to the health and education sectors over the past 5–10 years; compare per capita figures from this analysis with those of other countries in the region and beyond, as appropriate; review the composition of expenditures in the health and education sectors over the same period; assess how budget allocations to the sectors are likely to change based on past trends, government priorities, and perceptions of stakeholders; and assess the financial sustainability of the project in terms of financing recurrent costs and other costs, as appropriate.

(vi) Estimate the financial resources required to sustain an ECD program over the next 10 years and suggest the budgetary allocations for different government levels.

(vii) Assess the adequacy of the internal control and audit system, and the quality of the Government’s financial management practices.

(viii) Suggest financial covenants to monitor the project’s financial performance.


(x) Provide cost estimates for the project components and a disbursement plan in accordance with the ADB’s Guidelines for Financial Governance and Management of Investment Projects Financed by ADB (2002).

(xi) Prepare cost tables with appropriate cost categories, including clearly indicated unit costs for each input.

(xii) Estimate the costs of different preschool program models, and suggest an optimal mix of models for reaching children in need.

(xiii) Assess the financial management capabilities of the Office of the President, MOH, MOE, and MLSP, using ADB’s financial management assessment questionnaire. The assessment could also include a review of earlier ADB and other lender studies, and a review of the country diagnostic study of accounting and auditing prepared for the country. From these documents and assessments, make recommendations for institutional strengthening of financial management along with a recommended time-bound implementation plan.

12. **Social Scientist** (domestic, 4 person-months). The social scientist should have an advanced degree in a relevant field. The specialist should have extensive experience in needs assessment and designing and conducting social surveys. The social scientist will be provided a separate budget for hiring staff to conduct field studies and survey, and will undertake the following.

(i) Conduct needs assessment in collaboration with the other specialists.

(ii) Identify poor and vulnerable populations, and their objective and perceived needs.
Appendix 4

(iii) Investigate the ethnicity, family poverty status, gender of household heads, gender, and geographical location of children not attending preschool programs, and determine why they do not attend.

(iv) Examine the situation of children with special needs and assess the feasibility of their attending preschool.

(v) Investigate disparities in access by pregnant women and children up to 8 years of age to health care by ethnicity, poverty status of the family, status of household heads, gender, and geographical location.

(vi) Assess households’ out-of-pocket expenditures for ECD services, and budget-related constraints on behavior in seeking health care and preschool programs.

(vii) Assess the demand and willingness to pay for ECD services, including preschool programs, and examine the affordability of different interventions for the poor population.

(viii) Assess how much families know about child development and child care practice.

(ix) Identify a feasible way for the project to target poor children.

(x) Develop a community participation strategy.

(xi) Prepare a needs assessment report, and poverty and social impact assessment report in collaboration with the economist. The consultant should refer to the ADB Handbook for Poverty and Social Analysis (2001).

13. Both qualitative and quantitative methodologies will be used. The qualitative analysis will be substantiated by service mapping, secondary data, and surveying. Within each raion, ECD-related services and projects will be mapped and analyzed. Needs assessment findings will be used as references in designing ECE, MCN, and MCH interventions.

14. Oblast Coordinators (domestic, 10 person-months). The consultant team will recruit an oblast coordinator for each participatory oblast to work closely with the governor’s office, and to facilitate the TA work in the oblast and raions. The oblast coordinators should be from the locality and have knowledge of ECD. The coordinators do not have to be identified at the time of the technical proposal, but should be appointed by inception.