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Summary of mid-term reviews and major evaluations of country programmes

South Asia 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 mid-term 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 2004 and 2005.

Introduction

1. This report summarizes the MTRs of the country programmes for Afghanistan, Bhutan and Sri Lanka. It also discusses four of some 70 studies and evaluations completed in the eight countries of the region in 2004 and 2005.

* E/ICEF/2005/10.

Mid-term reviews

Bhutan

2. **Introduction.** A Steering Committee consisting of representatives from the Government and UNICEF managed the MTR, which took place in July 2004 and was based on reviews of individual programme components and an evaluation of the country programme in 2003. The findings of the national Youth Forum were considered in the sectoral reviews.

3. **The situation of children and women.** There has been sustained progress for children and women. Recent studies show a 3-per-cent increase in school enrolment and a reduction of gender disparity, with girls now constituting 48 per cent of enrolled students. Primary-school retention rates continue to be higher for girls (85 per cent) than boys (73 per cent). Nonetheless, a significant proportion of children, especially girls and those living in the southern districts and sparsely populated hilly areas, remain out of school, primarily because of a lack of schools and the security of children travelling long distances. Another major challenge is the persistently high maternal mortality ratio of 255 per 100,000 live births. Anaemia levels are extremely high among all population groups, with over 81 per cent of children under five years of age and 81 per cent of pregnant women iron deficient. Specific interventions targeting various groups have been initiated. Poor health and nutrition also result from inadequate feeding practices and lack of safe sanitation.

4. **Progress and key results.** The expanded basic education programme contributed to the establishment of a national policy and a Child Care Division in the Ministry of Education, revised policy guidelines for non-formal education and a policy on “child-friendly” schools. The establishment of 250 new non-formal education centres enabled 10,000 learners to enrol, of whom 81 per cent completed the post-literacy course, compared to 38 per cent in 1995.

5. Through the health and nutrition programme, UNICEF, the Ministry of Health and the World Health Organization (WHO) contributed to a strengthened immunization programme that achieved 85-per-cent immunization coverage (slightly below the target); maintained zero cases of polio and tetanus; established an integrated surveillance system for polio and a surveillance system to monitor vaccine-preventable diseases; and set up 20 new outreach clinics and upgraded five existing ones, which improved access to maternal and child health services, although the target of 70-per-cent access by 2005 turned out to be too ambitious. Access to emergency obstetric facilities increased through provision of such facilities in 9 of 15 target hospitals and the introduction of comprehensive training to non-specialists for the first time. Bhutan has satisfied all 10 WHO criteria for elimination of iodine deficiency disorders, but the targets for iron deficiency anaemia and undernutrition could not be reached. Nationwide iron supplementation to schoolchildren and small-scale community interventions for children under five years were carried out from 2004, but the lack of resources remains a bottleneck.

6. The child care and development programme planned to have 75 per cent of schools in the project areas equipped with well-maintained and adequate water supply and sanitation facilities. All new primary and community schools, and existing schools if needed, were provided with water schemes and separate latrines for girls, hygiene education was made part of the school curriculum and health and

nutrition coordinators promoted a healthy school environment. Supporting religious leaders to convey sanitation messages and to enhance early referral for illnesses and pregnancies was found to be successful. This target is likely to be achieved.

7. The key result of the planning, communication and participation programme was the upgrading of the Child Rights Commission to the National Commission for Women and Children. New partnerships for communication strategies have been initiated, such as with the Bhutan Broadcasting Service. *DrukInfo*, the national version of *DevInfo*, established within the National Statistical Bureau for maintaining databases and monitoring the Millennium Development Goals in partnership with the United Nations country team, was used in the generation of all statistical information for the country's report on the Goals.

8. **Resources used.** The regular resources allocation was \$1.7 million. The amount of other resources funding was much less than planned in both 2002 (38 per cent of the planned \$2.9 million budget) and 2003 (46 per cent of the planned \$2.9 million budget). The total budget for 2002-2003 was spent as follows: 44 per cent for the expanded basic education programme; 28 per cent for health and nutrition; 17 per cent for child care and development; 8 per cent for planning, communication and participation; and 2 per cent for cross-sectoral costs.

9. **Constraints and opportunities affecting progress.** Programme implementation faced several major constraints stemming from lack of clear accountabilities for programmes; a lack of clarity about operating at subnational level within a still evolving decentralization policy; and limited resources for monitoring at field level, which is extremely difficult due to rugged terrain and sparse population distribution. The new National Commission for Women and Children is a great step forward in bringing children's issues more systematically to the national planning and budgeting processes. Recent enhancement of the knowledge base through well-implemented studies (e.g., on nutrition status and child protection) have resulted in greater recognition of these issues and in options for better addressing them. Most of the issues noted as constraints were resolved through discussions with senior officials.

10. **Adjustments made.** A comprehensive programme reformulation, including the development of logical frameworks, helped to strengthen the alignment of the country programme with Bhutan's ninth five-year plan, the United Nations Development Assistance Framework (UNDAF) and the Millennium Development Goals. It also resulted in a clear agreement on results to be achieved while narrowing the focus from rather disparate activities to clear targets. Key modifications were: (a) focusing the education programme on improved access, quality and retention; (b) focusing the health and nutrition programme on improving the nutrition of infants and young children and addressing iron-deficiency anaemia, with support to the sustainability of the expanded programme on immunization (EPI); (c) refocusing and renaming the child care and development programme as the school water supply and sanitation and health promotion programme; and (d) scaling-up child rights promotional activities in a project supporting the National Commission for Women and Children.

