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Summary of midterm reviews and major evaluations of country programmes

West and Central Africa region

Summary

The present report was prepared in response to Executive Board decision 1995/8 (E/ICEF/1995/9/Rev.1), which requested the secretariat to submit to the Board a summary of the outcome of midterm reviews (MTRs) and major country programme evaluations, specifying, inter alia, the results achieved, lessons learned and the need for any adjustments in the country programme. The Board is to comment on the reports and provide guidance to the secretariat, if necessary. The MTRs and evaluations described in this report were conducted during 2006.

* E/ICEF/2006/18.



Introduction

1. This report summarizes the main results of the midterm reviews (MTRs) of the country programmes for Benin, the Republic of Congo, and Niger. The second part of the report concerns three key evaluations and one study that were conducted in 2006. The focus of the evaluations is on such priority issues as child survival, education, and humanitarian response.

Midterm reviews

Benin

2. **Introduction.** The MTR was coordinated by the Ministry of Development, Economy and Finance and involved more than 100 partners from government, United Nations agencies, domestic and international NGOs and bilateral and multilateral partners. The results of the review will provide input for the evaluation of the United Nations Development Assistance Framework (UNDAF) scheduled for April 2007.

3. **Update of the situation of children and women.** The period reviewed here witnessed the presidential elections of 2006 and the new government's commitment to promote economic growth and social development. Despite increased budget funding for the social sectors, economic growth fell to 3%. The under-five mortality rate (U5MR) is still one of the highest in the world, at 152 deaths per 1000 live births.

4. The prevalence of HIV/AIDS still stands at around 2%. In 2003-2004, net school enrolment rates were 90% for boys and 71% for girls, but the gap between boys and girls is still significant. Child trafficking and exploitation remains a concern.

5. **Progress and key results.** There has been significant progress in the survival and development of young children, contributing directly to the goal of reducing the U5MR by 25% by 2008, and thereby allowing Benin to get back on track towards achieving the Millennium Development Goals. The pilot project for the Accelerated Child Survival and Development Strategy (ACSD) produced an estimated 16% reduction in U5MR in the high-impact ACSD zones, and 11% in the expansion zones. The ACSD offers a high-impact, low-cost minimum intervention package. Experience and lessons learned with the ACSD have provided valuable input into the national strategy for maternal, infant and child health now in preparation. The programme's strategy is based on developing the capacity of health workers, provision of essential materials, and stepped up monitoring. There have been significant improvements in vaccination coverage rates for all antigens, as well as in vitamin A coverage, the disinfestation rate, and the rate of impregnated mosquito netting use, while measles and maternal and neonatal tetanus have been brought under control. Dracunculiasis (guinea worm disease) and poliomyelitis are on the way to being eradicated. The Integrated Management of Childhood Illness (IMCI) programme has been reinforced and expanded to clinics in 84% of the 31 target municipalities, and the community IMCI in a third of target municipalities.

6. With respect to water supply, the delay in funding for the project meant that only 18% of the 2008 target population has benefited.

7. The education programme has focused on providing technical support for development of the core education package in order to accelerate basic schooling for girls, and on mobilizing partners to promote it. The core education package is part of the 10-year education development plan (2006-2015) that was officially adopted by the Council of Ministers at the end of 2006, and endorsed by technical and financial partners, thereby making Benin eligible for the accelerated Education for All initiative. As to the goal of raising the gross enrolment rate for girls to 95% nationwide, two of the six intervention municipalities from the 2004-2005 programme have achieved rates above the national average; five of the 13 municipalities supported are on their way to reaching the 20% target set for 2008. The government's October 2006 decision to eliminate all enrolment fees and parents' contributions for kindergarten and primary school constitutes a move toward education for all and generally free schooling at this level.

8. Child protection. One of the major results was the reinforcement of the legislative and institutional framework, particularly with respect to child trafficking and juvenile justice. A law prohibiting child trafficking was adopted and promulgated in 2006. As well, subregional cooperation against child trafficking was reinforced through the adoption of common action plans and the signature of bilateral and multilateral agreements, including one with Nigeria. Eighty-four percent of child victims of trafficking and economic exploitation have been placed in care facilities or returned to their families, against the objective of 80%. With respect to juvenile justice, the ordinance instituting alternatives to imprisonment has been updated and is being incorporated into the Children's Code now under preparation. Procedural guidelines and principles have been prepared to care for the victims of trafficking. In institutional terms, coordination has been reinforced with the establishment of a national unit that will monitor and coordinate child protection services with technical committees and departmental branches.

