CATHOLIC RELIEF SERVICES

FOOD AND NUTRITION TECHNICAL ASSISTANCE

REPORT OF THE

CRS/HAITI DEVELOPMENT ASSISTANCE PROGRAM (DAP 2002-2007)

MID-TERM EVALUATION

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SO2: Increased effectiveness of FFP's PVO and Mission partners in carrying out Title II development activities with measurable results related to food security, with a primary focus on household nutrition and agricultural productivity.

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ACRONYMS

BCC: Behavioral Change Communication
BL: Baseline
CHW: Community Health Worker
CRS: Catholic Relief Services
CS: Cooperating Sponsor
DAP: Development Assistance Program
FANTA: Food and Nutrition Technical Assistance project
HH: Household
IMCI: Integrated Management of Childhood Illnesses
IPTT: Indicator Performance Tracking Table
IPBT: Indicator and Performance Benchmark Table
LOA: Life of Activity
LQAS: Lot Quality Assurance Sampling
MCHN: Maternal Child Health Nutrition
M&E: Monitoring and Evaluation
MTE: Mid-term evaluation
MCHN: Maternal and Child Health and Nutrition
MOH: Ministry of Health
PLWA
PTA: Parents Teachers Association
SA: Supervision Area
SES: Socio Economic Status
SO: Strategic Objective
SSNI: Social Safety Net Institutions
UCS: Unité Communale de Santé
UD: Unable to determine
USAID: United States Agency for International Development

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EXECUTIVE SUMMARY

INTRODUCTION

According to USAID/DCHA/FFP guidance, Title II Cooperating Sponsors are expected to conduct a series of evaluation exercises during the life of their Development Activity Programs (DAPs): a Baseline survey should be done before implementing the program, to know the conditions at the outset in intervention areas; a final evaluation is also expected at the end of the Life of Activity (LOA) to document the extent to which the program achieved its objectives; and a Mid Term Evaluation is recommended, about halfway through the life of the DAP, to help program managers assess progress made, whether or not the program is on the way to achieve its stated objectives, and make recommendations on ways to improve performance if need be. Although relatively good experience exists on the conduct of Baseline and Final Evaluations, little guidance exists on how to do Mid Term Evaluations—even though this may be one of the most important steps in the LOA to guarantee its final success. To address this gap, the Food and Nutrition Technical Assistance (FANTA) project teamed up with CRS/Haiti to pilot test a Mid Term Evaluation (MTE) methodology that would: 1) examine progress made in reaching DAP goals; and 2) formulate recommendations to help correct imbalances in areas found to be under performing. This report looks at the entire activity, from methodology development to results analysis and final recommendations.

SUMMARY OF STEPS OF THE MID-TERM EVALUATION (MTE)

The MTE results presented in this report are based upon data collected in CRS/Haiti's areas of intervention, namely in the Southern and Grande Anse Departments. The MTE was divided into two phases:

PHASE I: The first step in Phase I was to identify performance indicators for each sector evaluated in the MTE. A mid-term performance benchmark was set for each selected indicator taking into account its baseline value and LOA target. Samples targeted for data collection in each sector were also identified at this time, activity zones being subdivided whenever possible into Supervision Areas (SAs). On the basis of this preliminary work, the Team developed LQAS-friendly data collection instruments in which all questions were phrased to elicit a dichotomous (yes/no) answer. Data collection began December 9, 2004 and was completed by December 23, 2004. Completed questionnaires were analyzed early January 2005, allowing to separate activities that had successfully met their mid term targets from those that did not.

PHASE II: Focusing on indicators that seemed to be lagging in performance, the Team identified activities that merited further investigation. An analysis of constraints using qualitative methods was performed, including mainly focus group and key informant interviews. The qualitative, follow-up investigation of Phase II took place March 14-24, 2005. The report from the qualitative research, submitted April 2005, was used to elaborate a series of recommendations to improve project performance.

CRS/HAITI PROGRAM

The goal of CRS' proposed DAP is to sustainably reduce the level of food insecurity in vulnerable communities of the Southern Peninsula with a focus on the South and Grande-Anse departments and one area of the South East Department (Cotes de Fer). CRS will achieve this goal through integrated activities in four sectors: Health and Nutrition (Maternal and Child Health, Water and Sanitation, HIV/AIDS, Micro-finance), Agriculture, Food-Assisted Education and Humanitarian Assistance. To achieve this goal, CRS will secure private funds and other sources of funding to complement DAP resources.

METHODOLOGY

Conceptual Model

In an operational context, the role of the M&E system is to track and mirror the flow of actions that take place as project inputs are transformed into population-level impacts, and to verify that those impacts are indeed taking place. A good system will also inform project managers about the action to take if impacts are not occurring. To design the M&E, it is thus important to understand how the flow of activities is linked: conceptually, a project uses a set of *inputs,* and submits those to *processes* in order to generate *outputs*. *Outputs* in turn translate into *effects* at the target population level—*effects* which, in turn, are necessary to the materialization of the project's final *impact*. For instance: assume that a project wants to increase agricultural yields by offering farmers training in a new set of techniques[1]. To achieve this, the project lines up funds and technical specialists (*inputs*) and organizes a training course (*process*) in which it teaches farmers the selected techniques. The number of farmers trained constitutes the *output* of that activity. The number of farmers that effectively adopted the technique (a subset of those who were trained) are the *effect* of that activity. To the extent that adoption of the technique is essential to yield increase, then that *effect* must occur if the project is to achieve its desired *impact.* The M&E must reflect this process using objectively verifiable indicators.

Not all indicators to be used are of the same kind, however. Data relating to *inputs, processes* and *outputs* can be generated easily from routine project information and for those indicators, there is no need to do a survey. When it comes to *effects* and *impacts*, however, the project must go to the population in order to measure how many of the trained farmers actually adopted the technique. Being a decision that is highly personal to each farmer, this cannot be inferred from the project's book keeping records. A population-based data collection exercise is necessary to assess how many of the trained farmers adopted the technique or whether yields have increased or not.

From a logistical point of view, this distinction between sources of data (project-based versus population-based) is what distinguishes monitoring from evaluation: monitoring uses data from project records; evaluation uses data from the population (through a random survey, a census, etc). Population-based assessments being costlier than simple bookkeeping, project evaluations are occasional, rather than annual. Limiting the number of population-based queries, however, presents the project with the danger of not knowing whether the effects and impacts it is meant to achieve are indeed taking place: looking only at monitoring data, a project manager may fail entirely to detect that there is a problem with the adoption of the technique until it is too late to react. Unless a population-based evaluation is done during the life of the activity, the project will not know until its final evaluation that adoption rates are not as expected, thus jeopardizing its capacity to increase yields. Following that logic a central role of the mid term evaluation is to verify that the desired *effects* are indeed taking place. This is a central premise of this MTE model.

Because effects are manifested at the level of the population, however, the need for a survey remains. To reduce its cost, Lot Quality Assurance Sampling is used. LQAS uses binomial distributions properties, which are more efficient than normal distributions at assessing population-level probabilities of dichotomous outcomes. The great advantage of LQAS is that it requires much smaller samples than traditional population-based surveys. For instance, assuming an unstratified, homogenous universe of infinite size, and accepting α and β errors each set at 10%, a simple random sample of n=19 is sufficient to judge whether performance has reached or not a predetermined performance benchmark on a given indicator (Valadez, 1996). One additional feature that makes LQAS attractive is the possibility to go beyond the simple "pass/fail" judgment to compute population-level point estimates for indicators of interest (e.g. vaccination coverage, disease prevalence, etc). This is done by dividing the entire project

[1] We take for granted that the conceptual framework underlying the approach is sound; i.e. there is a cause-effect relationship between the technique promoted and eventual productivity increases. We do not discuss this here; but the issue was covered in the Baseline Survey Report where ample details are provided on the conceptual models used to guide intervention design in the CRS program.

area into several “supervision areas” and by combining the data across those to compute the *proportion* of “pass/fail” responses over the entire project area. (Note that there must be at least four SAs to make this statistically valid. This increases the total sample by a factor of similar magnitude; yet the potential advantages of the method in terms of cost will likely remain positive, as the new n will remain small compared to a traditional 30x30 cluster survey).

Design of the survey – Phase I

Indicator Selection and Formulation: An initial list was provided by CRS’ DAP Indicator Performance Tracking Table (IPTT). A particular emphasis was given to *effect-level* indicators. This initial list was then augmented with data CRS staff needed to improve the management of their activities. To comply with LQAS’ dichotomous requirement, all indicators in the resulting list were then worded to yield a pass/fail response.

Setting Performance Benchmarks: The second step was to set a performance benchmark for each indicator evaluated. We generally assumed that a project should see half of its effects materialized by the time it reaches its mid point. Obviously, linear rates are not always expected: certain effects take longer to manifest themselves, in which case the growth rate in adoption may show a curvilinear pattern. Also, particular activities may have started later, changing thus the expected growth curve. For those reasons, CRS staff and FANTA carefully considered each indicator before setting its benchmark. Lastly, benchmarks were established at 5% cutoff intervals (15%, 20%, etc). The final set of indicators and benchmarks is listed in Appendix 2.

Data Collection Questionnaires: The MTE Indicator and Performance Benchmark Table (IPBT) served as the starting point for the development of the Phase I questionnaires. While most of the indicators included in the IPBT translated into single questions, there were several indicators that required a series of questions in order to satisfy their informational requirements. Within each sector there were several questionnaires. The quantity of questionnaires depended upon the number of sampling groups; their composition reflected the characteristics of the target group to be sampled. Particular initiatives within the DAP program – such as civic education, HIV/AIDS education, and the promotion of proper hand washing techniques – were determined to have cross-sectoral relevance, and as such, questions relating to these initiatives were included in the other DAP sector questionnaires. The first draft of the questionnaires was developed by FANTA and presented to CRS for their input and feedback. After substantial consideration, revision, and expansion by the CRS DAP staff, the MTE Team Leader and FANTA, a second draft was completed and translated into French and Creole. These drafts were used in the training of the enumerators and field-tested. The questionnaires used in the data collection reflected the experiences of the MTE data collection team during field-testing.