Sri Lanka

11. **Introduction.** The MTR, conducted in October 2004, drew on programme reviews conducted at provincial level and at district level in conflict-affected areas. Children's participation was ensured through a process established for the development of the 2004-2008 National Plan of Action for the Children of Sri Lanka.

12. **The situation of children and women.** Prospects for women and children improved with the ceasefire agreement in 2002. With access to the conflict-affected areas, the number of internally displaced persons (IDPs) decreased from 700,000 in 2001 to 360,000 in 2004. Reconstruction and development progressed and basic social services are being gradually restored in these areas. Immunization coverage, at over 80 per cent, is almost in par with the rest of the country. However, disparities persist in such other areas as nutrition and water and sanitation infrastructure, especially in large IDP settlements. Significantly lower levels of child survival and development are also seen in population groups such as tea plantation workers, and in some dry zone districts.

13. At the national level, Sri Lanka has maintained high levels of achievement in child survival, maternal mortality reduction and primary and secondary enrolment with gender parity. While some progress has been made, undernutrition continues to be a challenge with 29 per cent of children under five years being underweight, with wide subnational variations. The rate of access to improved sources of water reached 75 per cent in 2000, and safe sanitation coverage is over 70 per cent. Institutionalization of children of mothers migrating to the Middle East is a growing tendency. Underage recruitment by rebel forces is a concern and nearly 1,400 reported cases of child recruitment remain unresolved.

14. **Progress and key results.** The programme for children affected by armed conflict enabled 7,000 children to return to school, over 1,400 underage recruits to receive social work assessments, and over 400 children engaged in hazardous labour to receive social work support. Some 48,000 children received non-formal education in 2002-2003. Demobilization of 1,600 child soldiers and prevention of recruitment were facilitated through a reporting framework and care network. Parents and caregivers have received information regarding education, health care, child protection and mine-risk education. An early childhood care model was piloted, but its scaling-up has suffered due to shortages of public health staff and low motivation.

15. The early childhood programme is implemented in 63 underdeveloped subdistrict divisions and 40 estates, slightly exceeding the targeted coverage. In the areas of the seven districts that have been monitored to date, 88 per cent women received iron supplementation, 85 per cent of households consumed iodized salt, 90 per cent of pregnant women received supplementary feeding from the Government (but only 58 per cent on a daily basis) and over 90 per cent of parents engage in child stimulation. The programme supported: the training of 2,500 public health midwives in integrated early childhood development (ECD), which focused on care practices for health, nutrition, psychosocial development and sanitation; national capacity-building to achieve 100-per-cent salt iodization; provision of iron supplements; awareness-raising campaigns; and installation of 197 water points and over 3,000 latrines. Following a needs assessment, emergency obstetric

interventions were improved in seven hospitals. The rate of low birth weight in 10 tea plantations decreased from 21 per cent in 2000 to 14 per cent in 2003. However, undernutrition remains high with 37 per cent underweight in 2003. Although UNICEF provides the total national requirement, vitamin A coverage was as low as 30 per cent. While cognitive development has not been assessed, 100 crèches and 100 preschools have been transformed into “child-friendly” development centres, and 1,900 teachers received training in child development. The approval of a national early childhood care and development policy was a great step forward.

16. The objectives of the learning years programme are to reduce non-attendance of 5-14 year-olds by 50 per cent and improve learning competencies in the targeted areas. In the former conflict districts, enrolment increased considerably through campaigns; supply of school kits; rehabilitation of 240 of 500 schools needing rehabilitation; training of teachers and principals; strengthened monitoring; and provision of water and sanitation facilities. In the other focus districts, where 15,000 children were estimated to be out of school, 55 literacy centres for 1,400 children and two drop-in centres for street children were established. To improve learning outcomes, 214 “child-friendly” schools were established as models for possible scaling-up. A study comparing 15 “child-friendly” with 15 non-“child-friendly” schools has shown not only a relative increase in enrolment in the former, but also higher learning achievements. However, students in non-“child-friendly” schools scored higher marks on the grade 5 scholarship exam. This suggested differences in scoring systems and the need for an exam based more on learning competencies. A comprehensive framework for reaching the Education for All goals in the context of a sector-wide approach (SWAp) has been initiated. The partnership between UNICEF and the Government in this area has expanded significantly.

17. The objective of the adolescence programme is to improve life skills and competencies relating to HIV/AIDS and sexually transmitted diseases among 20 per cent of the adolescents in the focus areas. Activities have resulted in 85,000 adolescents receiving life-skills training on substance abuse and HIV/AIDS prevention. Children in 100 schools have benefited from peer education networks. Awareness of HIV/AIDS communication has been strengthened through training of 500 health workers and 2,000 school teachers. Based on new evidence from an innovative study on emerging issues among adolescents, a national adolescent policy has been drafted.

18. The objective of the child protection programme is to reduce abuse, exploitation and violence against children and exploitation of women. The programme focused on capacity-building at the institutional and organizational levels. The results include the establishment of District Child Protection Committees in 15 districts; 60 per cent of police stations are functioning in a “child-friendly” manner; the establishment of crisis centres that provide counselling, health services and legal advice for women in eight districts; improved quality of care in 31 children’s homes in former conflict areas; and a reduction in mine injuries due to mine-risk education. The Committees contributed to the establishment of a consolidated action framework for the registration, reporting, follow-up and reintegration of under-age recruits in the former conflict areas.