9. HIV/AIDS. The cooperation programme contributed significant technical support to developing the components of the programme for prevention of mother-to-child transmission (PMTCT) and paediatric AIDS, and protecting orphans and vulnerable children (OVC). A national strategy of "peer educators" has been adopted. PMTCT is now practiced in 39% of the country's maternity units and has been integrated into maternal and child health services. The voluntary screening rate now stands at 90% in intervention zones. Cooperation with the World Bank, the World Food Programme (WFP) and Plan Bénin has strengthened the analysis of the situation and has produced practical guides and training modules for the psychosocial care of OVC.

10. Monitoring and evaluation are two important components of the cooperation programme. They have contributed to establishment of databases via DevInfo. This has made it easier to evaluate the results of the various programmes' interventions, and has improved the quality of studies and evaluations. The study also helped to prepare the Demographic and Health Study, which includes multiple indicator cluster survey (MICS) modules.

11. Following the influx of refugees from Togo in 2005, the cooperation programme in Benin succeeded in returning all Togolese refugee children to school, it cared for and reunited 255 children with their families, and it equipped health centres to provide medical monitoring for children and pregnant women. People living in the two refugee camps and surrounding areas have received drinking water

and sanitation services. To meet the food crisis in the north of the country, a nutritional recovery programme is underway. Two care centres have been established in collaboration with the WFP.

12. **Resources used.** Funding for the programme rose steadily over the reporting period, from \$6 million in 2004 to \$12.5 million in 2006. Between 2004 and 2006, the utilization rate was 93% for regular resources and 85% for other resources.

13. **Constraints, opportunities and lessons learned.** The presidential elections and the installation of a new government placed some constraints on programme implementation. Other factors, such as frequent teachers' strikes and intermittent fuel shortages, held up activities during the first three years of the programme. New opportunities for partnership are now emerging in Benin, including the World Bank's Booster Programme for Malaria Control in Africa, the United States President's Malaria Initiative, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Clinton Foundation HIV/AIDS Initiative, the commitment of technical and financial partners to the 10 year education plan and the national strategy for maternal, infant and child survival.

14. Several lessons can be drawn from this experience. The development of partnerships has been a key to the success recorded in all sectors: health, HIV/AIDS, water, protection and education.

15. **Recommendations and proposed adjustments.** The midterm review recommended among other things: (a) establishment of a partnership for scaling up interventions in the maternal, infant and child survival programme and preparation of a national strategy; (b) support for the government's decision to make kindergarten and primary education free and accessible to all, and reinforced advocacy for the adoption of a 10-year education plan; (c) strengthened cooperation against AIDS and for the comprehensive development of young children; (d) a cross-border approach to combat trafficking and female genital mutilation; and (e) further efforts to build monitoring and evaluation capacities.

Republic of Congo

16. The midterm review was chaired by the Ministry of Planning and UNICEF and involved various sectors, representatives of the United Nations system, donors, and the speaker of the children's parliament. The results of the five sectoral reviews were presented at the November 2006 meeting sponsored by the Ministry, with the participation of the UNICEF Regional Director, the social sector ministries, and representatives of the children's parliament, civil society, and other UN agencies.

17. **Update of the situation of children and women.** Since 2003, Congo has been committed to fighting poverty, and an interim Poverty Reduction Strategy Paper (PRSP) was finalized in 2004. Half the population lives below the poverty threshold. The heavy weight of debt (21% of GDP) tends to pre-empt investment in basic social services, despite the very high levels of funding available in the country.

18. The child mortality and U5MR rates are 75 and 117 per thousand live births, respectively. The country has a neonatal mortality rate of 33 per 1000 live births; 26% of children under five suffer from chronic malnutrition, and the situation is particularly severe in rural areas. The national prevalence of HIV/AIDS among young people between 15 and 24 years was estimated at 7.2% in 2001. The maternal

mortality rate (MMR) is 781 per 100,000 live births in 2005. More than half the population has no access to safe drinking water. Access to sanitation facilities is only 19% in the towns and less than 8% in the countryside. Childhood diarrhoea is the fifth-leading cause of hospital deaths.

19. In education, indicators relating to primary school access, equity and quality are still of concern. In 2005, the gross admission rate was 73%, but the system does not always have the capacity to accept all the children of primary school age. The school completion rate rose from 58% in 2004 to 61%. The girls/boys parity index is 0.95.