Sampling: The greatest benefit of LQAS is its low sample size requirements. Compared to usual sampling technique (such as cluster sampling which usually requires around 900 interviews) LQAS can content itself with a sample of size n=19 (provided certain conditions are met). It is thus very economical. However, the leanness of LQAS is also its weakness: the size of the sample is so small that it prohibits disaggregating the data into subsets, making the simplest analytical techniques (cross-tabulations, means comparison) impossible—unless stratifying, i.e. deriving an independent sample for each group or region of interest. When stratifying in LQAS, it is useful to distinguish between two types of strata: those based on geography (“supervision areas”) and those based on target groups. Subdividing by Supervision Areas (SAs) involves dividing the entire catchment area into smaller management units. Say that a project operates in four provinces. The catchment is the entire country program, but if activities in each province are programmed independently, it makes sense to obtain a LQAS sample in each province to examine how the project performs in each province. Obviously, the collection of four samples will make the study costlier, as it will raise the total number of data points to 76 (assuming four samples of size n=19) but this will convey two major benefits to the study: first, it will be possible to see where (and where not) objectives are being met, pinpointing areas where improvements are needed. Second, it makes it possible to derive coverage estimates for the indicators under review—i.e. not only will we able to say that the sample “passed” or “failed” on a given test; we will also be able to use the percentage of units across the four samples that passed on that test as a basis to compute a coverage estimate. This adds

an important analytical dimension to the survey, as will be shown later in the results section. Subdividing by Target Groups involves dividing the client population of an intervention into sets of individuals for whom expectations may differ; thus it makes sense to have different benchmarks for different age groups. As in supervision areas, dividing by target groups involves drawing a new sample for each group of interest. The advantage here is also twofold: first it allows setting different benchmarks for the same activity but for different groups. Second, it allows to pinpoint accurately in which group the project fails to reach its objectives, and thus to focus attention on that particular set of people. A final note on sampling: the method used to derive the desired sample size differs on the basis of the size of the universe. In situations where the universe size is infinite (i.e. >500 units) the binomial probability distribution can be used to derive sample sizes and decision rules. Where population sizes contain fewer than 500 units, however, the hyper-geometric distribution for cumulative probabilities must be used.

Supervision Areas: Before the sampling process could begin, CRS sector teams were tasked with organizing their program interventions into supervision areas. In the LQAS model, the minimum number of supervision areas necessary for aggregating the data to calculate weighted coverage estimates for program indicators is four. Each supervision area has its own participant list and thus the sampling was carried out based on that particular participant pool[2]. Where possible, the sector teams were encouraged to divide their supervision areas into universes of 500 units or more as this would allow sample sizes of 19, which according to the LQAS model, is sufficient to provide statistically representative data with acceptable confidence intervals. For those sectors with supervision areas with less than 500 units, it was necessary to undertake complex hyper-geometric calculations in order to determine appropriate sample sizes and corresponding benchmark decision rules. Sectors that were divided into four or more supervision areas included: Credit–Women and MCHN (with 500 or more units) and Education (required hyper- geometric calculations because there were less than 500 units). Sectors that had less than four supervision areas included: Agriculture and Credit–Colvol (with 500 units or more) and SSNI and Water and Sanitation (with less than 500 units thus requiring hyper-geometric calculations).

Sampling Lists: The generation of sampling lists proved more time consuming than was originally anticipated. The varying benchmark levels for each universe size under 500 required quite a few complex calculations and fundamentally necessitated the creation of a whole new LQAS table for hyper-geometric distribution. For the purpose of this exercise, a "participant" could be an individual (such as a member of a farmer *groupement),* an institution (such as a school), or a locality (from which a resident mother would be selected). Each type of "participant" group required separate sampling methodologies. The universe and the number of participants being known for each area, the sampling was done by starting with a random number using the sampling interval required to obtain the total number of participants for that particular area. For those sectors with individual participants, as was the case with Agriculture and Credit, the selection process was centralized and undertaken by CRS and FANTA, using a random number table, before the data collectors left for the field. Armed with the names of specific people, the data collectors visited the locality of residence of the individual, located her/him with the help of the community and/or local CRS volunteers, and carried out the interview. Participant lists that were comprised of institutions that receive support form CRS, such as Education, SSNI, and Water and Sanitation, the selection process was two-fold. The selection of the institutions was centralized and undertaken by CRS and FANTA, using a random number table, before the data collectors left for the field. The selection of the actual respondents, however, was carried out by the data collectors in the field - on the day of her/his visit to the institution. Data collectors used random number tables and numbered cards to identify respondents with the desired profile for interviewing.

Sampling by sector: Six major sectors (MCHN, Credit- women and Credit CHWs, Agriculture, Education, Safety Net and Water and Sanitation) and two cross-sectoral sectors (HIV/AIDS and Civic Education) were evaluated. A total of 1,110 interviews were conducted with 19 different groups.

Training: Training of data collectors for Phase I was done between November 29 and December 5, 2004. During the first three-day training, questionnaires were reviewed question by question to ensure

[2] In the case of the MCHN sector, the sampling was done on the whole population. The data base used for the baseline study (number of households per locality for each commune covered by the project) was also used for the MTE.

greater consistency in administration. The CRS manager responsible for each program first made a short presentation to explain the context of the study to the data collectors. Then, each question was discussed including the methodology on how to note the answer. After having reviewed the questions for each sector, the group was divided into small groups to practice the questions. The field-testing of the questionnaires was done in the rural area of Palmiste-à-Vin. Except for the Safety Net sector, all questionnaires were tested in the field by small groups of data collectors coordinated by a supervisor. The whole group went to a school, an MCH center, a spring capping, a school latrine, and a farmer's plot of land. With regards to the Safety Net questionnaires, two enumerators and two supervisors participated in the field-testing that was done in two orphanages in the area of Port au Prince. Based upon the number of interviews that needed to be carried out during Phase I, it was determined to divide the data collection team into seven teams--six composed of a team supervisor and three or four data collectors and one made of two data collectors for the Safety Net Institutions. Phase I data were collected by 23 enumerators and 6 supervisors.

Field Work: The Phase I fieldwork took place between December 9 and December 23, 2004. The number of interviews to be done in one day (5 to 6), the time estimated to reach each interviewee and the number of sectors to be covered were the criteria used to determine the areas to be assigned to each team which varied between two to seven communes. Each team of the six teams was made up of one supervisor and three or four enumerators. Before going to the field, each team received the complete list of people to be interviewed and sites to be visited for each locality in each commune. However, it was up to the Team Supervisor to determine the scheduling and assignment of interviews for the team. With regards to Safety Net questionnaires, two enumerators in the area of Port au Prince completed most of them. The remaining interviews were conducted by a team supervisor in the areas of Jérémie and Les Cayes. As explained in a previous section, the selection of some respondents was done in the field by the survey team. With the LQAS sampling methodology where the name of the locality (for MCHN sector) and/or the name of the participants (credit mothers) were pre-selected, the enumerators had to walk long distances to reach most of the respondents. The MTE Supervision Team comprised of the MTE Team Leader, a CRS staff person, and a FANTA staff person departed one day after the data collection team was dispatched to the field. The idea was that we would visit all of the different teams unannounced to check on their progress and assess their performance in the field. The supervisory visits were very useful for the entire team in that it provided the teams to raise questions or draw our attention to issues that were confronting them in the field. In a five-day span, the supervision team visited all of the field teams and was able to solve the administrative or logistical problems that the teams were facing.

Data Analysis: Analyzing LQAS data is straightforward, as it only requires assessing whether the number of defective units exceeds or not the decision rule implied by the desired benchmark. This is the most basic analysis done with LQAS data, and it was done here for all the indicators observed in the survey. More analysis was done however (where feasible) by dividing the population into four or more supervision areas, which made it possible to establish an overall prevalence point for an indicator by computing its ratio of "passes" to total sample (i.e. summing up the number of items that met the test across SAs and divide this by the total number of items sampled). This makes it possible to state not only which SA passed or failed the test, but whether the program as a whole, and across all its SAs also passes the test; and to identify which SA performed best against the benchmark. Where possible, such an analysis by SA was done here. This allowed orienting the effort of corrective action to where it was truly needed. In the end, such detail should be a powerful help to the project in its attempt to reach its stated objectives in all covered areas.

LESSONS LEARNED – PHASE I

Indicator and Performance Benchmark Table (IPBT): The IPBT, which was initially assembled to serve as the backbone for the questionnaires, later needed revision in order to reflect the complexities of the questionnaires it inspired in the first place. This situation did necessitate a further investment of time and energy on the part of CRS in the creation of new benchmarks and LOA values. Perhaps greater attention to the development of more complete lists of program indicators at the beginning could have avoided such a procedural step backwards later. More focused questionnaire development could also have minimized the time necessary for the revision of the original IPBT.

