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

Eastern and Southern 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 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 major evaluations described in the present report were conducted during 2001.

Introduction

1. In 2001, the Eastern and Southern Africa region (ESAR) conducted mid-term reviews (MTRs) in Angola, Botswana and Kenya. Major country programme evaluations included an end-of-programme evaluation for Mauritius, a country in transition; and end-of-programme cycle reviews in Eritrea and Lesotho. Many programme-level evaluations provided lessons learned on implementation of the human rights-based approach to programming and community capacity development. These are summarized following the structure of the five corporate priority areas in the medium-term strategic plan (MTSP). A concluding section presents key regional lessons learned from the Eastern and Southern Africa Regional Office (ESARO) end-decade review.

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Country mid-term reviews

Angola

2. **Process and methodology**. The MTR of the 1999-2003 programme of cooperation (E/ICEF/1998/P/L.8/Add.1) was led by the Vice-Minister of Planning and managed by a coordinating group involving relevant line ministries. Working groups on sectoral programmes were formed with the Government, UNICEF and other partners. One youth meeting and seven provincial meetings were held, at which representatives of both groups presented their findings and recommendations to the MTR meeting.

3. **The situation of children and women**. The programme of cooperation began shortly after the renewed conflict in 1998. By 2001, the number of displaced persons had increased from 3 million to 4 million, with about 100,000 children living outside their family environments. An estimated 1,500 people lost their lives or were maimed by anti-personnel landmines. The Household Income and Expenditure Survey showed that more than 60 per cent of families were living below the poverty line. Results of sero-prevalence studies on pregnant women in Luanda show a sharp increase from 3.4 to 8.6 per cent in 2001. Fifty-three per cent of children less than five years old are stunted, and less than 20 per cent are fully immunized. Only 5 per cent of births are registered. Three million children do not have legal citizenship status and, therefore, cannot enrol in schools. Seventy-eight per cent of adolescent girls have less than a grade 2 education. Social spending remains below 15 per cent of the total. An interim Poverty Reduction Strategy Paper (PRSP), drafted in February 2001, has yet to be finalized.

4. **Achievements and constraints**. The programme of cooperation incorrectly assumed that the Lusaka peace process would be effective. Nevertheless, the programme did adjust to these realities and made good progress in the areas of nutrition rehabilitation for internally displaced persons (IDPs) and providing increased attention to child protection issues. A Children's Parliament successfully gave profile and voice to children's issues. Hand-pump operations have been decentralized. Participatory methodology for behavioural change and hygiene practices has led to improvement in the management of water systems and health facilities by communities.

5. There has been good progress in integrating the mine awareness programme in the school curriculum. The target of training non-governmental organization (NGO) staff and teachers was partially met. The routine immunization programme is still weak, as large parts of the country are inaccessible due to the conflict, but quality tools are being used for polio eradication, including digital maps to the commune level. Significant demand has been created for the use of mosquito nets to prevent malaria infection. The teacher emergency package project has expanded slowly. Financially, there has been a substantial increase in UNICEF assistance over the period of the programme.

6. **Assessment of programme strategies: lessons learned**. The MTR recommended that the programme should focus on a few key areas for greater impact. In line with the draft United Nations Common Country Assessment (CCA), the country programme should define new strategies to deal with the root causes of the current health and nutrition situations resulting from poverty and conflict.

HIV/AIDS needs to be addressed explicitly in the revised programme. Cooperation with NGOs, especially at the subnational level, and the private sector was very positive and contributed significantly to the results achieved. A lack of contingency stocks affected the ability to respond rapidly to serious emergencies, such as the measles outbreak. Participatory methods have proved successful in the areas of hygiene, water and health services, and were clearly endorsed by the young people who participated in the MTR process. Youth participation needs to go beyond the successful Children's Parliament to be effective at all levels.

7. **Country programme management plan (CPMP)**. The CPMP will reflect the need for a new emphasis on HIV/AIDS and on achieving a mu1tisectoral approach to programmes. There will be an increased focus on the participation of children and youth. The status of the field offices will also be regularized to ensure adequate contact with partners at the provincial level and below.