20. Social problems continue to affect children. For example, 19% of births are not reported to the civil registry, especially among the pygmies. Sexual violence persists: rape, incest and sexual harassment. The economic weakness and widespread family poverty contribute to social exclusion, precocious sexuality and early maternity, exploitation and marginalization of the most vulnerable groups, such as orphans and child soldiers. The Pool region still suffers from insecurity, and the situation in the neighbouring Democratic Republic of Congo poses a potential risk of humanitarian disaster.

21. The cooperation programme has four sectoral components. Strategic and institutional interventions are conducted at the national level. In the convergence zones, a systemic approach is used for improving the quality of services. Finally, the programme is pursuing a holistic approach for the respect and enforcement of children's rights in poor or marginalized areas such as pygmy communities and certain urban zones.

22. The results of the programme for the survival and comprehensive development of young children are encouraging, although they are on the whole inadequate for achieving the programme's global objectives. The Expanded Programme on Immunization (EPI) has helped achieve 90% coverage for poliomyelitis, 79% for measles, and 90% for tetanus in 10 high-risk health districts. The review also highlighted some challenges, however: only 7% of pregnant women and 5% of children under five years sleep under an impregnated mosquito net. The still-high maternal and neonatal mortality rates stand in sharp contrast to the high levels of pregnancy monitoring and professionally assisted childbirth (86%), denoting a serious problem with the quality of the services. Access to water and sanitation is still very limited, especially in rural areas, with resulting high rates of diarrhoea and waterborne diseases.

23. The basic education component has provided substantial support for the primary education statistical services, with the updating of enrolment data and policy documents such as the National Strategy for Education for All and the study of literacy among girls. In primary schooling and education for girls, the results are disappointing, reflecting the fact that school materials are being provided to the detriment of investment in the quality of instruction.

24. The protection component made significant progress in promoting justice for juveniles and preparing a draft children's code in line with the Convention on the Rights of the Child, now under study by parliament. With an awareness campaign and substantial investment in birth registries, more services have been enlisted and 38% of births are now being registered.

25. The HIV/AIDS component has made significant progress with prevention activities among young people, but in the absence of a national communication strategy to change young people's behaviour only 2% of the total target population has benefited from the programme. As to PMTCT, the main achievements were the preparation of a national policy of standards, procedures and training modules in PMTCT and communications training for health workers, and counselling and care for seropositive women and newborns.

26. The social policy communication and planning component provided material and financial support for the 2005 EPS, with the inclusion of MICS indicators and training in the DevInfo software, planned for introduction in 2007.

27. Emergency interventions have helped to improve access to basic social services for flood victims in the Pool district and in Brazzaville, through: (a) rehabilitation and outfitting of school and health facilities; (b) supply of teaching materials, drugs and refrigeration equipment; (c) training for health workers and volunteer teachers; (d) construction of latrines and wells in schools, health centres and markets; (e) launch of a "peer educators" strategy for AIDS prevention in schools; (f) recording of children in the civil registry; (g) improved vaccination coverage rates; and (h) psychosocial counselling for displaced persons returning home.

28. **Resources used.** \$3.4 million in regular resources was allocated over the first three years, or 116% of the planned amount. \$6.2 million has been mobilized to date, or 138% of the planned amount (to which must be added \$2.1 million in emergency funding and \$1.6 million from other resources). Consequently, the level of other resources rose to \$12 million for the cycle as a whole.

29. Programme execution faced various constraints, the most serious of which were: (a) shortcomings in the policy framework; (b) inadequate functioning of the education, health, social and planning systems, including funding shortages; (c) weaknesses in coordinating interventions; (d) weak monitoring and evaluation; and (e) frequent shortfalls in funding, both from UNICEF and from the government.

30. There are many opportunities to be seized: (a) the integration into the PRSP of strategies for achieving the MDGs and the updating of data from the national surveys constitute a better basis for planning, monitoring and evaluating the programme; (b) advocacy efforts will help develop and implement documented service packages, which should have a scale-up and leverage effect on the interventions of other partners; (c) mobilization of government budgets and progressive assertion of national ownership over the programme will be decisive in achieving the expected results; (d) finally, the children's parliament should guarantee that children will participate in development programmes that concern them.

31. The systemic approach in the convergence zones has encountered constraints in both human and financial resources, as well as difficulties in the field. It is important to refocus interventions on a few specific zones, rather than attempt exhaustive coverage.

32. **Adjustments made.** Cooperation will now enter the definitive transition from the emergency model to a development model, based on capacity building, development and social policies, partnerships, and participation by children and communities.