Setting Performance Benchmarks: MTE performance benchmarks were set by CRS program staff and FANTA. For most indicators with LOA targets already set, it was assumed that the project had reached half of its effects by the time of the mid term evaluation. However, for the questions added during the planning of the MTE, mid-term performance benchmarks were included for all new indicators. The strategy for setting up mid–term benchmarks differed from one sector to another. Even though mid- term targets were set based on past and current program experiences, the team realized afterwards that for some indicators, results were either far below or far above the expected targets. With the pass/fail LQAS methodology, the level of the benchmark is a key determinant and requires an in-depth reflection at the planning stage; especially in case no baseline value is available. For sectors where the MTE result would be used as a baseline value, the subdivision of the catchment area into four supervision areas allowed for an extrapolation of the program coverage; a useful approach for calculating the baseline value. However, in the case of a single catchment area, the evaluation team was only able to discern whether the sample "passed" of "failed" the mid-term benchmark, an approach that is not as informative as one using program coverage as the baseline value.

Data Collection Questionnaires: This MTE collected an enormous amount of information on the overall performance of the DAP. For some sectors, the questions did not cover some important issues that could have been covered by the MTE. This is the case for the agriculture and the safety net sectors where numerous opportunities to measure project progress were missed. In a related issue, a system should have been put in place to monitor the inclusion of certain questions relating to such cross-sectoral topics as HIV/AIDS. Greater consistency in the inclusion of HIV/AIDS questions would have provided increased utility in terms of the manipulation of the data for comparison purposes across sectors and samples. The LQAS method is based on dichotomous outcomes (yes/no, pass/fail), and every effort was made to simplify the questionnaires in order to elicit such responses. Many of the issues investigated in Phase I, however, were quite complex and as such, necessitated more than one question in order to get at the desired data. In such situations, a single question may not have had specific relevance to a particular indicator, but when it was included in a larger data set, it gained its relevance and indeed, critical inclusion. The creation of data sub-sets was also an issue in the development of the questionnaires. As LQAS is based on sample sizes of 19, any decrease in the sampling numbers creates sub-sets. Sub-sets undermine the statistical attractiveness of the LQAS methodology because they change the sample size and thus, the benchmark decision rules; and depending upon the actual responses, hyper-geometric calculations may be necessary.

Sampling/Supervision Areas: Ideally, most sectors would have preferred to divide their catchment area into four supervision areas. However, the evaluation team had to estimate the cost/benefit of multiplying the sample by four. In some cases, the number of units was too small to be divided by four (for example, 21 school cisterns). In other cases, such as agriculture, the program had been working with only two associations, the association being the unit of analysis for the programmatic component. For both MCH and Education programs, the supervision areas corresponded to the programmatic areas. This strategy became very useful for programming purposes since it allowed the analysis of program performance to be done by programmatic area and for recommendations to be specific to each geographic area. Taking into account the benefits conveyed by sampling four supervision areas, the evaluation team would strongly recommend using this methodology as often as the number of units and the cost of the study would permit. Ensuring, whenever possible, that the programmatic area corresponds with the supervision area is also highly recommended.

Sampling/Sampling Lists: The most problematic issue that arose in the drawing up of sampling lists had to do with the selection of Alternates. Not enough Alternates were identified previous to the fieldwork for the sectors where lists had been drawn with the names of the participants (women credit and colvol credit). This resulted in valuable time being spent by the field staff communicating by telephone with CRS in Port-au-Prince and the redrawing of the lists for the selection of more Alternates. The need for Alternates was one that had been recognized early on in the process; what was not anticipated was many would be needed. In a survey that is under such tight time constraints as this one, the data collector does not usually have the luxury of returning to a site another day in order to interview a specific person. A greater amount of time should have been spent in assembling the participant lists for the micro-credit

sectors in order to ensure their relevance to the data requirements. For the HIV/AIDS sampling, SSNIs were divided into two supervision areas – SA1 was comprised of SSNIs that had received HIV/AIDS trainings, while SA2 had not received such training. For each SSNI, the data collector was tasked with interviewing six people, including two girls and two boys. Shortly after beginning the data collection, it became quite clear why certain of the SSNIs in SA2 had never received HIV/AIDS trainings; namely because they were centers for "special populations" like physically or mentally handicapped children, orphaned infants, etc. There were also single-sex centers and centers for young adult males. The populations in these centers thus precluded the satisfaction of the required number of completed samples. As a matter of fact, less than 75% of the necessary interviews of males took place at the centers of SA2, rendering the obtained data ineffectual. Identification of "alternates" sites would have solved some of the problems encountered with the SSNI sector. However, the comparison between SA1 and SA2 with regards to HIV/AIDS training would not have been appropriate since the two groups were different.

Training: The time allocated for the training was too short. Even though all enumerators had previous experience in surveys and questionnaires, this methodology was new to all of them. Many showed difficulties in filling the double negative questions that were found to be confusing. Changes were made during the field test questionnaires later on before the teams left for the actual fieldwork. Enumerators should have had more time for field testing to uncover problems related to phrasing sentences and inconsistencies with instructions provided to them. Since supervisors were responsible for reviewing the questionnaires in the field, additional training would have been important to help them identify the potential inconsistencies that had to be corrected later on by the CRS/FANTA team supervisors. The period for the field test was also too short. In her report covering the data collection period, the team leader reported a series of notes relative to the questionnaires. Those inconsistencies were corrected either in the field or before the data entry. In case the same questionnaires are used for a similar survey in the future, it would be important to include all such comments in a revised version of the survey.

Field Work: No major problems were encountered for sectors where the sampling list was made up of the names of localities or sites. The selection of alternates was one of the most problematic issues that arose in the field. This was largely a problem with Credit-Women and SSNI sectors. Three alternates per supervision area had been selected for the Credit-women sector but it became readily apparent that this was insufficient. Urgent decisions had to be made very rapidly since the change in the sampling interval directly affected the identification of all the alternates. Without effective means of communications such as the telephone, this change would not have been done in a timely manner and this would have caused a significant delay in the field work implementation for that sector.

Data Analysis: The primary analysis of LQAS data is notoriously simple, as it involves essentially measuring whether the number of "passes" equals or exceeds the number needed to meet the benchmark; and from that comparison, apply a pass/fail judgment at the program level. Some complexity is added when doing a secondary analysis of the data by SA to derive point estimates, confidence intervals etc; as was done here. Yet this pilot showed that, once the key principles are understood, this secondary analysis is also straightforward: CRS staff could easily and correctly perform the primary and secondary analyses by sector, once basic training had been done by FANTA. This augurs well for the replicability of the methodology, and is a good lesson learned that confirms the ease of use of LQAS in general.

QUALITATIVE ASSESSMENT – PHASE II

Identification of Problem Areas: After Phase I results had been analyzed, each CRS program sector team met with the FANTA team and the team leader to review and discuss results for all indicators measured during Phase I. The team focused on indicators that seemed to be lagging in performance and discussed if they merited further investigation. Problem areas were identified in four major sectors: MCH, Women credit, Colvol credit and School latrines. In addition to those four sectors, the CRS education team proposed to investigate during Phase II some key issues pertaining to education that were not addressed during Phase I. After having identified the areas to be investigated in each sector, the team proposed the potential source of information for each area. The team leader who was the main person

responsible for conducting the Phase II of the MTE compiled those comments and proposed a Phase II plan to the CRS/FANTA team including objectives, areas of investigations, methodology, locations and sources where to look for each information. Since most of the sectors identified for Phase II had covered four different supervision areas during Phase I, the team was able to propose specific supervision areas for Phase II, more specifically areas where the results had been less performing: Port a Piment and Aquin.

Selection of Methodology for Constraints Analysis: Qualitative methods used for Phase II of the MTE included focus group and key informant interviews. Focus groups were conducted with groups of mothers in the credit program, mothers with children 12-24 months old and not participating in the credit program, colvols, school directors, teachers and members of Parents Teachers associations. Key informants interviews were performed with field based CRS and partner staff, persons responsible for health centers and other key leaders in the communities.

Field Work: A total of 13 focus groups (7 in Port a Piment and 6 in Aquin) and 9 key informant interviews (4 in Port a Piment, 4 in Aquin and one CRS staff) were conducted during Phase II. All these interviews and meetings took place during a two-week period and were conducted by the team leader who has a long experience in qualitative survey methodology.

Results Analysis: The team leader compiled the results from all meetings and interviews for each sector. Since Phase II evaluation was implemented as a follow up investigation for Phase I, findings specific to Phase II and recommendations to improve project performance are combined with those of Phase I to ensure a comprehensive and integrated report for each sector.

Lessons Learned – Phase II

Identification of Problem Areas: Similar to the Phase I, some program staff wanted to investigate numerous issues. Time and cost constraints were important factors taken into consideration while planning Phase II. With the assistance of FANTA staff and the team leader, the CRS team was able to finalize a list of important issues to be investigated during Phase II. Some sectors did not identify any issues to be examined during Phase II. However, the education team proposed to investigate new issues pertaining to education that were not addressed during Phase I. This change in Phase II planning affected the timing for the fieldwork. It is recommended that the complete set of performance indicators for each sector be identified at the beginning of the study.

Selection of Methodology for Constraints Analysis: With regards to the credit mothers program, the original plan for Phase II included the areas where problems had been identified. Field experience showed that conducting additional interviews with key informants in areas where the credit program has been successful revealed to be a highly informative process. While providing valuable explanations why the program has been successful in some areas and not in others, this information also contributed to a better understanding of the difficulties encountered in problematic areas.

Field Work: Since the composition of the group will influence the dynamic of the focus group, the selection of the participants is a very important issue. The process must be supervised by an external person who should follow the rules and criteria set by the team leader. It is also important to take the time to understand the mentality of the people living in the area targeted by the study before conducting qualitative research in a that area.

Results Analysis: The variety of program sectors and the wide range of groups and participants who were interviewed were identified as strong points during Phase II. This methodology facilitated the results analysis process because it provided a wide range of information from which the most significant elements were withdrawn.