Botswana

8. **Process and methodology**. The Ministry of Finance and Development Planning chaired the Joint Planning Committee. Thematic working groups were established around three developmental age groups of the child: from 0-6 years old; from 6-12 years old; and from 12-18 years old. Working groups were multisectoral and involved government ministries, NGOs, United Nations agencies and donors. Both the original country programme and the amendment were reviewed. The MTR meeting for the 2000-2002 programme (E/ICEF/1999/P/L.17), involving over 60 participants from the Government, the United Nations, NGOs, donors and youth, approved the findings and recommendations of the working groups.

9. **The situation of children and women**. In Botswana, 98 per cent of urban and 85 per cent of rural populations have access health services, over 90 per cent of the population have safe water, and the net primary school enrolment is 98 per cent. However, Botswana has one of the fastest growing HIV infection rates and the highest prevalence of HIV in the world. HIV prevalence among pregnant women attending antenatal clinic ranges from 30 to 53 per cent. Deaths among teachers increased 60 per cent from 1994 to 1999, due mostly to AIDS. Up to 80 per cent of adults and over 30 per cent of children in some hospital wards have HIV-related conditions. There are about 78,000 orphaned children below the age of 15 years. The infant mortality rate (IMR) increased from 37 per 1,000 live births in 1988 to 57 in 2000. United Nations Development Programme (UNDP) projects that IMR will increase to 148 per 1,000 live births by 2010 because of the HIV epidemic. The under-five mortality rate (U5MR) declined from 53 per 1,000 live births in 1988 to 45 in 1996, but increased to 75 in 2000. Life expectancy declined from 65 years in 1997-1998 to 46 in 2000.

10. **Achievements and constraints**. From July 2000, the prevention of mother-to-child transmission (MTCT) programme expanded from two pilot communities to seven. It planned to cover all 23 districts by the end of 2001. UNICEF, a lead partner with the Government, provides technical, financial and material (including anti-retroviral drugs) assistance. Forty-five per cent of women attending antenatal care agree to participate in counselling and testing. All district health teams were trained to improve programme management and service delivery, but implementation of the safe motherhood and Integrated Management of Childhood Illness programmes was slow. UNICEF

involvement in early childhood education (ECE) was limited to providing technical support for the development of curriculum oriented to minority language groups in remote areas.

11. **Assessment of programme strategies: lessons learned**. The programme strategy adopted by the country office of "assessment-analysis-action (pilot, demonstrate and mainstream)", a rights-based "triple A" process, was an inadequate scale of response to the HIV/AIDS epidemic. HIV/AIDS requires an accelerated national response, and the triple A process must be implemented at the national level. The MTR endorsed the adoption of strategies focusing on national coverage of programmes. The social mobilization strategy focused on private sector coalitions and established useful partnerships with communities in programme design and implementation. HIV/AIDS requires the involvement of communities and adolescents. Community capacity needs strengthening. While some activities to strengthen national-level capacity were implemented, further efforts will be needed.

12. **CPMP**. MTR recommendations emphasized that UNICEF should strengthen its financial and technical capacities to effectively support the Government and communities in fighting HIV/AIDS. The country programme structure remains unchanged except in the education programme, which adds two projects — ECE and primary school transformation. Although the country programme is structured by sectors, implementation will focus on the three developmental stages of the child — 0-6, 6-12 and 12-18 years old.

Kenya

13. **Process and methodology**. The MTR of the 1999-2003 country programme (E/ICEF/1998/P/L.10/Add.1) was launched with the Ministry of Finance and Planning. It had five thematic groups: (a) young children; (b) rights of school-age children; (c) district and community capacity development; (d) social mobilization for rights; and (e) emergency and development. The review process included national and district governments, non-governmental and civil society organizations, United Nations partners and donors. A key decision was to reflect a joint commitment to human rights. Programme reviews held at national, district and community levels included children's and women's perspectives.

14. **The situation of children and women**. The situation has deteriorated since 1998. One half of all Kenyans now live below the poverty line; most cannot afford basic services. HIV/AIDS was declared a national disaster. Under-five mortality and malnutrition among children are rising. There is progress on achieving gender parity in primary education, but enrolment and retention rates fell in some areas. There are 14,000 vacancies for primary school teachers, due mainly to HIV/AIDS. The worst drought in 60 years affected over 4 million people.