33. The objectives of the various sectoral programmes will need to be reformulated to make them more consistent with national objectives. This will include placing the early childhood development programme back under the education programme, reconfiguring the comprehensive childhood development programme within the child survival and development component, and integrating the PMTCT operationally into the prenatal consultation units, with a training strategy for the national AIDS programme, and a higher profile for the water and sanitation project. The review also recommended restructuring the education programme into four components (early childhood development, access and equity, quality of education, and institutional and strategic support); restructuring the protection programme into three components (development of social policies and national capacities, protection of the most vulnerable, and combating violence and abuse); and restructuring the communications project into three components (advocacy and social participation, information, and communication with the public and partners).

34. With respect to geographic coverage, the review recommended a national approach with high-impact interventions in health and in primary education, and a systemic approach in urban and rural areas, consistent with an analysis of vulnerabilities for the multisectoral interventions.

35. With respect to the “mature” components, the review proposed the development of exit strategies, with technical and logistic support that would see these projects through to the end of the programme in 2008.

Niger

36. The midterm review was held in Niamey in October 2006, and was chaired by the Minister of Regional Planning and Community Development (*Ministre de l'aménagement du territoire et du développement communautaire*). It involved sectoral ministers and ministerial representatives, all the UN agencies, community representatives, decentralized services, parliamentarians, members of the children's parliament, civil society, representatives from member countries of the Executive Board present in Niger, and the regional office of UNICEF.

37. **Update of the situation of children and women.** Niger is considered one of the poorest countries, and its indicators are alarming. In 2005, 62% of the population was living below the national poverty threshold. Despite improvements on the macroeconomic front, the national government's financial capacity remains very weak in the face of tremendous needs for basic social services: only 7% of the budget goes to health, and 17% to education.

38. According to the MICS, the U5MR has dropped sharply (by 38% between 2000 and 2006). However, children remain at very high risk in Niger. The leading causes of childhood deaths are malaria (59%), acute respiratory infections (15%) and diarrhoea (14%). At 1,600 per 100,000 live births, the MMR is one of the highest in the world. In 2005 Niger suffered a severe food and nutritional crisis that affected more than 3.6 million people, and at least 800,000 children. The chronic malnutrition rate among children under five years remains very high (rising by 44% from 2005 to 2006).

39. The gross enrolment rate in primary school rose to 62% in 2006 (55% for girls). However, the primary school completion rate for boys and girls remains low,

at 36%. Gender equity in education is improving only slowly (in primary school, the equity index is 0.7%).

40. The prevalence of HIV/AIDS among adults remained stable at 0.7% in 2006. Only 13% of girls and 16% of boys between the ages of 15 and 24 are aware of methods for preventing AIDS. The number of AIDS orphans was estimated at 46,000 in 2006, versus 23,000 in 2005.

41. Access to safe drinking water fell in 2006 (to 46%). Access for children and women to proper health services is also very low (19% in 2006).

42. The percentage of children registered at birth has declined (32% in 2006). On the other hand, the percentage of female genital mutilation victims has fallen by half (2% in 2006). The percentage of working children aged five to 14 years declined by almost half (38% in 2006). The legal framework for the protection of children and women remains inadequate.

43. **Progress and key results.** Progress recorded over the three years of programme implementation can be attributed to the following factors: (a) greater coverage of health and education services; (b) aid coordination and stronger partnerships between government, donors and the UN system; (c) greater resource mobilization capacity on the part of UNICEF; and (d) stepped-up financial contributions from development partners.

44. The country programme is structured in five components. Over the three years, the programme made a significant contribution in terms of giving effect to children's rights to survival, development, and protection in Niger.

45. The health and nutrition programme supported national health strategies for controlling epidemics or preventable diseases. The ACSDD, with the EPI +, was introduced in two pilot health districts and showed good results in expanding the coverage of basic services and reducing the U5MR by at least 20%. The programme supported reinforcement of the EPI through the supply of vaccines and cold storage facilities. It also organized mass campaigns against measles, and "national vaccination days" coupled with the distribution of vitamin A capsules. The programme achieved its 80% vaccination coverage target against preventable diseases. In morbidity terms, the number of measles cases declined from 63,000 in 2004 to 212 in 2006; the prevalence of diarrhoea dropped from 40% in 2000 to 28% in 2006, and cases of acute respiratory infections fell from 36% to 31%. The local transmission of the polio virus has been halted. The 2005 campaign for mass distribution of impregnated mosquito nets made them available to 86% of households, 55% of children and 48% of mothers. The number of dracunculiasis cases fell from 123 to 66. IMCI treatment was expanded in 24 of the 31 targeted health districts, with planning and management capacities reinforced for district officials and training for community health workers.