19. The objective of the rights-based, policy analysis and advocacy component is to create a national movement for children, an enabling environment of “child-friendly” policies and legislation, and enhanced resources for the realization of

children and women's rights. A key result is the development of the National Plan of Action for Children of Sri Lanka 2004-2008, together with the Government's commitment to social investment in children and related budgetary provisions. The Plan includes clear objectives that the country programme can support to reach the goals of *A World Fit for Children*. Monitoring of progress towards the Millennium Development Goals was supported through *DevInfo*, which was established in the Presidential secretariat. Other outputs include a training manual on human rights-based approaches, a field-based monitoring mechanism, a number of surveys providing strategic information and baselines at district level, and studies and evaluations in support of advocacy for children's issues.

20. **Resources used.** The planned budget for 2002-2003 was \$4 million. However, following the peace agreement, \$21.7 million was received, of which \$18.3 million (84.3 per cent) was expended as follows: children affected by armed conflict (33 per cent); ECD (41 per cent); learning years (14 per cent); adolescence (2.1 per cent); protection (7.2 per cent); and planning and advocacy (1.9 per cent).

21. **Constraints and opportunities affecting progress.** Key constraints were a shortage of human resources, particularly in the ECD programme, which relies heavily on health workers; a low commitment to fighting HIV/AIDS; and poor compliance with agreements on child recruitment by rebels. During the peace process, the country programme expanded its interventions to benefit children and women affected by conflict. Following a review of the programme in 2002 by the Canadian International Development Agency, the United Kingdom Department for International Development (DFID) and UNICEF, the programme focus changed from humanitarian assistance to development cooperation. The Action Plan for Children Affected by War, signed in 2003 by both parties, has provided a great opportunity to implement a multi-faceted programme in the north and east, for which UNICEF has taken an overall coordination role in close partnership with the International Labour Organization, the United Nations Development Programme and the Office of the United Nations High Commissioner for Refugees.

22. **Adjustments made.** The primary adjustments are to ensure that the country programme supports the National Plan. These include: (a) consolidating and expanding the Plan with major stakeholders to ensure that the Liberation Tigers of Tamil Eelam abide by their commitments against under-age recruitment, that the Government provides adequate human resources and infrastructure rehabilitation and that UNICEF and other partners increase their capacities to respond more effectively to the needs of children and their families; (b) the programme for children in armed conflict will shift from a humanitarian to a development approach where applicable, consolidate "catch-up" and non-formal education and strengthen capacity-building, particularly at managerial and technical levels; (c) the ECD programme will focus more on reduction of malnutrition among children and consolidating interventions by the Ministry of Health, the Food and Agriculture Organization of the United Nations, the World Food Programme and WHO; (d) through the learning years programme, there will be greater coordination with the Ministry of Education in the framework of an education SWAp to address the quality of education, while maintaining the focus on out-of-school children; (e) the adolescent HIV/AIDS programme will pursue expansion of established networks of peer educators, more focus on institutionalizing life skills-based education and a strengthened response to HIV/AIDS; and (f) the protection programme will focus on

consolidation and institutionalization of the protection frameworks initiated in the past two years, with an emphasis on juvenile justice.

Islamic Republic of Afghanistan

23. **Introduction.** The MTR was held in November 2004. UNICEF-supported programmes were evaluated through joint reviews, consultative groups or ad hoc committees at national and provincial levels, with partners from the Government, non-governmental organizations (NGOs) and United Nations agencies.

24. **The situation of children and women.** While more than two years of relative peace have brought optimism to the lives of Afghan children and women, the challenges of survival, security, access to social services and employment continue. Although the Back to School campaign brought 40 per cent of girls and 66 per cent of boys to primary school, from a situation where only 36 per cent of boys and almost no girls were enrolled three years ago, 45 per cent of 7-12 year-olds remain out of school. In the past three to four years, measles immunization coverage has increased to 95 per cent among 6-59 month-old children. The number of polio cases was reduced from 27 in 2000 to three as of November 2004. However, other factors keep the under-five mortality rate at between 172 and 210 per 1,000 live births, the fourth highest rate in the world. Diseases caused by poor sanitation are widespread, as 69 per cent of rural and 39 per cent of the urban population use unprotected sources for drinking water, and 75 per cent do not have access to safe sanitation. Poor nutritional status (40-60 per cent of children are stunted) contributes to high mortality and morbidity. Nine out of 10 rural Afghan women deliver their children without skilled birth attendants, resulting in a maternal mortality ratio of over 1,600 per 100,000 live births, among the highest in the world. Children continue to be exposed to abuse and exploitation. About 8,000 minors are still in the fighting forces and child labour remains prevalent, with 28 per cent of boys and 34 per cent of girls aged 7-14 years working. Child kidnapping, smuggling and trafficking are on the increase.