15. **Achievements and constraints**. The Children's Bill was passed in 2001 with UNICEF assistance. Its provisions include national guidelines on children's welfare, legal assistance, custody and care of children, foster care, guardianship and adoption. It creates the National Council of Children's Services and establishes Children's Courts to hear cases regarding parental responsibility, children's institutions, custody, maintenance and guardianship.

16. The programme contributed to achievements in immunization, supplementary feeding, the provision of school materials, water point construction and information, education and communication (IEC) materials. In drought areas, emergency assistance reduced malnutrition levels. Progress in capacity-building and advocacy was harder to assess, partly because the master plan of operations (MPO) goals were insufficiently specific or measurable.

17. **Assessment of programme strategies: lessons learned**. Commitments made at district and community levels have often not been kept with regard to support for capacity-building and the delivery of services. A major lesson learned was that programme resources are insufficient for quality implementation in all 19 districts as envisaged in the MPO. The decentralized strategy of the MTR proposes a more focused engagement, with a small number of "learning districts". In these pilot learning districts, direct service delivery will take place in selected communities in an integrated way.

18. **CPMP**. Project-level reorientation will avoid vertical and sectoral implementation, the marginalization of advocacy and the inadequate evaluation of programmes. Emphasis will be on community capacity development, decentralization and cost-sharing. The focus will be on geographically integrated, cross-sectoral interventions, including HIV/AIDS, which will be allocated 60 per cent of resources. The programme will implement policies to realize children's rights in selected communities in the "learning districts". In those districts, there will be community-level support to a wide range of the MTSP priority areas, including service delivery. District administrative and management capacity and work-planning processes will be strengthened.

End-of-programme cycle evaluations and reviews

Mauritius

19. **Process and methodology**. The thresholds of gross national product (GNP) of $2,895 per capita and U5MR less than 30 per 1,000 live births were reached in the early 1990s. In 1997, the Executive Board decided to gradually phase out regular resources allocations in such countries. The 1996-2000 country programme was evaluated to yield lessons for the 2001-2003 programme of transition to zero regular resources (E/ICEF/2000/P/L.31) and to address challenges arising from the gradual modification of the UNICEF presence.

20. **The situation of children and women**. Mauritius has an exemplary record of economic and social development. However, major disparities still persist in terms of early childhood development (ECD), education pass rates and child protection.

21. **Achievements and constraints**. The country programme was designed to address World Summit for Children/National Programme of Action (WSC/NPA) goals. It focused on health and education. The 1998 MTR reformulated the country programme to a rights-based programming approach, taking into account new government policies, and with a greatly reduced focus on the WSC/NPA goals, which had largely been achieved. Protection issues were only partially addressed, and disparities received inadequate attention. There was an increased focus on ECD and adolescents.

22. The Government and civil society demonstrated their commitment to the fulfilment of children's rights, but some innovative activities were dependent solely on UNICEF funding (e.g. child protection). UNICEF served as a catalyst, with a focused child-centred and intersectoral approach, a function that needs to be ensured on a continuous basis. This would require the strengthening of some government services, e.g. the Ministry of Women's Rights, Child Development and Family Welfare. Civil society was not sufficiently involved, and the participation of the private sector was not fully ensured.

23. **Assessment of programme strategies: lessons learned**. The previous and current country programmes were in line with national and UNICEF policies. Strengthening of coordination and cooperation within the CCA/United Nations Development Assistance Framework was largely successful. Goals were often over-ambitious, especially those involving training programmes. The evaluation showed positive results in terms of outputs, outcomes, impact and fulfilment of rights. Some programme components could not go to scale owing to a lack of policy decisions, national budget allocations and availability of qualified staff.

24. The evaluation concluded that a more gradual transition would allow Mauritius to better address the broad commitments and responsibilities involved in the realization of children's rights. Economic and social indicators (GNP per capita and U5MR) suggest that capacities exist, but key issues of unfulfilled rights still need to be identified (situation analysis), articulated (social mobilization and advocacy) and eventually addressed (identification of actors). These functions are normally part of a UNICEF-supported country programme. The current 2001-2003 transitional programme should focus on support to the creation and development of a national body to assume these functions. The evaluation recommended a continued UNICEF presence to pursue issues related to children's and women's rights beyond 2003, in some modified form, with all feasible possibilities being considered.