MAJOR RESULTS AND RECOMMENDATIONS FOR PROGRAM OPERATIONS

Agriculture

Results	Recommendations for Program Operations
• All 11 indicators measuring the adoption of improved agricultural techniques by farmers and perceptions of farmers on women participation in farmers' associations met the MTE target (*)	• Continue project activities as currently structured and implemented by Caritas and CRS and extend in new zones using the same program strategy

(*) Note: Had the performance benchmarks been set higher, thus making it more challenging for the farmers to pass on the indicators, weaknesses in the project may have been revealed and hence, reinforced.

Community Credit Program

Results	Recommendations for Program Operations
Phase I: • Targets met for issues related to group management, solidarity amongst members, selection process, literacy and numeracy levels • Even though no additional money spent on food for children, less food is used from the household production and food diversity is increased because of increased access to markets • Participants in Port-à-Piment area have more difficulty to reimburse their loans **Phase II:** • All people interviewed agree that the credit conditions offered by the Caritas-CRS credit program are more advantageous that the other credit programs. However, they believe that the interest is still too high since they have to use a large part of their profit to be able to pay the interest. • In Port a Piment where participants have difficulty reimbursing their loans: - Participants acknowledged the impact of the credit program on social capital, they learn how to work as a group, the credit allowed them to meet emergency without having to borrow from loan sharks. But the credit did not help them in improving their economic situation. - *Problems encountered:* extreme poverty, obligation to use part of the loan to satisfy family obligations, lack of past business experience, no other sources of income to cover part of the monthly interest payments, Port a Piment is not active trade area. - Many women had to abandon the credit program since their profits are not sufficient to make interest payment. Some women are still paying interest on a principle they are gradually reimbursing. - *Selection criteria*: participants not selected from rally-posts, selection criteria not correctly applied. Too much disparity among group members (less solidarity).	• CRS micro-finance staff together with its partner should immediately address the findings specific to credit groups in Port-à-Piment, formulate concrete recommendations for the continuation of the program in that area, specially for participants who experience difficulties, and ensure the recommendations are rapidly applied • CRS micro-finance field staff together with their partner field staff should conduct a rapid analysis of all other micro-finance women groups (a sample in each programmatic area) to verify if no other groups are experiencing situations similar to Port a Piment • With regards to on-going groups, CRS should work closely with its partner to: - Provide in-service training to their field staff (credit officer) on a regular basis - Ensure list of participants is always up to date - Examine current conditions of payments: interest rate and loan capital - Reinforce training programs for all participants (including how bankbooks work) - Enhance the involvement of group members in the decision making process - Ensure group committees share loan management information with all group members - Involve all group members in the selection of new participants to replace those who decide to quit the group and ensure new members fulfill group criteria - Enhance the involvement of the colvol in the selection of the new members and in the overall group management - Review program strategies to ensure autonomous groups continue to receive support from the credit officer

Results	Recommendations for Program Operations
• In Aquin where many groups are "autonomous" (they have reimbursed the loan principle) : - All beneficiaries acknowledged the significant improvements in their living conditions since they joined the credit program - They learn how to work as a group and to better organize themselves, can meet emergency without having to borrow from loan sharks - Payment of monthly interest is not a problem; many women are "true" business women and Aquin is an active trade area. - Reimbursement of loan principle every six months (cycle) is the most difficult issue. To be able to reimburse the loan principle, they sell part of their products or an animal (if they have other small business) or borrow from friends. If all group members bring back their money on the same day, it is returned to them on the same day. If any participant does not return part of the loan, no one in the group receives their new loan. This strategy unduly penalizes those who have made sacrifices to bring back their money. - *Selection criteria:* No problem at the beginning, most participants selected from rally-posts using participation and credibility criteria. Problems arose when members started to quit the program and the replacement process was not well defined (not necessarily from same community and the group is not consulted). Reimbursement problems often with those new members. • More food for young children: - *Aquin*: even though, no additional money is spent on food for children, less food is used from the household production and food diversity is increased because of increased access to markets - *Port a Piment*: credit did not directly contribute to better child feeding but women report dipping in their business inventory to feed their children. • Recommendations made by participants/key informants: - Review and apply participant selection criteria (credibility, authentic business women, same background) - All credit program participants should receive training on marketing issues to better identify their type of business - Decrease the interest rates - No requirement to reimburse the principle at the end of each cycle - More training and support from the credit officer - The whole group and the community colvol should be consulted when a member must be replaced - Management issues: bank book should be in the hands of the group and not the credit officer, information on bank transactions should be shared with the whole group (not only the committee), credit officer should continue to support "autonomous" groups, review the role of the committee (the group is kept out of the decision-making process) - In Port a Piment (not a commercial area), micro-credit loan could be used for small food processing projects	• With regards to new groups, CRS should work closely with its partner to: - Limit micro-credit programs to areas with active trade activities - Ensure guidelines for receiving credit are being correctly applied; types of investment, and past business experience are essential criteria - Ensure credit participants attend training on business development and training before receiving the loan - Apply all recommendations made for the on-going groups (listed above) • Partner's capacity building: - CRS staff should pursue and reinforce partner's capacity building on management of micro-finance programs - CRS micro-finance staff should increase supervision visits at the field level • Overall program strategies: - Based on the overall MTE findings and the above recommendations, CRS micro-finance staff, together with regional micro-finance advisors, local micro-finance partners and other micro-finance institutions should examine the current loan management conditions in the CRS micro-finance program (interest rates, reimbursement of the loan principle, types of business, length of the cycle) and make recommendations for potential changes that would allow better loan conditions for program participants leading to increased profit, thus contributing to the improvement of the overall socio-economic conditions in the DAP targeted areas.

Colvol (Community Health Workers) Credit Program

Results	Recommendations for Program Operations
Phase I: • Targets met in issues related to loan management, group solidarity and credit program being an incentive for their work as a CHW • CHWs have more money to spend on things such as clothing, medical care and school fees but do not spend more money on food than before they received their loan **Phase II:** • Credit program management: colvols express concerns with CRS' decision to change the management from CRS to its partner, Caritas. Change will be at their disadvantage since interests will be returned to Caritas and they would have to reimburse the loan principle at the end of each cycle. For many years, Colvols have been managing their credit fund themselves under CRS supervision; the interest was reinvested in their loan. With the change of management, many colvols started paying the existing loans and plan on discontinuing their participation in the credit program. • Advantages of the credit program for the colvol: the credit program helped significantly improve colvols' living conditions, quality of life and self-esteem. • Impact of the credit program as an incentive for Colvol participation in MCHN activities: the credit program encourages the colvols to do their best in participating in the very demanding work expected of them in the MCHN program. The credit represents a small compensation for the volunteer services they provide to their communities. The colvol is the link between the hospital and the community and the most important worker in the health system. Key informants report that the health center's success is directly related to the colvols' presence. • Other elements to motivate the colvols: more training, learn how to give vaccines, have access to first aid kit, stretcher to transport urgent cases. Other benefits such as special rate for health services, identification badge, participate in large meetings of colvols from different centers to exchange ideas and share experiences.	• CRS programming team should immediately reconsider the decision of transferring the colvol micro-credit program to Caritas. CRS should first meet with the colvols (not only the committees), evaluate the success and weaknesses of their credit program and propose strategies that will benefit the colvols without negatively affecting their important volunteer work in their community. The micro-credit loan is an incentive for the colvols who are the core strength of the MCHN program. All important decisions and/or significant changes in the micro-credit program should be analyzed by the micro-finance team together with the MCH team. Meetings with colvols should be done for many groups at the same time to give them the opportunity to share ideas and experiences. • The MCH team should promote and organize (annual) regional meetings of colvols from different health centers to discuss issues that affect them, exchange ideas and share experiences. • The MCH team, in collaboration with the MOH staff, should continue to train more colvols in the administration of vaccines and analyze other strategies suggested by the colvols to increase their motivation. Small project proposals and diversification of health sector funding sources could support some of those special requests suggested by the colvols.

Water and Sanitation

Results	Recommendations for Program Operations
Phase I: • School cisterns met all targets for condition and maintenance • Mixed results for school latrines: met targets for cleanliness but failed for some maintenance issues (doors closed, seat covers) • Capped springs: target met in 16 out the 20 indicators measuring the quality and maintenance of water points and fountain areas; positive efforts made for the reforestation of spring surroundings and behavior change associated with the capped spring	School latrines • Ensure all latrines follow construction standards set by CRS water and sanitation team, with special attention to functional locks on the doors, cover on the latrine seat and locks from the inside • Reinforce those aspects during training of PTAs and other local partners implementing water and sanitation projects • Reinforce school structure responsible for maintenance of school latrines

Results	Recommendations for Program Operations
Phase II: • Maintenance problems observed in school latrines not related to misunderstanding between PTA and school management staff but to lack of information and slight negligence	Capped springs: • Reinforce the importance of maintaining the spring area clean and keeping the drainage canals clear. Include those topics in the training targeting water committees, CHWs and rally post participants – for new spring cappings and for previously built systems.

Education

Results	Recommendations for Program Operations
Phase I: • PTA committee member: All four indicators measuring participation in school activities met the targets in four SAs • School director: Two indicators related to participation in managerial training met the benchmarks. Participation in Health, Hygiene and Nutrition training did not pass in one new SA where directors might not have yet received such training • School teacher: Two indicators related to participation in pedagogical training met the benchmarks. Participation in Health, Hygiene and Nutrition training did not pass in one new SA where directors might not have yet received such training • Female and male students: All indicators related to school canteen were met **Phase II:** • Causes of school dropout: primary cause associated with lack of financial means (increase in school fees and cost of living)– student returned home because of non-payment of school fees and periodic suspensions/ absences often leads to complete school drop out. • Use and assessment of training materials provided by CRS: high level of satisfaction with CRS work expressed by teachers, directors and PTA members. Number of pedagogical boards per school is insufficient. High rates of resignation of teachers after they received training sessions (transfer to other schools for salary issue). • PTA contribution to school development: through CRS training sessions, PTA and school directors gradually came to understanding with one another. PTA member implement numerous activities that contribute to the development of their school.	• Share Phase II results with field staff and partners: issues of school dropout because of non-payment of school fees and transfer of teachers who have received CRS training to non-CRS supported schools. • Include those issues for discussions in community meetings with PTAs, and federation of PTAs to propose concrete plans to address those issues at the school and community levels. • Emphasize advocacy training for PTAs and federation of PTAs and assist them in their fundraising efforts for community education activities.