25. **Progress and key results.** Contributing to the objective to reduce child and maternal mortality and morbidity, 6.7 million children were vaccinated against polio and 11.5 million against measles. This 95-per-cent coverage rate is the highest ever reached in a complex emergency situation and a quantum leap from a situation of virtually no vaccination of rural children. National Immunization Days (NIDs) also provided 5.7 million children with vitamin A supplementation, children under one year of age with birth registration, and families with awareness messages about nutrition, hygiene promotion and mine-risk education. Three million women were immunized against tetanus. The EPI has been rebuilt, including construction of cold rooms for vaccine storage, enabling 150,000 children to be immunized every three months. Returnees and IDPs benefited from nine piped water schemes, 1,167 community wells and 649 family latrines. The first centre for emergency obstetric care was established in Kabul and 31 provinces have operational health facilities with emergency obstetric care. In collaboration with the Japanese International Cooperation Agency (JICA) and the United States Agency for International Development (USAID), a midwifery training programme is underway. With assistance from United Nations Programme Fund (UNFPA), WHO and UNICEF, the national HIV/AIDS control programme is developing a national strategy on HIV/AIDS.

26. The objective of the second programme is to reduce malnutrition and micronutrient deficiency disorders. Knowledge was generated and disseminated through studies including the first national micronutrient survey. Advocacy was initiated on exclusive breastfeeding, food fortification and lobbying for investment in the flour milling industry. The percentage of households around Kabul using iodized salt increased from less than 1 to 19 per cent, and in Kabul from 5 to 37 per cent immediately after the establishment of the first salt iodization plant.

27. The third objective, to improve school enrolment, with a special focus on girls' education, was addressed through the Back to School campaign. Through establishing temporary learning spaces, rehabilitating 193 schools, training 52,000 teachers and providing teaching and learning materials such as 10 million textbooks, this campaign exceeded the target of more than 4.7 million Afghan children receiving an education. Some 127,000 IDP children also enrolled. The School Water and Sanitation Initiative provided 1.1 million pupils with access to water in schools, and 1,000 community water points. The country programme, in collaboration with such partners as JICA, USAID, the World Bank and Columbia University (United States), supported the Ministry of Education to improve teacher training policy; develop a new curriculum; form a multi-stakeholder group on teacher education; establish standards for teaching; and develop an education management information system.

28. The fourth objective is to improve protection of children from violence, abuse and exploitation through such cross-sectoral projects as birth registration campaigns, training in mine-risk education and preventing abuse and violence against children. Mine-risk education helped to reduce the number of victims of landmines and/or unexploded ordnance from 350 a month in 2002 to 100 a month in 2004. The Government signed the Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict, and disarmament, demobilization and rehabilitation processes that are specific to children are under way. As of November 2004, 3,731 child soldiers had been demobilized. A plan of action for the prevention of child trafficking was developed. Following UNICEF advocacy, the Ministry of Labour and Social Affairs has agreed to discontinue the establishment of new orphanages and to adopt a non-institutionalization policy; drafted a Juvenile Code; established a Juvenile Rehabilitation Centre; and conducted a comparative study between the Convention and Afghan laws.

29. The fifth objective, to avert widespread humanitarian crises through improved preparedness and response, resulted in mainstreaming preparation and responses to new and ongoing crises within programmes. Nearly 400,000 returnees and 120,000 IDPs received educational supplies and new water points. UNICEF was the first agency to respond to the Government's drought appeal through pre-positioned water tanker trucks. In 2004, more than 1,100 families affected by natural disasters received assistance.

30. **Resources used.** Of the country programme budget of \$204.5 million for 2003-2004, \$20.4 million was in regular resources, of which \$22.5 million (110 per cent) was expended as follows: health and nutrition (28.5 per cent); education (21.1 per cent); water, sanitation and hygiene promotion (13.5 per cent); child protection (11.2 per cent); planning, monitoring and evaluation (10.2 per cent); and cross-sectoral costs (15.4 per cent). The planned other resources budget for 2003-2004

was \$184.1 million, of which \$105.4 million (57.3 per cent) was spent for: health and nutrition (42.8 per cent); education (36.3 per cent); water, sanitation and hygiene promotion (10.9 per cent); child protection (5.8 per cent); planning, monitoring and evaluation (2.4 per cent); and cross-sectoral costs (1.8 per cent).

31. **Constraints and opportunities affecting progress.** The campaign approach proved very effective in reaching households through use of female volunteers to deliver multiple services of immunization, birth registration and vitamin A provision, and to disseminate educational messages. Engaging religious leaders has proven effective in increasing girls' enrolment, health and protection. Capacity-building of government and local partners through the provision of policy and technical experts to various ministries, allocating staff for inter-agency cooperation and technical collaboration with leading outside institutions all have positively affected progress.

32. The change to province-based programming was affected by deteriorating security and frequent travel restrictions resulted in a reduced UNICEF field presence. However, the counterparts functioned well with such established programmes as NIDs and Back to School campaigns. Progress suffered in newer programme areas such as emergency obstetric care and disarmament, demobilization and rehabilitation. Security restrictions also hampered UNICEF zonal offices in supporting local government to launch new programme areas.

33. **Adjustments made.** The MTR, together with the ensuing country programme evaluation, described in paragraphs 34-40 below, provided the basis for strategies in the next country programme cycle.