46. In the nutrition area, the programme strengthened national prevention and care capacities for moderately and severely malnourished children, with the development of a new national nutritional care policy in partnership with some 20 NGOs and the WFP. As a result, at least 800 nutritional care centres were rendered operational during the food emergency. Community capacities for the surveillance and prevention of moderate malnutrition were also strengthened. Thanks to the prompt responses of UNICEF, NGOs and partners to this emergency, the prevalence of acute malnutrition declined from 15.3% in 2005 to 10.3% in 2006.

47. The HIV/AIDS component supported expansion of the transmission prevention strategy to 21 health districts, and increased pregnant women's access to reproductive health services. The percentage of women testing positive for HIV/AIDS doubled from 0.7% in 2000 to 1.9% in 2006.

48. The basic education programme helped improve enrolment in 600 primary schools and supported community management of schools in the 12 departments of the concentration zones, in cooperation with the WFP and other partners. With this intervention package, UNICEF was able to increase its contribution by 5% nationwide, and access to basic education has improved considerably.

49. The protection programme reinforced national capacities for dealing with child protection issues. The national partnership with NGOs for promoting the rights of at-risk children was reinforced, and UNICEF provided assistance to 5,144 women and children requiring special protection. A total of 725 OVC and their families receive help with income generating activities. The integrated basic services programme made a very significant contribution to strengthening community capacities to deal with food insecurity and to enhance access to safe drinking water.

50. The planning, evaluation and communication programme provided effective support to UNICEF's advocacy campaign for placing children's priorities on the political agendas of the host and donor countries, and for establishing and reinforcing partnerships with traditional chiefs, the media, and community radio stations in particular.

51. During the three years of the programme there was a significant improvement in the availability of regular and reliable statistics, and in the understanding of children's problems, thanks to training in results-based management, the conduct of some 30 studies and evaluations and household surveys, and strengthened national capacities for data gathering, processing and analysis, through introduction of the DevInfo database in Niger.

52. **Resources used.** The rate of resource mobilization and use was very high. In all, \$81 million was made available over the three years of programme implementation. Other resources account for 77% of funds mobilized, versus 24% from regular resources. The resource absorption level was 89%.

Constraints, opportunities and lessons learned

53. The constraints relate essentially to: (a) families' inability to pay for social services; (b) human capital shortages in the programme's national counterpart; (c) inefficiency in the decentralized services; (d) delays in providing substantiation for advances to the government; (e) delays in providing inputs for the interventions; and (f) the geographic dispersal of interventions.

54. There are four main lessons to be drawn from the midterm review: (a) the ACSD has been shown to be an effective strategy for reducing child mortality; (b) the malnutrition crisis of 2005 was of such scope that it had a disastrous impact on child survival; (c) the measles campaign achieved a significant reduction in epidemics in 2004 and 2005; and (d) the integrated basic services strategy often does double duty with sectoral programmes.

55. **Recommended adjustments.** Six major adjustments are recommended: (a) the cooperation programme should be extended in 2008, in line with the conclusions

from the UNDAF midterm review; (b) the number of concentration zones should be reduced; (c) a malnutrition directorate should be created within the Ministry of Health in order to strengthen policy formulation and the institutional framework for coordination and management of the nutrition component; (d) a new nutrition programme should be established, separate from the health programme, in order to address the nutrition problem more efficiently, while preserving the achievements of the integrated field interventions for child survival; (e) the integrated basic services programme should be transformed into a programme for local development and water and sanitation; (f) the staffing composition of the UNICEF office should be revised to reflect the scope of children's problems and the burden of resource management.

Principal evaluations

Evaluation of the rapid response mechanism: UNICEF and the Office for the Coordination of Humanitarian Affairs (OCHA) in the Democratic Republic of Congo

56. Since 2004, UNICEF and the Office for the Coordination of Humanitarian Affairs (OCHA) have had in place a rapid response mechanism (RRM) for providing immediate assistance to people suddenly displaced by conflicts, natural disasters or epidemics. The RRM was implemented in partnership with international NGOs. The provinces concerned are North and South Kivu, the Ituri district, Katanga, and Maniema. According to the 2007 humanitarian action plan, 1.2 million people have been displaced in the eastern provinces of the country.