25. **CPMP**. Major changes in the country programme structure were introduced originally by the 1998 MTR, which reformulated the country programme along guidelines of a rights-based programming approach, taking into account new government policies and strategies. The new transitional 2001-2003 country programme modified only slightly the revised structure of the previous cycle by including an institutional capacity-building strategy in the child rights promotion and realization programme. The focus of the two other cross-sectoral programmes — ECD and adolescent development — remained unchanged. Options for optimizing the transition in Mauritius, as analysed in the evaluation report, will be discussed among all national stakeholders and UNICEF, with the aim of fine-tuning the strategy for modifying the presence of UNICEF in the country after 2003.

Eritrea

26. Eritrea conducted an evaluation of the 1996-2000 country programme (E/ICEF/1995/P/L.11). The report is not yet finalized, but includes the following lessons learned. Public sector staff shortages are acute due to the war. The failure to identify an appropriate partner adversely affected implementation of some programmes. Good progress was made with iodized salt, and traditional birth attendants (TBAs) are providing valuable services without reliable income. The use of community-based feeder schools resulted in an increased rate of successful

transition to the next level of the education system by increasing access. In operations, the training of counterparts in liquidation procedures was helpful in reducing non-liquidated cash assistance to Government.

Lesotho

27. The review of the 1997-2001 Lesotho country programme (E/ICEF/1996/P/L.2/Add.1) included over 50 partners and stakeholders, and used log-frame tools. HIV/AIDS prevalence among adults is now 26 per cent. The numbers of orphans and child-headed households have increased. IMR and U5MR are stagnant, and immunization coverage has worsened. Net enrolment rates declined from 76 per cent in 1993 to 60 per cent in 1997. The subsequent introduction of free primary education resulted in an increase in net primary enrolment from 63 to 71 per cent. There was a more dramatic increase in Standard One enrolment, although drop-out rates remain high. UNICEF advocacy contributed to the development of child protection legislation, ECD and non-formal education policies, an HIV/AIDS policy and strategic plan, and youth and gender policies. Children with disabilities were integrated in 30 more schools. Local infrastructure was developed through community capacity-building, which now needs public sector support. The country programme objective of community participation was not fully achievable.

28. The general direction of the new country programme should stress rights-based programming and results-based management, with an emphasis on advocacy, social mobilization and going to scale. HIV/AIDS remains the number one priority; community ownership and sustainability of projects can increase access to services. The successful processes used in universal salt iodination and the nutrition baseline analysis can be applied to other activities. The programme will continue to have four vertical programmes, with some realignment of projects. New priority areas in the next country programme will be an integrated approach to early childhood care and development, adolescent development, protection and social policy development.

Major programme-level evaluations

29. The evaluation strategy approved by the ESARO Regional Management Team began in 1996. It focuses on evaluation planning, the dissemination of lessons learned and capacity development. All countries have Integrated Monitoring and Evaluation Plans, which are updated during MTR processes and, in some countries, annually. ESARO promotes the publication and dissemination of evaluation results. One major evaluation was recently published in the journal “Evaluation and Program Planning”. Twelve rights-based programme evaluations on HIV/AIDS will be published in August 2002. Capacity development in evaluation was supported through a training workshop on emergency evaluation as well as through support to 12 national networks of evaluators and leadership of the inter-agency African Evaluation Association.

30. In ESAR, HIV/AIDS is the most pressing of the five organizational priorities of the MTSP (girls’ education, integrated ECD, immunization “plus”, fighting HIV/AIDS and protection of children from violence, abuse, exploitation and discrimination). An assessment of regional-level progress, based on the “Regional end-decade progress report” evaluation, precedes the programme-level evaluations described in each of these priority areas.