Major country evaluations

Islamic Republic of Afghanistan

34. **Purpose of the evaluation.** The development of the 2006-2008 programme was supported by an evaluation of the country programme. As findings and recommendations were fed into the draft country programme document (CPD), the evaluation was carried out under the guidance of the UNICEF Evaluation Office as a fast-track exercise from February to April 2005. This DFID-funded project also served as a pilot case for a country programme evaluation methodology in a conflict-affected country. Building on the MTR, it:

(a) Provided a more in-depth assessment of the relevance and appropriateness of the country programme as well as the role, design and focus of UNICEF support to the realization of children's rights;

(b) Assessed the sustainability and connectedness of supported initiatives in an environment of considerable security concerns and high political volatility;

(c) Assessed progress made in a human rights-based approach to programming and results-based management in an unstable context;

(d) Examined the country programme's alignment with and contribution to the UNICEF medium-term strategic plan (MTSP), Core Commitments for Children in emergencies and goals until 2015 (those of the Millennium Declaration and *A World Fit for Children*).

35. **Methodology.** The evaluation, which covered the current country programme of cooperation (2003-2005), took place at a general level, using strategic goals and a results-oriented approach as a reference and benchmark framework. It focused on four of the five objectives of the country programme, addressing challenges related to: (a) child and maternal mortality and morbidity; (b) malnutrition and micronutrient deficiency disorders; (c) improved school enrolment with a focus on girls' education; and (d) protection of children affected by war. With regard to the fifth objective, the country programme evaluation builds on the MTR report concerning progress made in mitigating widespread humanitarian crisis through preparedness and response. The evaluation has been a participatory process and key information was triangulated and validated with partners through workshops. A team of senior officers from UNICEF headquarters, the country office and an external consultant carried out the evaluation.

36. **Conclusions, lessons learned and recommendations.** The conclusions are reflected in the draft CPD (E/ICEF/2005/P/L.36) and the country programme management plan 2006-2008. The evaluation found that all four programme components were highly relevant to and well-focused on the situation of children and women where basic service coverage was very low and many children were victims of violence, abuse and exploitation. The country programme has contributed to significant increases in coverage in health, nutrition, water, sanitation and education services — a singular achievement in the context of the challenging programming environment in Afghanistan. A main challenge identified was the sustainability of results. Focused efforts to quickly achieve large-scale coverage competed with concerns for a more systematic management of programmes (e.g., routine immunization), quality of infrastructure and services (e.g., in water and sanitation, Back to School), development of institutions and social mobilization that are needed for sustainability. The human rights-based approach to programming and results-based management both need improvement.

37. The evaluation recommended that major interventions initiated under the current country programme should continue, but with greater emphasis on quality. Pilot experiences should be on a more limited scale and have the potential to feed workable, high-quality solutions into national policy development. Shifting implementation of programmes and projects to a more developmental approach, with challenges related to capacity-building and partnerships with other agencies will have implications that may involve a transfer of responsibility for implementation to the Government and/or from UNICEF staff at central level to field locations. An integrated long-term vision should be developed for the reduction of child and maternal mortality and morbidity and increasing national capacity-building.

38. In education, increased attention needs to be given to quality education and gender equality, rather than only to gender parity. Gender-sensitive education could improve the overall quality of education to align the programme with the objectives of the UNDAF and the new MTSP. The Government should be supported not only through increasing enrolment but also through promoting retention and completion, perhaps through a new slogan, "Stay in School". The next country programme should also focus on high-quality and low-cost construction of school buildings and on water supply and sanitation. Given the large numbers of children and adults who are too old to enrol in regular primary school, the country programme should demonstrate prototypes of non-formal education that could be replicated or

mainstreamed in national policies and strategies. The child protection component should emphasize capacity-building of government and other partners. It should establish a social observatory function that combines systematic research with advocacy and social mobilization to raise public knowledge and strengthen protection networks.

39. In order to fill the gaps in the human rights-based approach to programming, the next programme should ensure that the immediate underlying and structural causes of non-realization of human rights are understood and monitored and that appropriate strategies are formulated and implemented. Similarly, it should support the Government and civil society in designing and implementing strategies that empower girls and women and also involve boys and men in the process. The next country programme should follow a rights-based approach more closely.

40. The evaluation proved valuable input to the design of the next country programme (2006-2008) in terms of shaping the focus of different programme components, making the strategies more effective in moving from recovery to a more development orientation, and planning for a more human rights-based approach and results-based management. Actions are already planned for developing staff capacities and orientation on these aspects.

Mid-term review of rural hygiene, sanitation and water supply project (Government of Bangladesh, DFID and UNICEF)

41. **Purpose of the evaluation.** Fewer than 40 per cent of the rural population of Bangladesh have access to adequate sanitation. In 1999, the Government's Department of Public Health Engineering, with implementation assistance from UNICEF, launched the rural hygiene sanitation and water supply project. The purpose was to improve standards of hygiene practices and behaviour, particularly of the poor, on a sustainable basis while ensuring adequate sanitation and safe water supplies in low-water-table and saline areas and in the Chittagong Hill Tracts. This was to be achieved through: (a) increased awareness; (b) access to appropriate and safe sanitation and water supply technology; and (c) supportive institutions.

42. A project funding agreement for 26.9 million pounds sterling was signed with DFID. After a two-year inception period ending in 2001, the project commenced a development phase, to set up and demonstrate innovative models that can be scaled-up to meet the demands of the poorest people for water, sanitation and hygiene. The project is covering 1.6 million households within a population of about 8 million and is one of the world's largest hygiene-focused interventions.