MCHN

Results	Recommendations for Program Operations
Phase I: Breast feeding and Infant feeding practices: • Targets met for: giving only breast milk on day of birth and breastfeeding their infant within one hour of birth • Targets not met for: giving colostrum to infants, providing the adequate number of daily complementary feeds to children between 6 and 24 months; and providing children 6-24 months with the appropriate dietary diversity Diarrhea and diarrhea management: • Three aged groups failed the target on % without diarrhea in last two weeks • Most of the SAs passed the benchmark and the weighted average on diarrhea management but unequal performance levels across the SAs (37% children given ORS during diarrhea at the time of baseline and 60% at MTE) Health cards, Child Immunization and Vitamin A supplementation: • Thanks to joint action between CRS and the Ministry of Health, all targets met for all age groups for all indicators Pre-natal and Post natal Care: • Targets met for indicators dealing with immunization during pregnancy, the number of prenatal visits, the prenatal visit with trained provider before the third trimester of pregnancy and the postnatal visit within 45 days of delivery • Fewer mothers attend postnatal visits in the area of Aquin compared to other areas. Results of **Phase II** show that women in Aquin did not attend postnatal clinic because there was a disruption in food supplements for many months. Colvols report that youngest women attend the postnatal clinic more than the older women. • Results more successful for mothers of younger children: recent exposure might be associated with better performance (95.6% of mothers of children 0-6 months of age who received prenatal visit with trained provider before third trimester of pregnancy) • Target (35%) not met for mothers who gave birth in a health facility. Reasons reported not to deliver in a health institution (**Phase II):** distance too long between home and health center, not in agreement with some conditions for delivery at hospital (such as fear of delivery table, fees too high, nice clothes not available, no respect of local customs….) Participation in program activities: • Participation in rally-posts: participation of children and mothers met the benchmark in three SAs except in the area of Aquin and Grande Anse Factors that motivate mothers to take their children to the rally-posts (**Phase II**): vaccination, weighing, education	Infant feeding practices: • The adoption of these practices (giving colostrum to infants, provide adequate number of daily complementary feeds to children between 6 and 24 months, and providing children 6-24 months with the appropriate dietary diversity) is crucial to reducing malnutrition rates and CRS should strive to better understand the constraints that may impede mothers from adopting those important practices and emphasize those practices in training of CHWs and health staff and in education sessions to caregivers Diarrhea and diarrhea management: • Should continue to emphasize the BCC messages on the importance of applying simultaneously all three components of appropriate treatment of diarrhea: ORS, increased liquids and same or more food Postnatal visits in Aquin: The MCHN team should ensure that the management staff in Aquin hospital implement program activities according to the norms and procedures. Delivery in health institution: share results of Phase II with hospital health staff, include those topics in health staff training and discuss concrete changes to improve the environment when women give birth in a health facility. Participation in program activities: • Vaccination being the most important motivating factor for mothers to participate in the rally-post, CRS MCHN team should continue to support MCHN centers with strategies to increase vaccination activities in the rally-posts

Results	Recommendations for Program Operations
session, Vitamin A, deworming medicines, reminder by the colvol, colvol's "way of doing", popularity of the colvol, distance between post and household. Lack of motivation of mothers of children 12-24 months directly linked with the perception that children who have completed their vaccinations are at less risk. • Participation in mothers' clubs: All SAs passed the benchmark of 25% (40.2% among the youngest group) • Perceptions of mothers about CHWs' knowledge and skills: for mothers of children 0-6 and 6-12 months old, all of the SAs met the targets on five indicators; the area of Port a Piment, Roche a Bateau and Coteaux did not pass the target for 12-24 months old for the communication on the child's weight	• CRS staff and CHWs should emphasize the issue that children older than 12 months are still at risk and mothers should continue to take them to the rally posts • Recommendations from mothers in Aquin (Phase II-qualitative) to improve the rally-posts: reorganize and improve the logistics in rally posts to avoid mothers waiting too long; conduct education sessions for smaller groups to facilitate better participation
Food Supplementation Program during Pregnancy and after childbirth: • 82.5%, 100% and 72.5% of mothers (children 0-16, 6-12 and 12-24) received food supplements during their last pregnancy (note that the sampling was done at the population level) • Results on the "regularity" of food supplementation during pregnancy and after childbirth did not meet the expected targets • Food rations (**Phase II)**: mothers report receiving the correct amount of commodities. Irregularity due to disruptions in the stock is the major problem.	Food supplementation during Pregnancy and after childbirth: • CRS MCHN staff and Commodity Management Office should analyze issues of regularity of food deliveries and propose solutions to improve the situation
Knowledge, skills and participation of Community Health Workers: • All CHWs passed the benchmarks on five indicators measuring their perceptions of knowledge except for their ability to provide immunization • Results on their technical knowledge were mixed: passed on immunization and diarrhea management and ORT but did not pass on some infant feeding issues such as the number of times a on-year-old child should be fed each day and the criteria reference for malnourished children (note that the benchmark had been set at 95%) • CHWs in both SAs cleared the 75% benchmark for completion and submission of rally posts reports and 85% for participating in the monthly continuing education session	Knowledge, skills and participation of Community Health Workers: • Address critical gaps in CHWs knowledge via monthly continuing education sessions and formal refresher training courses • Use LQAS to monitor CHW's levels of knowledge in various SAs on a regular basis and after refresher training courses • Ensure CHWs have materials they need to carry out their responsibilities properly
Hand washing knowledge and techniques: • Safety Net program participants most knowledgeable on hand washing techniques, followed by the Education program and mothers participating in the MCHN program. CHWs met the targets for three indicators and failed on three. • "After using the toilet" and before eating" messages met the target but the indicator "before feeding children" failed in all groups • Correct hand washing techniques: all four groups in Safety Net program passed, some Education groups passed (school children did not pass), and all three groups of mothers failed to pass for the international method of hand washing techniques	Hand washing knowledge and techniques • Messages on hand washing should be reinforced in all programs, but specially so in the MCHN program for CHWs and mothers (improvements in hygiene behavior may present an opportunity for better child nutrition and health outcomes) • A standardization of messages across programs could be instrumental in improving hand washing knowledge and techniques

HIV/AIDS

Results	Recommendations for Program Operations
Safety Net Institutions with HI/AIDS training and with no HIV/AIDS training (management staff and children): • Both groups passed and failed same benchmarks on knowledge on "means of transmission" • Both groups have fairly good perception of "personal risk" • Both groups met the targets on "stigma and discrimination" Schools (PTA member, School director, Teacher, Female and Male children): • All three groups met targets on commonly known ways of avoiding HIV/AIDS transmission, on general knowledge of HIV/AIDS and notions of Personal risks and stigma and discrimination	• Transmission messages should be reinforced and expand upon the public health messages that are currently being spread by the media • Discrimination and stigmatization issues must be addressed with the youngest program participants in order to contribute to improved conditions for PLWA on the societal level • Reinforce the technical capacity of the local partner that are providing training to enable them to provide better quality training to the communities

Safety Net

Results	Recommendations for Program Operations
Indicators used as "baseline" • Management and staff can name 2 or more universal rights of children • Some centers failed to meet the benchmarks for cleanliness (kitchen area, toilets/latrines) (*) • Centers did not pass the 70% benchmark for % of centers without food shortages in the center canteen in the last months • Center staff met the target on maintenance of financial ledger • Both groups of female children met the targets on" going to school, having a birth certificate, having eaten a CRS supplied food and something other than a CRS supplied food in the last 24 hours	• Strengthen Health, Hygiene and Nutrition training in Safety Net institutions to underscore the critical links between cleanliness and good health • Create a checklist of regular cleaning tasks for centers' staff • Include cleanliness indicators in the supervision visits of CRS Safety net staff

* Note: indicators relating to centers' cleanliness should have been set higher (the MTE benchmark was 50%)

Civic Education

Results	Recommendations for Program Operations
13 indicators measured on 11 groups (from above programs) as baseline information: • Expected performance benchmarks were different for all groups and depended upon the perceived or verified levels of community and civic involvement, education levels and past CRS interventions with specific target groups • School directors passed all 13 questions	• Design civic education training programs that speak to the needs and constraints of each target group; particularly mothers, CHWs, PTA members and school teachers

CONCLUSION FOR METHODOLOGY DEVELOPMENT

The FANTA team was very satisfied with the overall undertaking. As a pilot study, it confirmed LQAS's potential for the conduct of mid term evaluations; and highlighted the usefulness of the qualitative research in Phase II. However, several lessons were learned that should be applied in future such applications.