MTSP priority area 1: Girls' education

31. Net primary school enrolment in ESAR grew from 60 to 86 per cent during the last decade. Botswana, Kenya, Mauritius, Seychelles and Swaziland maintained enrolment of 91 to 100 per cent for both sexes, while Malawi and Uganda made significant improvements. Female enrolment jumped from 57 per cent in 1990 to 83 per cent in 1999. The highest percentages of out-of-school girls are in the Horn of Africa and post- or current emergency countries. Eight of the 22 countries in ESAR have gender parity in enrolment. The probability of a child entering grade 1 and reaching grade 5 increased in five countries, but decreased in another five. Seven countries are on target for 80 per cent of children realizing primary education rights.

32. A baseline study in **Comoros**, undertaken by the United Nations Educational, Scientific and Cultural Organization and UNICEF, identified practical action points for improving the quality, equity and efficacy of the education system, and optimizing the use of resources. Aspects studied included formal and informal education, staffing and curriculum. Forty-nine per cent of schools lacked water, electricity and toilets, and were poorly attended. Canteen services were inadequate to address malnutrition problems. Fifty-nine per cent of schools and 32 per cent of students lacked textbooks. School directors and 59 per cent of teachers were inadequately trained. Instructional materials were worn out by the widespread practice of doubling numbers of students. Over 70 per cent of students had illiterate mothers and 18 per cent had only one meal per day. Scores on standardized tests were very low, with wide discrepancies between areas and by gender. More female teachers are needed to encourage the education of girls.

33. In **Namibia**, a field assessment of attitudes and work ethics of teachers was conducted to find ways to improve morale. The study methodology included a desk review, 6 school visits, observations of 31 teachers at work, 32 in-depth interviews, focus group discussions and questionnaires filled out by teachers in 57 schools. Teachers and principals were committed and hardworking, but lacked job satisfaction, were demoralized and felt neglected by their superiors. Work ethics were good, as demonstrated by the rarity of absenteeism, doing private business while at school, not preparing for lessons or using corporal punishment. Lessons learned include that schools in towns furthest from the main roads performed poorest (for reasons, see paragraphs 40-42 below on the Tanzanian pro-poor expenditure study). Effective, performance-related remuneration and the provision of practical advice on how to discipline students are needed.

34. In the **United Republic of Tanzania**, three studies looked at achievements and constraints in education. One study found that boys were commonly given preference over girls in both primary education and complementary basic education. At school, girls have lower performance, are less confident and communicate less with teachers. Another study created a model and indicators to measure the quality of education, and developed an effective and accurate monitoring mechanism. It highlighted the need for a vision of what should be achieved, and appropriate policies and plans for effective leadership in a supportive environment. Examination systems must be free from information leaks and favouritism. All types of intelligence and abilities (including music and construction-building skills) should be recognized and developed. The third study, published in the journal "Evaluation and Program Planning" in 2002, found that school mapping has a positive impact on enrolment, attendance, reducing drop-out rates, decision-making and planning. It is

a valuable tool for ongoing assessment, analysis and action, and for reductions in disparities in rights.

MTSP priority area 2: Integrated ECD

35. In ESAR, median IMR declined by 21 per cent from 102 to 82 per 1,000 live births over the decade. Median U5MR declined by 15 per cent from 155 to 135 per 1,000 live births. More recently, these mortality rates have been rising again as a result of the HIV/AIDS epidemic. Data on maternal mortality is incomplete, but apparently there were slow declines in the region. Seven countries may still have maternal mortality ratios (MMRs) of 1,000 per 100,000 live births or more (five of these have no data since 1990).

36. About one third of the children in the region are under weight. Stunting varies widely, from 5 per cent in the Seychelles and 10 per cent in Mauritius, to over 50 per cent in Angola and Ethiopia. The majority of countries report either no change or worsening malnutrition over the decade. The worst wasting is in the Horn of Africa and Botswana. Iodized salt consumption has risen very rapidly, and the median level is now over 70 per cent. In six countries it is over 80 per cent. Only five countries achieved the target of having only 10 per cent or fewer births of infants weighing below 2,500 grams.