43. The development phase, if successful, would be followed by an implementation phase extending the coverage to 35 of the 64 plain land and three Chittagong Hill Tract districts. A key challenge for the development phase, therefore, was to determine if the evidence justified the scaling up of the project. An MTR was carried out to provide: (a) an assessment of achievement against the project's logical framework; (b) an assessment of the factors that have constrained achievement and the extent to which they might be overcome through modifications to the implementation design and/or resources; (c) an assessment of achievement against the recommendation of the output to purpose reviews; and (d) key lessons including an assessment of the projects contribution to the achievement of the Millennium Development Goals for water and sanitation in Bangladesh.

44. **Methodology.** The review took place between 14 February and 3 March 2005. The team was selected and contracted by DFID. The review included a desk review of evaluations and studies commissioned by the project team; two output-to-purpose reviews carried out by DFID teams; quarterly and annual project reports; monitoring reports by an external agency; discussions with key partners; and field visits to Rangpur and Gaibandha districts for the purpose of assembling first-hand evidence and assessing whether this was consistent with other information. The Government/UNICEF project team gave the review team a comprehensive report on the achievements of the development phase.

45. **Conclusions, lessons learned and recommendations.** The review observed that the objectively verifiable indicators have largely been met and that a sufficient evidence base does exist to justify continued support by the Government and DFID. Three of the four outputs were rated as “likely to be largely achieved”, namely: (a) whole communities in project areas adopt and practice improved key hygiene behaviour; (b) whole communities in project areas have access to, use and maintain affordable safe excreta disposal options; and (c) whole communities have year-round access to and use adequate water for key hygiene and sanitation practices.

46. A fourth output, supportive institutional framework, functioning especially at the Union level, was rated “likely to be completely achieved”. This assessment was based on objectively verifiable indicators of logical frameworks that were revised as recommended by a previous purpose-to-output review, focusing sharply on the development phase. Consequently, the assessment was more positive than might normally be expected at the mid-point of a project. The revised logical frameworks were considered to be a great challenge and the MTR concluded that the project team has made considerable progress. Moreover, the project has demonstrated that it is capable of changing the hygiene behaviour of whole communities, an achievement that few hygiene and sanitation interventions have equalled. The review also scaled down the risk assessment from high to medium, based on a comprehensive risk analysis.

47. The MTR considered whether the progress is attributable to the project by considering two hypotheses: (a) progress in project areas is not considerably better than in non-project areas; and (b) project areas focused on upazillas (subdistricts) that were already more advanced at the start of the project. Evidence gathered in field visits enabled the review team to reject the first hypothesis. The second hypothesis was also rejected on the basis of an analysis of latrine coverage, which showed that although the coverage was higher at the base line in the project districts (28 per cent and 31 per cent compared to 20 per cent in non-project upazillas), the increase was much higher in project upazillas (21 per cent and 33 per cent) compared to non-project upazillas (6 per cent and 10 per cent). While recognizing that the sample size was too small for statistical significance for the first hypothesis, and that latrine coverage alone is an imperfect indicator, the review team considered the findings as indicating that the project had a positive impact on progress.

48. The lessons learned include a need to recognize and value the contributions made by project partners and to maximize the good relationship of UNICEF with the Government. Three best practices were noted: hygiene promotion as the primary focus; the Department of Public Health is delivering services based on community action planning; and independent monitoring and evaluation have led to project benefits. In programme management, DFID has moved from micromanagement to a

more hands-off approach which has been beneficial. When working with trusted partners that have adequate systems in place, quarterly reporting is of questionable value and adds to transaction costs.

49. The review made detailed recommendations for the design of the implementation phase, which have been thoroughly discussed by project partners. The main recommendations concern the outline design of the implementation phase and included a more sharply focused goal and a purpose that places added emphasis on the Millennium Development Goals and the Government's policies, including the new poverty reduction strategy paper. In order to sustain the improved outcomes, outputs were proposed to ensure that changes in hygiene behaviour are practised habitually and to clearly define the role of the public and private sectors in service provision. The project team is now using the MTR recommendations to guide the preparation of a five-year implementation phase.

50. The project's success lies in a strong partnership that was built gradually between UNICEF and the Department of Public Health and Engineering. The key contribution of UNICEF was to support the Department in adopting a planning process that enables communities to develop plans that feed into the higher-level plans, thus enabling a "bottom-up" process. A major input was substantial technical assistance, including the preparation of a detailed inception report, monitoring tools, communication tools, a manual of procedures and training. The Department and UNICEF jointly managed the project. Two national NGOs played an active role to provide training to all project stakeholders. Local NGOs provided the link to the communities, enabling them to voice their needs and make decisions through the preparation of community action plans. These plans resulted in a change of practice by the Department, which previously had subsidized water points mostly for those who could afford to pay for them. The community action plans led to more of the poorest communities receiving the subsidized water points and the sanitation and hygiene improvement inputs. Contributing to this process was a group of NGOs that trained nearly 4,500 community hygiene promoters and para-workers who systematically brought the communities' voices to the plans and ensured their participation in implementation and monitoring through community mapping of facilities and other techniques.

Health and injury survey: Bangladesh

51. **Purpose of the evaluation.** Bangladesh has made impressive progress in reducing child mortality in recent years, lowering the U5MR from 144 to 69 per 1,000 live births between 1990 and 2003. The primary reason for this achievement was the control of infectious diseases. However, the existence of injuries as another major cause of child deaths and disability had been suspected for some time but evidence was lacking. To fill this knowledge gap, the Bangladesh Health and Injury Survey was carried out by the Directorate General of Health Services and the Institute of Child and Mother Health under the Ministry of Health and Family Welfare, in collaboration with UNICEF and the Alliance for Safe Children.