Phase I (LQAS Surveys)

- The entire exercise consists in evaluating whether progress made corresponds to that expected. To do so, one must assume that LOA objectives are reasonable to start with. That, however, can be problematic: for many indicators we simply don't know how much improvement can be achieved in a given time frame; and a program's objectives (mid term and LOA) can easily be set too high, or too low. When interpreting results, the analyst should be wary of this and always ask whether initial objectives were too ambitious, or too modest. If need be, targets can be adjusted in light of the findings from the mid-term.
- Unlike final evaluations, the MTE focuses on beneficiaries, not on the population at large (unless they are one and the same). Because of this, MTE results may be far higher than LOA results, especially where a program is effective in changing outcomes among beneficiaries. The benchmarks might therefore be different, arguably, at those two time points. The interpretation of results should also be clear about whom inferences are made.
- A tension exists between the amount of detail to be provided by the evaluation, and the cost of collecting and analyzing the data. Two factors in particular play in this: (i) what questions should be asked; and (ii) who should answer them. On the first point, the M&E Officer must guard against overloading a survey with questions that do not lead to implementation recommendations. The preference is to concentrate on effect indicators. On the second point, the multiplication of strata (e.g. teachers by grade; or mothers by age group of their child) rapidly leads to sample inflation, denying the benefits of LQAS. Principles to apply here are: (a) define a new sample group only if this group is a particular target for the program; (b) consider parallel sampling if this is possible; (c) recall that SAs are themselves a stratifying device.

Phase II (Qualitative research)

- Phase II is as important as Phase I and should not be given less attention.
- The experience and quality of the qualitative study field staff is critical to its success. A specialist should be hired to do this piece of the work.
- Selecting the site for carrying out the qualitative research is critical to the findings. The selection of respondents for Phase II is purposive and should focus on sites and population groups that were found to display the problem.

CHAPTER 1 - INTRODUCTION

1.1. INTRODUCTION

According to USAID/DCHA/FFP guidance, Title II Cooperating Sponsors are expected to conduct a series of evaluation exercises during the life of their Development Activity Programs (DAPs): a Baseline survey should be done before implementing the program, to know the conditions at the outset in intervention areas; a final evaluation is also expected at the end of the Life of Activity (LOA) to document the extent to which the program achieved its objectives; and a Mid Term Evaluation is recommended, about halfway through the life of the DAP, to help program managers assess progress made, whether or not the program is on the way to achieve its stated objectives, and make recommendations on ways to improve performance if need be. Although relatively good experience exists on the conduct of Baseline and Final Evaluations, little guidance exists on how to do Mid Term Evaluations—even though this may be one of the most important steps in the LOA to guarantee its final success. To address this gap, the Food and Nutrition Technical Assistance (FANTA) project teamed up with CRS/Haiti to pilot test a Mid Term Evaluation (MTE) methodology that would: 1) examine progress made in reaching DAP goals; and 2) formulate recommendations to help correct imbalances in areas found to be under performing. This report looks at the entire activity, from methodology development to results analysis and final recommendations.

1.2. SUMMARY OF STEPS OF THE MID-TERM EVALUATION (MTE)

The MTE results presented in this report are based upon data collected in CRS/Haiti's areas of intervention, namely in the Southern and Grande Anse Departments. The MTE was divided into two phases: Phase I encompassed the development of the survey instruments, the collection of survey data, and its analysis; Phase II examined the bottlenecks identified in Phase I, using qualitative research methods. The quantitative data collection of Phase I took place from December 7 to December 23, 2004. The qualitative, follow-up investigation of Phase II took place March 14-24, 2005. The steps involved in each Phase are listed in continuation, and developed in later sections.

> **PHASE I:** The first step in Phase I was to identify performance indicators for each sector evaluated in the MTE. A mid-term performance benchmark was set for each selected indicator taking into account its baseline value and LOA target. Samples targeted for data collection in each sector were also identified at this time, activity zones being subdivided whenever possible into Supervision Areas (SAs). On the basis of this preliminary work, the Team developed LQAS-friendly data collection instruments in which all questions were phrased to elicit a dichotomous (yes/no) answer. Data collection began December 9, 2004 and was completed by December 23, 2004. Completed questionnaires were analyzed early January 2005, allowing to separate activities that had successfully met their mid term targets from those that did not.
>
> **PHASE II:** Focusing on indicators that seemed to be lagging in performance, the Team identified activities that merited further investigation. An analysis of constraints using qualitative methods was performed, including mainly focus group and key informant interviews. The report from the qualitative research, submitted April 2005, was used to elaborate a series of recommendations to improve project performance.

CHAPTER 2 – CONTEXT OF MID-TERM EVALUATION

2.1. CRS/HAITI PROGRAM OVERVIEW

The goal of CRS' proposed DAP is to sustainably reduce the level of food insecurity in vulnerable communities of the Southern Peninsula with a focus on the **South and Grande-Anse departments and one area of the South East Department (Cotes de Fer)**. CRS will achieve this goal through integrated activities in four sectors: Health and Nutrition (Maternal and Child Health, Water and Sanitation, HIV/AIDS, Micro-finance), Agriculture, Food-Assisted Education and Humanitarian Assistance. To achieve this goal, CRS will secure private funds and other sources of funding to complement DAP resources.

CRS has implemented Title II food activities in Haiti for over four decades, targeting the most vulnerable groups: children 0-5 years of age, pregnant and lactating mothers, primary school students, and institutionalized persons (orphans, hospital patients, tuberculosis and HIV/AIDS out patients and the elderly and displaced), through schools, health centers, and safety net institutions. FY 02-07 DAP improves upon the previous program by more effectively targeting needy communities, providing more efficient and effective service delivery and applying lessons learned from previous Title II funded and complementary food security programs. This DAP employs an integrated approach to its programming, implementing multiple sectoral interventions in the same communities, in order to increase the impact, sustainability, and efficiency of each.

The Maternal and Child Health Component of the Health and Nutrition Program will improve the quality of health services in health institutions located in the DAP targeted areas working through the Health Communal Unit (UCS: Ministry of Health structure grouping health institutions by region). New activities include support to immunization, IMCI and `ti-foyer`(Home-based Nutritional Demonstration using the positive deviant approach). In addition to MCH activities targeted at health facilities, a Water and Sanitation program is integrated into Education and Social Assistance programming. CRS private funds support HIV/AIDS activities while pursuing the current food supplementation of HIV/AIDS beneficiaries. Interventions in micro-credit continue to support health activities targeting Volunteer Community Health Workers and a limited number of female participants.

In addition to integrating and focusing on geographical areas, CRS included Agriculture as a new DAP sector, based on CRS/Haiti's long-term experience in that area. While reinforcing current partners, program activities in agriculture are implemented on the Southern coast through support to local peasant associations.

CRS phased-out school-feeding as a stand-alone activity after one year in all four current DAP departments, while strengthening community structures in schools that have received a package of interventions to accompany food during the phase out period. A complete Food Assisted Education package is implemented in 150 schools in the South and Grande-Anse departments for which CRS private funds complement the food-assisted activities.

In the Humanitarian Assistance Program, food distribution continues to serve the most vulnerable such as orphans, abandoned and street children, the physically and mentally disabled, and chronically ill and aged persons. Levels of beneficiaries will be maintained due to limited DAP resources. This sector fosters linkages between Social Safety Net Institutions and broader civil society, facilitating channels for advocacy and community empowerment, and empowering the former to diversify their sources of funding. To consolidate efforts, share experiences and develop collective projects, the children's shelters were grouped by geographic locations in FY03. Nine federations known as ruches were formed. At the beginning of FY03, HIV-AIDS training of Safety Net institutions staff and children was introduced thanks to additional funding from the USAID local Mission.

Beginning FY05, all DAP sectors will be reinforced by a Civil Society/Human Rights component (CRS privately funded) through training programs in civic education, citizen rights and responsibilities and

advocacy. These efforts will contribute to the sustainability of proposed interventions and reach the CRS/Haiti DAP goal of reducing the food insecurity level in targeted communities.

The purposes of the Title II commodities are the following: 1) nutritional and caloric supplementation for pregnant/lactating women, nutritional recuperation of undernourished children under five and nutritional supplements for immediate family members, 2) daily feeding of school aged children, 3) food for humanitarian assistance/safety net activities, 4) incentive for beneficiaries to participate in all programs, 5) monetization to cover the costs of these activities. Monetization supports the costs of interventions that will improve the accessibility and quality of health services, increase the food security support given to persons living with HIV/AIDS, provide access to micro-credit for MCH groups, increase the availability and utilization of potable water and sanitation facilities in targeted communities and partnering institutions, and increase access to food through improvement of agricultural productivity while implementing a phase-out plan for stand-alone school feeding activities.

The US Local Mission funds complements the Monetization funds for specific costs such as program materials, salaries, warehousing and other administrative expenses.

The number of beneficiaries to be reached by each program during the five-year period is presented in the following table:

Program Component	Number of Beneficia-ries During FY 02	Number of Beneficia-ries During FY 03	Number of Beneficia-ries During FY 04	Number of Beneficia-ries During FY 05	Number of Beneficia-ries During FY 06	Number of Beneficia-ries Over LOA (**)
Health and Nutrition (including HIV/AIDS) (food distribution beneficiaries + caretakers)	92,000	59,900	74,250	80,150	80,150	226,400
Water/Sanitation (new every year)	30,200	35,000	40,000	40,000	43,000	188,200
Credit (on-going and new clients: women and CHWs)	4,885	6,074	6,373	6,573	6,520	7,823
Agriculture & Infrastructure (new farmers only)	500	400	450	350	300	2,000
Education (school children only)	78,350	60,000	48,000	50,000	50,000	148,350
Social Safety Net (food distribution beneficiaries only)	16,200	18,000	18,000	22,000	22,000	56,200
TOTAL	222,135	179,374	187,073	199,073	201,970	628,973

(*) Includes those covered by direct distribution as well as those participating solely in monetization-funded activities
(**) Total LOA beneficiaries does not equal the sum of beneficiaries in each FY since the same beneficiary could stay in the program for more than one year

Monitoring and Evaluation Units already integrated in each major sector of interventions continue to monitor a series of progress indicators and focus on data quality control and feedback to partners. An Early Warning System is in place in project areas. CRS conducted an integrated baseline study to determine the initial values and carry out subsequent monitoring activities to determine progress of the program at specific intervals. Program evaluations will be conducted at mid-term and final points.