57. The main thrust of this approach is to ensure coordinated and appropriate intervention within 72 hours. Generally speaking, RRM intervention will last for three months. The strategy targets the most vulnerable groups by providing them with non-food items, shelter, and water and sanitation, as well as emergency education services. Under current agreements, the international NGOs receive funds from UNICEF to cover operating costs, the purchase of prime necessities, and the maintenance of emergency stocks. They may also receive money from the OCHA contingency fund for supplementary interventions. The intervention begins with a quick multisectoral assessment and includes a significant monitoring and advocacy dimension. The approach is regarded as flexible, and can be adapted to other forms of humanitarian intervention.

58. Two years into the programme, UNICEF and OCHA commissioned an external evaluation of the RRM. It focused on the following topics: selection of beneficiaries; vital sectors beyond the RRM; the link between the RRM and other interagency initiatives and the reform of humanitarian assistance; and the performance and impact of the RRM. The lessons learned from the evaluation and the resulting recommendations will be used to strengthen the RRM strategy in the Democratic Republic of Congo and in other countries.

59. The methodology used in this evaluation combined qualitative and quantitative approaches, using interviews with beneficiaries and focus groups discussions, interviews with humanitarian workers, local authorities and civil society, as well as field visits and documentary reviews.

60. In terms of eligibility, the RRM gives priority to persons who have been displaced for at least three months. The evaluation recommended this criterion as a

flexible measure of vulnerability, while recognizing the need to apply other criteria, depending on the context. Of the 1.5 million beneficiaries since October 2004, 815,000 people received non-food kits or emergency shelter; water and sanitation projects benefited 693,500 people; and 13,500 children received emergency school supplies.

61. All the humanitarian clusters need emergency stocks to respond to humanitarian needs when they arise. The RRM allows UNICEF (the lead agency for non-food items and shelter in the country, and for the education and water/sanitation clusters) to meet this requirement effectively. Other clusters subject to sudden emergencies (food, health and protection) could also consider adopting an RRM-type solution for assuring prompt response.

62. One of the shortcomings of the RRM identified in the evaluation is the problem of providing a holistic response to acute and immediate needs in other sectors, such as food, health and protection.

63. Several lessons and recommendations have been drawn. The RRM can be adapted to nearly all sectors in similarly complicated settings where several humanitarian agencies may be competing for funding from a limited number of donors. Chad, Darfur and Somalia are potential candidates for application of an RRM in places where insecurity makes vital resources inaccessible.

64. The evaluation recommended that the data monitoring and collection system be reinforced so as to measure all RRM interventions over time.

65. Finally, the evaluation recommended that a similar mechanism, based on the results of the RRM evaluation, should be developed for the agencies responsible for the humanitarian, health, food and protection clusters, where acute unmet needs persist.

Interagency health evaluation in Chad

66. A number of organizations are supporting health initiatives among Sudanese refugees in eastern Chad, and among refugees who have moved into the south of the country from the Central African Republic. These organizations are also assisting local communities in those two regions of Chad. This intervention was the subject of an interagency evaluation.

67. The evaluation had two objectives: (a) to measure the humanitarian response to the situation in Chad; and (b) to help the Ministry of Public Health, UN agencies, NGOs and other partners to respond to the health needs of local people and refugees. Chad is expected to use this evaluation in order to: (a) examine progress and the performance of the humanitarian response and its interface with the national health system; (b) prepare and update a joint action plan embracing all those involved in the humanitarian response. An action plan will be developed for implementing the recommendations from the evaluation.

68. The methodology consisted of documentary review and analysis, semi-structured interviews with all stakeholder groups, direct field observation, and visits to the refugee camps, as resources permitted. The evaluation examined the relevance, efficiency, effectiveness, impact and consistency of the response to this humanitarian crisis.

69. The evaluation revealed that activities in the fields of health, nutrition and water/sanitation are highly pertinent in light of the objectives. However, most refugees did not see the need for health education, family planning, or HIV/AIDS prevention. This perception made it more difficult to pursue activities in these fields.

70. Communication and logistics resources have been satisfactorily coordinated, and have supported the many activities in the different locales and sectors. Most interventions have been very effective in terms of medical consultations, nutritional surveillance and the supply of drinking water. Aid effectiveness is reduced, however, by the lack of security along the roads leading to the refugee camps, and poor coordination among the principal UN agencies involved.

71. The Office of the United Nations High Commissioner for Refugees and nearly all partner NGOs have sound operational capacities. However, alternative approaches could have produced the same results at lower cost, or better results with the same resources. Costs could have been reduced if NGOs were able to pre-position emergency supplies, in the absence of regional stocks for responding to epidemics.