52. **Methodology.** This comprehensive and well-designed survey had four components: (a) a cross-sectional national survey to assess the incidence of injury; (b) a case-control study to determine risk factors of drowning; (c) a behavioural study examining knowledge, attitude and practices related to injury; and (d) a risk

survey to examine the prevalence of certain risk factors for child injury in the home environment. With a sample of 171,366 households and a total surveyed population of 819,429, the cross-sectional survey was the largest injury survey ever performed in a country. The survey was conducted from January to December 2003.

53. **Conclusions, lessons learned.** The findings showed that there is a previously unrecognized epidemic of child injury in Bangladesh. Injury is the leading killer of children over one year of age. An estimated 30,000 children under 18 years of age die each year in Bangladesh - roughly 83 children per day. Injury accounts for 38 per cent of classifiable deaths in children aged 1-17 years. Injury-related mortality increases as children get older, rising from 2 per cent of deaths among infants to 29 per cent of deaths in children one to four years old, 48 per cent in children five to nine years old, 52 per cent in 10-14 year-olds, to as much as 64 per cent of the deaths of 15-17 year-olds. Non-fatal injuries are equally staggering. Almost 1 million injuries occurred in the year prior to the survey, meaning that each day, roughly 2,740 children were injured badly enough to require medical care or lose days of school or work. Injury leads to 13,000 permanent disabilities a year, mostly from falls. Boys are more prone than girls to non-fatal injuries – falls, burns, cuts, near drowning, animal bites, electrocution, etc., except poisoning. Injury was also the leading killer of the parents of Bangladeshi children. Each day, about 13 children lose their mother due to suicide, road traffic accidents and violence, and about 21 children lose their father from the same causes.

54. Injury is a stage-of-life issue and all children are to be considered at risk. The overwhelming issues in infancy are drowning and suffocation, whereas in early childhood it is drowning. In middle childhood and adolescence, there is a complex mix of injury issues with suicide taking over in late adolescence.

55. Drowning is the single largest cause of death of children after infancy, accounting for 26 per cent of deaths in children one to four years old. Drowning, road accidents, burns, falls, suffocations and intentional injuries affect children at different stages in their lives. Given the complexity of the problem, an effective response requires the broad integration of interventions for injury prevention, response and rehabilitation into child survival programmes in Bangladesh; environmental improvements to roads and around water; and technical innovations and legislative change to improve safety standards. It is important to focus programmatic efforts on under-five mortality but activities should not be limited to that age group since the gains made in one age group are lost in another as children mature. In view of this fact, the survey suggests that a new child mortality rate, including children up to age 17 years, should be included as a standard indicator for child survival programmes.

56. The lesson from this ground-breaking survey is that in order to continue the downward pressure on child death and morbidity, injury will have to be targeted as effectively as other causes of child death. Interventions for injury prevention, control and rehabilitation should be developed as integral parts of Bangladesh's development efforts. Injury is already one of the priority areas for action in the Health, Nutrition and Population Sector programme, and the findings led the UNICEF country programme to reorient its strategies toward a more cross-sectoral approach for the reduction of child mortality and morbidity. The next country programme (2006-2010) has as a key result that children are protected from injuries

and drowning, and through cross-sectoral strategies, will support the development of policies and pilot interventions.

Evaluation of Nepal's biannual preschool deworming programme

57. **Purpose of the evaluation.** According to national surveys, more than 50 per cent of preschool children in Nepal suffer from general malnutrition and 75 per cent are anaemic. Worm infestation is one of the major causes of the high prevalence of malnutrition. To address this problem, deworming of children aged two to five years with a single dose of Albendazole (400 milligrams) has been integrated with the community-based national vitamin A capsule distribution, which biannually reaches over 90 per cent of all children aged 6-59 months. The deworming component was integrated in 14 districts in 1999 and full national coverage was reached in October 2004.

58. **Methodology.** In 2003, an evaluation was conducted jointly by WHO and UNICEF to assess the impact and effectiveness of the programme. The evaluation involved pre- and post-intervention cross-sectional surveys in four districts. Baseline data were collected prior to April 2003, when deworming was integrated for the first time in those districts. This evaluation provided better insight into the causes of malnutrition and the effectiveness of this method to help address it.

59. **Conclusions, lessons learned and recommendations.** The evaluation found that the intervention has succeeded in deworming more than 85 per cent of children in all four rounds. With each round of deworming, the prevalence of the infection has progressively declined. At baseline, about 40 per cent of the children were infected and after the fourth round of deworming, the prevalence had decreased to 16 per cent. Significant reductions were also seen in the intensity of worm infection. The mean load of roundworms decreased from 4,330 eggs per gram in the baseline to 463 eggs per gram after the fourth round of deworming, a total reduction of 90 per cent. Similarly, the mean load of hookworm infection decreased by 50 per cent.

60. With the decline in worm infection, anaemia status showed great progress. The 47-per-cent prevalence of anaemia at baseline decreased to 29 per cent after the first round of deworming and to 11 per cent after the second round. After the third and fourth rounds, the prevalence remained the same. The mean haemoglobin level also increased from 11.0 grams per decilitre to 11.4 to 12.2 after the first and second rounds of deworming. The impact was highest in reducing severe and moderate anaemia. Compared to the baseline, severe anaemia has virtually disappeared and moderate anaemia has sharply declined. After the second round of deworming, most of the anaemia cases were mild.