Details on program objectives and activities are presented in **Appendix 1**. Additional information is available in FY02, FY03 and FY04 Annual Results Reports. The joint baseline report is also an important reference document.

2.2. EXPECTED RESULTS BY LIFE OF ACTIVITY (LOA) AND MID-TERM

Table I shows the baseline value, the expected LOA and mid term targets for all indicators to be measured during the mid term evaluation. No baseline value is available for the indicators which were not investigated at the beginning of the program. The program team had to set LOA and mid term targets for those additional indicators. Moreover, some LOA targets were intentionally left blank for some

indicators that did not have baseline values. In such cases, the weighted coverage levels revealed in the MTE would serve as baseline values for these indicators.

Table 1: Indicators, Baseline Values, LOA and MTE targets by sectors

AGRICULTURE			
INDICATORS	**BL Value**	**LOA target**	**MTE target**
Land Characteristics			
Percent of farm association members that have a dry and cool place for seed storage	n/a	90%	80%
Percent of farm association member plots that use either green fertilizer or compost	n/a	80%	70%
Percent of plots visited that use Level A/courbe de niveau techniques	n/a	90%	75%
Percent of farm association members that planted beans in the plot of land used for CRS activities	n/a	95%	90%
Percent of farm association member plots that use/used the promoted planting density for beans	n/a	80%	60%
Percent of farm association member plots that use the promoted planting density for plantains	n/a	80%	60%
Percent of farm association member plots with one or more recommended anti-erosion systems ("ramp pay", "clayonnage", or live barrier)	n/a	90%	80%
Percent of farm association member plots visited with one or more anti-erosion systems in place ("ramp pay", "clayonnage", or live barrier)	n/a	90%	75%
Percent of farm association member plots that have at least 50 trees planted on them	n/a	60%	40%
Gender issues within farmers' associations			
Percent farm association members that report the inclusion of women was a guiding principle in the formation of their association	n/a	95%	90%
Percent of farm association members that think that women should be allowed membership in the groupement	n/a	90%	80%
Percent farm association members that can state one concrete benefit for the active involvement and membership of women	n/a	90%	80%
MICRO-CREDIT – Community (women)			
INDICATORS	**BL Value**	**LOA target**	**MTE target**
Participation in rally-posts			
Percent of credit participants who participated in a rally post before they joined the credit program	n/a		70%
Percent of credit participants who have participated in a Rally Post since they joined the credit program	n/a		50%
Percent of credit participants who have children less than 5 years old	n/a		70%
Selection process			
Percent of credit participants who feel the selection process for receiving micro-credit loans is fair and democratic	n/a		75%
Percent of credit participants who feel that the Steering Committee was selected in a fair and democratic manner	n/a		80%
Management of loans			
Percent of credit participants who would like to continue in the micro-credit program	n/a		85%
Percent of credit participants who think they are capable of managing their loan well	n/a		70%
Percent of credit participants who think they are capable of managing their business efficiently	n/a		60%
Percent of credit participants who made a profit from their business activities last month	n/a		80%
Percent of credit participants who have never had a problem paying any of the monthly loan payments	n/a		80%
Group Solidarity			
Percent of credit participants whose group has assisted a fellow group member when s/he had a problem paying back her/his loan	n/a		35%
Percent of credit participants who think that their group's Steering Committee does a good job managing the micro-credit program	n/a		80%

Literacy/Numeracy/Understanding Bank Books			
Percent of credit participants who know how to sign their name	n/a		30%
Percent of credit participants who feel confident in their addition and subtraction skills	n/a		30%
Percent of credit participants who report not having any difficulty in understanding how their bank book works	n/a		85%
Percent of credit participants who have read the financial agreement that they signed with the steering committee of the group in order to get their loan	n/a		20%
Changes in household wealth			
Percent of credit participants who never had to borrow money from another source since they received their loan	n/a		65%
Percent of credit participants who spend more money on food than before they received their loan	n/a		75%
Percent of credit participants who feel they have more money now to spend on things such as clothing, medical care and school fees than before they received their loan	n/a		70%
Percent of credit participants who think that the amount of their loan was enough to improve their business activities as they would have liked	n/a		50%
Percent of credit participants whose school aged children all go to school	n/a		60%
Percent of credit participants whose school aged children were all going to school before they joined the credit program	n/a		40%
MICRO-CREDIT (Community Health Workers – colvols)			
INDICATORS	**BL Value**	**LOA target**	**MTE target**
Management of their loan			
Percent of Colvols who think they are capable of managing their loan well	n/a	90%	75%
Percent of colvols who think they are capable of managing their business activities efficiently	n/a	85%	75%
Percent of Colvols who made a profit from their business activities last month	n/a	70%	60%
Percent of Colvols who have never had a problem paying any monthly loan payments	n/a		70%
Group solidarity			
Percent of Colvols whose group assisted a fellow group member when s/he had a problem paying back their loan	n/a	50%	40%
Changes in household wealth			
Percent of Colvols who have never borrowed money from another source since their received their loan	n/a		60%
Percent of Colvols who state that they spend more money on food than they did before they received their loan	n/a	85%	80%
Percent of Colvols who feel they have more money now to spend on such things as clothing, medical care, and school fees/costs than before they received their loan	n/a	65%	60%
Percent of colvols who think that the amount of their loan was enough to improve their business activities as they would have liked	n/a	60%	50%
Percent of Colvols whose school-aged children all go to school	n/a	85%	80%
Percent of Colvols whose school aged children all went to school before they received their loan	n/a		65%
Credit program as an incentive to work as CHWs			
Percent of Colvols who think that the micro credit loan program is an incentive for them to work as a Colvol	n/a		50%
Percent of Colvols who report that they would continue to work as a Colvol even without the micro-credit program	n/a		60%
WATER AND SANITATION - CISTERNS			
Indicators	**BL value**	**LOA target**	**MTE target**
Percent of cisterns with walls intact	n/a	90%	70%
Percent of cisterns without standing water	n/a	90%	80%
Percent of cistern faucets equipped with a handle	n/a	95%	90%
Percent of cisterns without a leak/drip	n/a	90%	70%
Percent of cisterns with water flowing from the faucet	n/a	90%	70%
Percent of wash basins without garbage or debris	n/a	85%	65%
Percent of wash basins without animal feces within 10 meters	n/a	85%	65%

WATER AND SANITATION - LATRINES			
Indicators	**BL Value**	**LOA target**	**MTE target**
Percent of latrines found to be clean (no trash lying on the floor, no feces visible)	n/a	75%	60%
Per cent of latrines free of visible soiled toilet paper or other used paper	n/a	75%	60%
Percent of latrines visited where all latrine doors were closed upon arrival	n/a	75%	60%
Percent of latrines with functioning doors	n/a	95%	80%
Percent of latrines with doors equipped with working inside locks	n/a	85%	65%
Percent of latrines with seat covers in all stalls	n/a	75%	60%
Percent of latrines with all latrine covers down	n/a	75%	50%
Percent of latrines that had at least one broom available	n/a	75%	40%
Percent of latrines located at an appropriate distance from water source	n/a	90%	70%
Percent of latrines located at an appropriate distance from the school	n/a	95%	70%
Percent of schools with very little garbage lying around	n/a	80%	70%
Percent of schools where the garbage disposal is used	n/a	90%	80%
WATER AND SANITATION – TRASH DISPOSAL			
Indicators	**BL Value**	**LOA target**	**MTE target**
Percent of sites with trash can easily accessible to school children	n/a	95%	80%
Percent of schools without garbage lying around	n/a	85%	70%
Percent of trash disposal areas with acceptable levels of garbage in them *where the level of trash in the garbage pit was below the level of the ground or surrounding wall)	n/a	85%	70%
WATER AND SANITATION – SPRING CAPPING			
Indicators	**BL Value**	**LOA target**	**MTE target**
Spring capping area			
Percent of spring capping free of garbage or debris	n/a	75%	65%
Percent of spring capping will walls intact	n/a	85%	70%
Percent of spring capping covered by lid	n/a	85%	70%
Percent of spring capping with lid firmly in place	n/a	85%	70%
Percent of spring capping surrounded by a canal on three sides	n/a	85%	70%
Percent of spring capping canals that are at least 20cm deep	n/a	85%	70%
Percent of spring capping with front area free of standing water	n/a	95%	80%
Percent of spring capping surroundings protected by vegetation	n/a	80%	50%
Water point/fountain area			
Percent of water point/fountain free of garbage or debris	n/a	75%	65%
Percent of water point/fountain surroundings free of standing water	n/a	90%	80%
Percent of water point faucet or fountain pipe with water flowing	n/a	85%	75%
Percent of water point/fountain where there are no animals within 5 meters	n/a	90%	80%
Percent of water point/fountain where there are no animals feces within 5 meters	n/a	90%	80%
Percent of communities with a spring capping that have a committee to manage the system	n/a	80%	65%
Percent of respondents who state knowing at least one member of the spring capping committee	n/a	80%	65%
Percent of respondents who state they have never seen the system dry	n/a	75%	60%
Percent of respondents who state they have never seen the system broken or damaged	n/a	75%	60%
Percent of respondents who state they have never seen people doing their laundry at the water point/fountain	n/a	75%	60%
Percent of respondents who state they have never seen people watering their animals at the water point/fountain	n/a	80%	65%
Percent of respondents who state they have never seen people bathing at the water point/fountain	n/a	80%	60%
Behavior change			
Percent of respondents who state that their family treats the water with bleach before drinking it	n/a	30%	20%
Percent of respondents who state that their family has less diarrhea since the	n/a	75%	65%

construction of the spring capping			
Percent of respondents who state using more water since the construction of the spring capping	n/a	80%	70%