72. Refugees account for a significant portion of the local population in the intervention zones. Over-exploitation of natural resources, in particular firewood, is therefore inevitable. While possibilities exist for countering this unexpected adverse impact, they have not been considered. Moreover, the cost of living has risen in towns located near the refugee camps. This has been offset in part by job creation and the expansion of commerce, to the benefit of local people. These constitute unexpected positive impacts. The expansion of health services has been very positive for the health of refugees. For example, the evaluation showed that morbidity and mortality rates among refugees have improved, and are lower than the levels observed in emergency situations. The nutritional situation of refugees was in fact better than that of the host population.

73. It was found that the provision of health services in the camps was not sufficiently coordinated with the services offered by the health districts. There has been little effort to assure consistency between the policies and strategies pursued by various humanitarian and development organizations in the fields of health, agriculture and environmental programmes, particularly vis-à-vis the local population. The prospects for sustainability and integration are weaker in the semiarid East (where return is still the preferred option) than in the forested South, where the land is more fertile (and where the integration of refugees is a viable option).

74. The following recommendations were made: UN agencies should rationalize the use of their resources. Responsibilities should be clearly described and distributed from the outset of the humanitarian crisis and they should be reviewed regularly. Where national health services exist, humanitarian aid should support them for the benefit of local people and refugees alike, instead of maintaining parallel health services in the camps. There is a need for efforts at sexual education and understanding HIV/AIDS prevention in the camps. Violence and sexual abuse against women should be tracked and reported more closely, so that victims can receive proper care and preventive measures taken.

Evaluation of the social marketing campaign for vitamin A. and the vitamin A supplementation programme in Nigeria

75. This evaluation was undertaken one year into the intensive awareness campaign sponsored by UNICEF, through sensitization and advocacy meetings, national and local appeals, and the mass media. The goal of the campaign was to improve public knowledge and awareness about vitamin A. and vitamin A-fortified foods, and to encourage manufacturers to respect food vectors. Evaluation was commissioned to re-evaluate local peoples' understanding of vitamin A and their awareness of vitamin A-enriched flour, sugar and vegetable oil. The outcomes will point the way for more effective social marketing of these products to increase their consumption in Nigeria.

76. The population sample was divided into three socioeconomic categories, all concentrated in urban centres: (a) high-income, low-density;(b) low-income, high-density; and (c) very low income and very high density.

77. The main technique used for the sampling was the itineraries method. Data collection methods included structured interviews, questionnaires, observations in open-air markets, and private interviews with key officials in government agencies involved in the fortification programme. A benchmark study had been conducted in 2002.

78. The evaluation showed that more than 69% of consumers know about vitamin A, thanks to the UNICEF publicity campaign. The comparable figure in 2002 was 42%. This means that advocacy and outreach efforts have brought awareness to an additional 27% of the population, compared to the benchmark; 51% of respondents who know about vitamin A are women, and 49% are men. This is an important measure of public knowledge about vitamin A, because women are more likely to go to market and to visit primary health care centres. Vitamin A awareness was greatest among high-income, low-density groups (43%) and lowest among respondents in very high density areas (23%). The level of awareness was highest in Lagos, at 65% of respondents, and lowest in Maiduguri, where only 27% recognized the logo.

79. The current media and advocacy campaigns have achieved a national coverage rate of 52%; 35% of persons interviewed had seen the campaign on television, and 29% had heard it on radio, 12% had heard the campaign discussed in primary health centres, 10% knew about it through formal education, around 1% had read the campaign brochures and posters, 3% had read about it in the newspapers, 7% had read the packaging, and 3% heard about it from friends.

80. The compliance level of the major manufacturers was also assessed. Flour and sugar manufacturers were 100% compliant. However, there are still several places where powdered sugar can be found without the logo, where the goods are repackaged with no visible mention of origin, and where the source of vitamin A fortification cannot immediately be confirmed. The compliance rate for vegetable oil is estimated at 82%. All the major manufacturers are fortifying their product, but observations revealed that great quantities of oil with no logo and with no fortification are still available on the market.

81. In general, these results show that there has been an appreciable increase in public awareness of vitamin A. As well, the level of compliance among manufacturers in fortifying flour, sugar and vegetable oil is very high.

82. The study had some limitations. There were problems in obtaining information from government officials, who felt they had been excluded from the awareness campaign. In addition, basic financial, production and sales data could not be obtained from most manufacturers.

83. The recommendations from the evaluation include: stepped-up advocacy among manufacturers, and particularly those producing vegetable oil, to secure their lasting commitment to vitamin A fortification; further publicity campaigns about the importance of vitamin A-fortified foods for the human body; the need for a national impact study to evaluate the level of vitamin A in people's organisms, compared to the benchmark data.