37. One half of the countries in the region increased access to improved water; most recorded dramatic improvements when the definition was changed in 1999 from safe to improved water. Nevertheless, only 57 per cent had improved water in 1999. Ten different countries achieved increases in access to safe sanitation facilities, with the regional median rising. There are, as yet, no systematically collected indicators of child psychosocial and cognitive development, although a number of community-level indicators and systems are being piloted.

38. A **South African** evaluation assessed the behavioural change component of water supply and sanitation in 378 schools. Access to adequate sanitary facilities in schools ranged from 5 to 40 per cent; most of those in the 40 per cent range were urban and peri-urban. Access to water for hand-washing varied from 10 to 30 per cent. Teachers locked toilets for their exclusive use. Boys objected to girls using facilities. They did not want “girl problems” brought into their facilities. Boys and teachers assaulted girls in the toilets. Girls were ridiculed when walking to the toilet. They could not wash up during their menstrual cycle so they missed school. Girls feared physical abuse from their parents when they reported problems. Children need training in decision-making, creative and critical thinking, self-awareness and empathy, coping with difficulties, communication, interpersonal skills, relationships and responsibilities.

39. In the **United Republic of Tanzania**, an evaluation of the safe motherhood project, supported by UNICEF and the Norwegian Agency for International Development, assessed whether the project attained its aims of increasing advocacy activities, improving services for mothers, and expanding family life education and family planning. The evaluation methodology included desk reviews, site visits to project and non-project areas, in-depth interviews and focus group discussions. Participants included staff members, men, women (including pregnant women), village health workers, local leaders and TBAs. Lessons learned on realizing women’s rights included the need to learn more about the causes of maternal

mortality, the need to bring emergency obstetric care closer to women, and the gains from expanding and refining the role of TBAs.

40. A study in the **United Republic of Tanzania** evaluated flows of pro-poor Government expenditure in eight priority sectors. A desk review was followed by a multi-level survey of government, local council and grass-roots stakeholders. Interviews were conducted in remote and non-remote primary schools and health facilities, and with direct beneficiaries.

41. It was found that the budget system treats salary expenditures as a primary item and considers non-salary expenditures as a residual item. As a result, non-salary expenditures on vitally needed equipment are often inadequately funded and may be distributed on a sporadic and unreliable basis. This irregular disbursement has promoted losses, especially at the subnational level. Because sectoral heads in local authorities do not know how much funding they are supposed to receive or when it will arrive, reallocations and losses can occur without their knowledge.

42. Perhaps in response to budget cuts, sectoral heads themselves have reallocated non-salary funds in favour of activities that benefit the council staff at headquarters at the expense of service units. Travel and vehicles are favoured at the expense of school materials and medical drugs. Schools and health service units that are more remote tend to receive less funds and supplies the more remote they are. However, the system for the distribution of drugs to remote health service units is more reliable than that for other supplies.

43. Contrary to conventional wisdom that goitre does not affect populations that consume large amounts of seafood, goitre does occur in the **Zanzibar** islands. A survey assessed goitre prevalence in 11,967 students and the availability and utilization of iodized salt in 15,842 households. Salt samples were taken from 121 salt traders. Focus group discussions were held in 27 villages and involved 546 participants, including teachers, parents and village leaders. On Unguja, 59 per cent of salt traders carried iodized salt and 64 per cent of homes had iodized salt. On Pemba, only 3 per cent of traders carried iodized salt and only 1 per cent of homes had it. Only 32 per cent of the salt traders had ever heard of problems with iodine deficiency disorders.

44. In **Zimbabwe**, two water and environmental sanitation projects were evaluated: an integrated rural water supply and sanitation project and a community-based management of water project. The evaluations used desk studies, site visits, interviews with key informants, community focus group discussions, mapping and feedback. The first project provided and rehabilitated water and sanitation facilities. Most water goals were met or exceeded. Many households drilled boreholes at their own expense. Sanitation targets were exceeded. Diarrhoeal incidence decreased. Community ownership of the water and sanitation facilities increased, but less than one half of the villages had toolkits to make repairs. The community-based management project enabled communities to plan and manage their own water systems, dramatically reduce the time when the water system is non-operational, rehabilitate 25 per cent of the non-functioning water points, and improve hygiene behaviour in 60 per cent of the population. Unlike the first project, the community-based management project found that communities are prepared to buy spare parts and to maintain their water facilities. Lessons learned included successes in cost-sharing, responsibility for school water and sanitation, and the inclusion of innovative technologies. Communities adapted community-based management to other programmes such as schools and HIV/AIDS.