61. The cost for integrating deworming with the biannual vitamin A supplementation was 17 cents per child. After the integration, the only recurring cost is the cost of deworming tablets of 2 cents per child per year (two rounds). After an initial cost-sharing arrangement with UNICEF, the Government has now taken full responsibility for procurement of deworming drugs.

62. The findings of the impact evaluation show that deworming is highly successful in terms of outreach, coverage and impact and that biannual deworming is one of the most cost-effective health interventions in Nepal. The evaluation also noted that deworming had not disturbed or negatively affected the coverage of the

vitamin A supplementation. On the contrary, focus group discussions with community volunteers and mothers showed that deworming during the vitamin A distribution had made the distribution event more popular.

63. The deworming component initially targeted children aged two to five years. Based on the fact that the evaluation found that deworming reduced anaemia in all age groups, the Ministry of Health lowered the age limit for deworming to one year as per the recommendation of WHO. In the October 2004 distribution round, about 2.8 million children aged one to five years were dewormed, which included an additional of 90,000 one-year-old children.

64. The evaluation confirmed that in a country with a high prevalence of worm infestation, biannual deworming implemented through a nationwide programme is a successful and highly cost-effective intervention. Deworming can be easily integrated into a well-functioning vitamin A supplementation programme. As more than 60 countries are presently conducting vitamin A supplementation, most with high coverage, there is potential to address the problem of worm infection on a global scale.

65. The results of the impact evaluation in Nepal have been used extensively to advocate for deworming in general and integration with vitamin A supplementation specifically. The findings have been shared in several international conferences and were included in a WHO/UNICEF joint statement on deworming of preschool children. The Nepal experience was also used as a concrete example in a WHO/UNICEF manual on integration of deworming into vitamin A distribution. Countries in West Africa are already considering adopting this procedure.

66. This effective low-cost initiative was built on an existing robust project where the Government of Nepal, UNICEF, USAID and UNFPA shared the costs of the female community health workers programme. Later, vitamin A distribution was added to this programme with support from USAID and UNICEF, and later by the Australian Agency for International Development. Based on a successful experience in Lucknow India, UNICEF proposed adding deworming along with vitamin A distribution. This was funded by the government of Nepal and UNICEF throughout the country. In addition to funding, UNICEF, in close collaboration with WHO, provided technical assistance for training which is now completed, leaving only the drugs as recurrent costs.

Strengthening the evaluation function in the region

67. One key issue identified as essential for improving the evaluation function in the region is the need to clearly articulate the expected results of evaluations. The MTR is now used as an opportunity for country offices, partners and the Regional Office to review the existing results frameworks and modify them along with a logical framework analysis, where needed. A second issue was the absence of baseline surveys and continual monitoring of data. Country offices have been addressing this issue and are increasingly doing so. Some good examples are Nepal's Decentralized Action for Children and Women programme, under which periodic mini-surveys are conducted; and Bangladesh's rural sanitation, water supply, hygiene and sanitation project, where baselines were established and results-based monitoring fed into implementation decisions.

68. Improving the quality of evaluations has been a challenge. In order to raise awareness of quality standards, the meetings of the regional monitoring and evaluation network have been used to discuss and agree on procedures for using standards of evaluation and of evaluation reports. It has been agreed that conformity to these standards will be a requirement of any consultancy for evaluations. An analysis of evaluations submitted to the Regional Office, using the assessments carried out by the Evaluation Office, has shown a small increase in overall quality. The areas of common weaknesses related to the assessments of the use of results-based management and human rights-based approaches to programming, stakeholder participation, gathering views of non-beneficiaries, cost analysis and use of lessons to prioritize actions. These findings have been communicated to the monitoring and evaluation officers and a one-day training session on standards was conducted at the 2004 regional meeting, with assistance from the Evaluation Office. The findings of the global meta-evaluation conducted by the Evaluation Office were presented to the Regional Management Team (RMT).

Conclusion

69. The year 2004 saw three MTRs, the results of which have already been utilized to sharpen the focus and strengthen the strategies in UNICEF-supported country programmes. There was also a significant effort to align more clearly the expected results with UNDAFs, the Millennium Development Goals and national plans.

70. The attention to the evaluation function has been strengthened. Several good evaluations have been carried out and there are good examples of evaluation findings being used in making adjustments to programmes.

71. More needs to be done both in terms of quality of evaluations and utilization of findings and recommendations. Enhancing the management response to evaluations will be a priority through RMT meetings, a process that has already begun. Targets related to quality assurance of evaluations and the management response, have been included in the Regional Office's Management Plan for 2005-2006. A draft regional evaluation plan, to be finalized in consultation with the RMT, identifies regional evaluation priorities and actions for quality assurance, supporting the evaluation function and overseeing the accountabilities at the country level. Support to national capacity-building and regional forums for evaluation will be a strong focus for sustainability of the function.

72. Based on the office management plan targets and the regional evaluation plan, a set of criteria will be agreed with the RMT and used to strengthen the evaluation function. A constraint to performing the evaluation function has been the limited human and technical capacities. A competency-based recruitment procedure will be established and capacity development for monitoring and evaluation will be accorded high priority. A regional roster of evaluation consultants is being set up. The Regional Office's capacities will also be strengthened for building evaluation capacities in the region.