Study of access and performance disparities in basic education in Mali, 2000-2005

84. This study analyzed the dimensions, the geographic distribution, and the causes of basic education disparities in Mali in terms of access and quality. It offered some recommendations for reducing these disparities.

85. The study was based on school surveys conducted each year since 2002-2003 by the Ministry of Education. It covered the municipalities and used education indicators such as gross and net admission rates, gross and net enrolment ratios, enrolment ratios by age group, repetition rates, promotion rates, and student/teacher ratios. Field interviews were conducted.

86. The study showed that access to primary education is generally low throughout the country. Access improved between 2002 and 2005 in nearly all regions, but much remains to be done to achieve universal education. The regions of Mopti, Tombouctou, Ségou and Kayes have the lowest access rates in primary school. Only the Bamako District has a gross ratio higher than 100%. There is very little disparity between girls and boys in either the low-access areas (Mopti, Tombouctou) or the high one (Bamako).

87. The study also showed a great heterogeneity among regions in terms of access to education. Access to intermediate school is much lower than for primary school, and gender disparities are much more pronounced. Mali can be divided into two zones in terms of gender equity. The North (Mopti, Tombouctou, Gao, Kidal) is more egalitarian in terms of girls' enrolment. The south, embracing the other regions, betrays much sharper disparities between girls and boys.

88. The access rate to grade 1 for girls is 4 to 15 points lower than that for boys, except in Mopti and Tombouctou, where girls have greater school access than boys. However, even when they go to school, girls face enormous difficulties in completing the primary level. In intermediate school, the situation of girls is much more alarming. The access rate to grade 6 for girls is far lower than that for boys in all regions.

89. The proportion of females (20%) in education is very low. As to the retention rate, a child entering grade 1 in Bamako has twice the chance of reaching secondary school as does a child in Kidal or Tombouctou. Depending on the region, the chances of completing primary school vary greatly, from 44% in Kidal to 84% and Bamako, and the chances of completing intermediate school vary between 25% and 51%.

90. The northern regions (Kidal, Tombouctou and Gao) have the highest repetition rates in primary school. The proportion of repeaters among girls and boys is the same, in all regions.

91. The analysis identified a number of factors that explain the low access and the poor quality of education in Mali. The most important factors are the work overload of women in rural areas; customary law, which discourages women's emancipation, especially in rural areas; the persistent prejudice that treats women as inferior; early marriage and pregnancy; mass illiteracy among parents; large family size; the economic costs and the opportunity costs of education for parents; long distances to reach school; inadequate school and educational infrastructure; inappropriate curriculum contents, and the quality of teaching.

92. The study made the following recommendations: adopt policies that will target the most underserved municipalities (the government could set itself the objective of improving school access and education quality in the 100 municipalities with the lowest indicators); design and implement a type of school adapted to the nomadic lifestyle of the North (Bozo fishing communities, Peuls and Tuareg herders); bring the curriculum more closely into line with local employment opportunities for fishing, farming, herding, handicrafts etc.; lower the grade 1 entry age to 5 years, and thereby reduce the opportunity costs for parents, especially with respect to girls.

General considerations on the evaluation function in the region

93. The Regional Office, in cooperation with the country offices, is now implementing a strategy for improving the evaluation function. This will serve to enhance its quality and ensure that it makes a significant contribution to knowledge, especially regarding regional priorities such as child survival, girls' education, and protection.

94. In 2006, the execution rate of studies was 70 out of 80. In addition, 23 of the 36 evaluations and 28 of the 34 surveys planned were completed. Use of the evaluations in the country offices is still confined to the project level.

95. With UNICEF support, a number of countries have created local evaluation associations affiliated with the African Evaluation Association (which includes Burkina Faso, Cameroon, Cote d'Ivoire, Ghana, Niger, Nigeria and Senegal). These represent strategic partners for UNICEF. They are increasingly taking part in efforts to raise awareness of the strategic role of evaluation in development, to strengthen national capacities, and to guarantee quality through the use of the African Evaluation Standards.

96. The Regional Office provided Benin, Congo and Niger with the technical support necessary for preparing their midterm reviews, and it also oversaw the quality of the reports. It participated as well in the evaluations conducted in Benin, Ghana, Mali and Senegal, in order to measure the impact of the ACSO initiative. The results of these evaluations are not yet available.

97. Strengthening the evaluation function is a key component of the Regional Office's management plan for 2008-2009, as a tool for improving programming quality and contributing and sharing knowledge.