MTSP priority area 3: Immunization "plus"

45. Vaccine coverage in the region started the 1990s with only one country — Mauritius — reaching the WSC target of 90 per cent coverage with combined diphtheria/pertussus/tetanus vaccine. By 1999, four more countries were exceeding the goal. In some countries, though, coverage worsened. The highest coverage rates are for tuberculosis (regional median 87 per cent), while the lowest rates are for neonatal tetanus (regional median 53 per cent). Median measles vaccine coverage for ESAR began the decade at 75 per cent, declined to 63 per cent by 1997, and finished the decade at 72 per cent. Emergencies and conflicts accounted for a great deal of the annual fluctuations.

46. Immunization coverage in **Burundi** dropped from 86 per cent in 1990 to 60 per cent in 2001. An evaluation of the vaccine logistical system in Burundi outlined a national supply plan for vaccines and other consumables, described an effective monitoring and electronic database system, inventoried equipment, and recommended a plan for rehabilitation and maintenance. The report made recommendations on the choice and use of supplies, the introduction of a national policy on safe disposal, the introduction of new cold-chain appliances, and the choice of transport methods. It concluded that $2.3 million are needed for the expanded programme on immunization (EPI) logistical system.

MTSP priority area 4: Fighting HIV/AIDS

47. The region is seriously affected by the HIV/AIDS epidemic, with 17.6 million adults and children infected in 1999, including 9.3 million women of reproductive age and 0.7 million children aged 0-14 years. Eight countries reported an adult prevalence of less than 10 per cent, but at the other extreme, 36 per cent of the population of Botswana are HIV positive, and South Africa has 4.1 million people (20 per cent) known to be infected. In seven countries, one fifth of the population are infected. It is estimated that 8.2 million children in ESAR are orphaned, most from HIV/AIDS. Regionally, the knowledge about transmission is high, but behaviour change lags behind. Knowledge of at least one way to prevent MTCT is high, although in Burundi and Somalia, it is known by less than 50 per cent of women.

48. An evaluation of a scaled up prevention of MTCT programme in **Botswana** included a cross-sectional study of infant feeding practices, and the perceptions and participation of mothers and health workers. Among HIV-positive mothers who chose formula feeding, 89 per cent formula-fed exclusively; only 20 per cent of those choosing breastfeeding did so exclusively. One problem was that mothers received little advice on abrupt cessation of breastfeeding. Mothers who weaned experienced health problems and criticism. Health workers' knowledge of HIV, of transmission and of counselling was poor. There may have been a negative spill-over effect (non-infected and non-tested mothers at programme sites had much higher rates of formula feeding than women in non-programme sites). Some recommendations were the same as those in the 2000 pilot study evaluation, i.e. to increase staff knowledge and counselling skills, improve IEC given to mothers, increase community awareness and support, strengthen monitoring, and review policies and protocols.

49. In **Mozambique**, a cost-benefit analysis of a prevention of MTCT programme used the methodology of the Joint United Nations Programme on HIV/AIDS. Costs

examined included those of treating an HIV-positive child, improving maternal and child health services, counselling and voluntary testing, treatment with nevirapine and providing substitute milk. The analysis considered the costs of implementing these different components in one city. When costs are subtracted from benefits, the net costs of programme components vary from zero to $156,712 per year, depending on the scenario adopted. Some 140 deaths per year would be averted in the city. The most expensive scenario included increased health staff and substitute milk. The authors advise that, although expensive, increased health facility staff would result in potential unmeasured, additional benefits: lower rates of horizontal transmission of HIV; better care for pregnant women and lower MMR; and better birth spacing and family planning.

MTSP priority area 5: Protection of children from violence, abuse, exploitation and discrimination

50. The situation of children affected by armed conflict in ESAR did not improve. There are about 2 million refugee children and about 4 million IDP children. Children are recruited in large numbers in the Great Lakes area. There are about 14,000 child soldiers in Burundi and 7,000 in Angola. There were some marked successes. In south Sudan, UNICEF and its Sudan People's Liberation Movement/ Army and NGO partners demobilized more that 4,164 child soldiers during 2001. The African Charter on the Rights and Welfare of the Child and the Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict came into force in February 2002. To date, only Kenya has ratified the Optional Protocol, although seven other countries have signed it. More countries are expected to confirm their commitment to this important tool for protecting children at the United Nations Special Session on Children, to be held from 8 to 10 May 2002.

51. **Eritrea** assessed psychosocial capacity in orphanages using group discussions and interviews. Most orphans said that the care they received made them more optimistic about their future and enabled them to pursue their goals with hope and confidence. Psychosocial capacity in orphanages is almost non-existent, and no formal mechanisms exist for the development of psychosocial services.

52. In **South Africa**, violence against women and girls is widespread in communities and schools, with seriously inadequate responses from schools and the legal system. Case studies of eight schools in four districts assessed the nature and dynamics of violence against girls in schools, examined school responses and identified key areas for interventions. The study included urban and rural townships where most people are black, a "coloured" township, and a former white urban setting. The methods used were participant observation and 304 single and group interviews. Documentary data, such as school rules, and codes of conduct were collected and reviewed. The study led to changes in the programme for the promotion of girls' education rights, the prevention of HIV/AIDS, and the protection of children from violence, discrimination and abuse.

53. **Uganda** implemented an extensive literature review on orphans followed by a field survey of 326 households with orphans in eight districts and a study of gaps in care. HIV/AIDS was the leading cause of children being orphaned. Considerable resources are available, but they reach only a small proportion of households in need. The formulation of a specific policy on orphans and implementation of existing legal frameworks to fulfil rights was recommended.

ESARO regional end-decade review

54. The "Regional end-decade review of progress" included sections on lessons learned over the decade on the WSC/NPA process and on the multiple indicator cluster surveys (MICS). The WSC/NPA process was quite successful in establishing links between global, national and subnational plans. The profile of child-related development issues was raised in the national consciousness in many countries, especially those in which a good process was followed and government ownership was well established.

55. In several countries, including notably South Africa and Uganda, the NPA continues to be a significant national process. Countries in which the NPAs were linked to the President's Office appear to have had a more sustainable process. As countries in Eastern and Southern Africa are doing worse than developing countries in general, several WSC goals were found to be overly ambitious, although the inclusion of a monitoring framework into the NPA preparation process was helpful. Countries experienced some difficulties in determining programme costs and resource gaps. The series of world summits that followed the WSC may also have over-stretched ministries of planning and diluted the impact of the WSC/NPA process.

56. Mid- and end-decade reporting using household MICS benefited from the participation of directors of national statistics offices in ESAR by convening them in regional workshops at the start of and close to the end of mid- and end-decade survey processes. Each of these four workshops with the directors made a number of recommendations: to produce a list of end-decade indicators (recommended by the ESAR directors in 1996, adopted by UNICEF globally in 1999); to use the SPSS system rather than EPI software to process data (recommended in 1995, adopted by UNICEF globally in 1999); to use a standardized costing framework for all surveys in all countries (model framework produced in 1999, adopted by UNICEF globally in 2000); and to properly archive micro-data (recommended in 1995, adopted by UNICEF globally in 1999).

57. Problems that emerged included the assumption by UNICEF that country-level surveys could "march in step" irrespective of national survey plans and the delayed availability of the model questionnaires and data analysis computer programmes.

58. Memoranda of understanding developed with other agencies for the MICS processes, including with the Economic Commission for Africa and the United Nations Population Fund, were considered helpful. A more informal regional collaboration between the UNICEF ESARO MICS process and the World Bank Core Welfare Indicator Surveys through joint participation in survey planning workshops was also useful.

59. Total costs of MICS ranged from $70,000 to $1.2 million, with UNICEF contributions to the total costs ranging from $44,000 to $256,000. Costs to UNICEF were no different between "stand-alone" MICS and those integrated with Demographic and Health Surveys, but the stand-alone MICS tended to cover a higher proportion of the indicators desired by UNICEF.