EDUCATION			
Indicators	**BL Value**	**LOA target**	**MTE target**
PTA committee members			
Percent of PTA members who attended at least one PTA meeting in the last 4 months.			50%
Percent of PTA members who state that they participated in a health-related activity at school in the past six months		95%	60%
Percent of PTA members who state that they personally participated in a PTA small project in the past 12 months		50%	30%
Percent of PTA members who have participated in a training event given by CRS for PTA members			80%
School directors			
Percent of School Directors who have ever received managerial or administrative training from CRS while an employee of their school			80%
Percent of School Directors who feel that the training they received improved the overall quality of their management or administrative performance			40%
Percent of School Directors who received any Health, Hygiene, and Nutrition training from CRS while the director at their school.			80%
Teachers			
Percent of Teachers who have ever received pedagogical or teacher training from CRS while an employee of their school			75%
Percent of Teachers who feel that the training they received improved the overall quality of their teaching performance			40%
Percent of Teachers who received any Health, Hygiene, and Nutrition training from CRS while teaching at their school.			75%
Students			
Percent of students who state that they received a meal the last day they were at school		95%	80%
Percent of students who state that the quality of the meal as good		70%	50%
Percent of students who state generally eating all the food given to them at school.			80%

HEALTH AND NUTRITION			
Indicators	**BL Value**	**LOA target**	**MTE target**
Breast Feeding and Infant Feeding Practices			
Percent of children (0-11.99 months) given breast milk only on day of birth	32.5%	50%	40%
Percent of infants (0-11.99 months) breast fed within 1 hour of birth	6.2%	16.2%	20%
Percent infants having received colostrum	53.0%	95%	80%
Percent of children (0-5.99 months) currently being breastfed	95.8%	95%	95%
Percent of children (6-11.99 months) currently being breastfed	98.5%	98.5%	95%
Percent of children (12-23.99 months) currently breastfed	60.0%	70.0%	65%
Percent of infants (0-5.99 months) who are exclusively breastfed	16.8%	26.8%	20%
Percent of children (6-11.99 months) who were fed the appropriate number of complementary feedings in the last 24 hours	55%	60%	60%
Percent of children (12-23.99 months) who were fed the appropriate number of complementary feeds in the last 24 hours	41.1%	46.1%	45%
Percent of children (12-23.99 months) who received the 3 food groups (“constructeur, “energetique”, “protecteur”) in the last 24 hours	n/a	n/a	80%
Diarrhea Prevalence			
Percent of children (0-5.99 months) without diarrhea in the last two weeks	80.1%	85.1%	80%
Percent of children (6-11.99 months) without diarrhea in the last two weeks	60.1%	65.1%	65%
Percent of children (12-23.99 months) without diarrhea in the last two weeks	61.2%	66.2%	65$
Percent of children (6-23.99 months) with diarrhea who were given ORS	37.4%	60.0%	50%

Percent of children (6-23.99 months) with diarrhea who were given increased liquids during diarrhea	44.6%	n/a	50%
Percent of children (6-23.99 months) with diarrhea who were given the same or more food	27.4%	n/a	40%
Percent of children (6-23.99 months) with diarrhea receiving continued feeding during diarrhea	15.2%	25.2%	20.0%
Percent of children (6-23.99 months) with diarrhea receiving additional food after diarrhea episode	36.4%	46.4%	40%
Percent of children (0-23.99 months) with health card or birth certificate with date recorded	n/a	n/a	90%
Percent children (6-23.99 months) receiving Vitamin A capsule in last six months	45.7%	80%	60.0%
Percent of children (12-23.99 months) fully immunized (3 doses polio)	26.7%	36.7%	35%
Percent mothers (children 0-23.99 months) who have a health card	58.7%	n/a	80%
Percent mothers (children 0-23.99 months) who received at least 1 tetanus shot	83.8%	n/a	70%
Percent mothers (children 0-23.99 months) fully vaccinated against tetanus during last pregnancy (received 2 shots or was already fully vaccinated)	63.8%	73.8%	70%
Percent mothers (children 0-23.99 months) with at least 3 prenatal visits with a trained provider	79.6%	84.6%	80%
Percent of mothers (children 0-5.99 months) who received pre-natal visit with trained provider before third trimester of pregnancy (7 months)	81.4%	n/a	80%
Percent of mothers (children 0-23.99 months) who had a trained health provider assist the delivery	32.3%	37.3%	70%
Percent of mothers (children 0-23.99 months) who gave birth in a health facility	9.7%	n/a	35%
Percent of mothers (children 0-23.99 months) who made at least one postnatal visit with a trained health provider within 45 days of delivery	19.1%	24.1%	25%
Participation in program activities (rally-posts and mothers' club)			
Percent of children who have participated in a Rally Post in the last month	n/a	90%	80.0%
Percent of mothers who have participated in a Rally Post in the last month	n/a	80%	70.0%
Percent of mothers who participated in an educational session at a Rally Post in the last month	n/a	80%	70.0%
Percent of mothers who are members of a Mothers Club	n/a	50%	25%
Participation in program activities (Perceptions of Mothers on CHW's knowledge on Health Issues and Communication Skills)			
Percent mothers who think educational sessions provide practical information	n/a	n/a	70%
Percent mothers who think immunization provided by the health facility is valuable	n/a	n/a	95%
Percent mothers who think growth monitoring services that Colvol provides are useful	n/a	n/a	95%
Percent mothers who know if child's weigh increased or decreased in the last month	n/a	n/a	70%
Percent mothers who think information provided by Colvol is easy to understand	n/a	n/a	75%
Percent mothers who think Colvols are knowledgeable about nutrition information	n/a	n/a	80%
Participation in program activities (health facility-food supplementation)			
Percent of mothers (0-11.99) who received food supplementation during last pregnancy	n/a	80%	80%
Percent of mothers (12-23.99) who received food supplementation during last pregnancy	n/a	80%	70%
Percent mothers who report receiving rations regularly each month during pregnancy	n/a	n/a	80%
Percent of mothers who received food supplementation regularly since birth of child	n/a	n/a	80%
Percent mothers reporting receiving the correct ration from the health center	n/a	n/a	95%
Distance to water source and source of water			
Percent mothers reporting water collection taking 30 minutes or less	74.2%	n/a	75%
Percent mothers that fetch their water from a protected water source	56.2%	66.2%	55%
MCHN- CHWs (colvols) (knowledge, skills and participation)			
Indicators	**BL Value**	**LOA target**	**MTE target**
Perceptions of knowledge and skills			
Percent of Colvols who feel totally confident in their skills to provide quality health services to their communities	n/a		90%
Percent of Colvols who feel confident in their ability to provide nutritional messages to their communities	n/a		90%
Percent of Colvols who feel confident in their ability to provide maternal health messages to their communities	n/a		90%

Percent of Colvols who feel confident in their ability to measure a child's weight	n/a		90%
Percent of Colvols who feel confident in their ability to record a child's weight on the Road to Health cards	n/a		90%
Percent of Colvols who feel confident in their ability to provide immunizations	n/a		60%
Technical knowledge			
Percent of Colvols who can identify the vitamin deficiency which causes bad vision (Vitamin A)	n/a		90%
Percent of Colvols who know how many times a day a one-year old child should be given something to eat	n/a		60%
Percent of Colvols who state that it is okay for a mother to breastfeed when she has a fever	n/a		70%
Percent of Colvols who can recognize the symptoms of scabies when given a description of the condition	n/a		75%
Percent of Colvols who know that a child with a weight for age below -3 standard deviations should be referred to a health center immediately	n/a		95%
Percent of Colvols who mention using at least one Adult Participatory Learning technique during their educational work	n/a		95%
Percent of Colvols who feel that the trainings they received in the social marketing of ORT has been useful to their work with mothers in their communities	n/a		90%
Availability of materials and supplies			
Percent of Colvols who, in the last 30 days, have not had a shortage of any of the supplies or materials they needed to do their job correctly	n/a		60%
Percent of Colvols who, in the last six months, have not had any difficulties providing the expected services to their communities due to inadequate supplies or materials	n/a		60%
Participation in monthly activities			
Percent of Colvols who brought their report to the last Colvol meeting they attended	n/a		75%
Percent of Colvols who attended the Continuing Education session at the last Colvol meeting they attended	n/a		80%
Percent of Colvols who discussed the micro-credit program at the last Colvol meeting they attended	n/a		75%
Percent of Colvols who correctly state it is not okay to give a 5 month old child ORT	n/a		80%
Percent of Colvols who correctly state that when a child has diarrhea the mother should give the child more food than usual	n/a		80%

HAND WASHING KNOWLEDGE & TECHNIQUES–Cross sectoral (MTE target for each group)

KNOWLEDGE: % who know when to wash their hands

% who wash their hands ….	**Health-Nutrition**		**Credit**	**Food Assisted Education**		**Safety Net**	
	CHWs	**Mothers**	**Women**	**PTA Members**	**School Directors, Teachers, Students**	**Directors & Staff**	**Children**
a. after using the toilet	80%	70%	70%	80%	80%	70%	70%
b. after changing babies' diapers	20%	20%	20%	20%	20%	20%	20%
c. before preparing food	80%	70%	70%	20%	20%	70%	20%
d. before eating	80%	70%	70%	80%	80%	70%	70%
e. before feeding child	80%	70%	70%	20%	20%	70%	20%
f. working in the garden/coming home from school or market	20%	20%	20%	20%	20%	70%	20%
g. after playing	NA	NA	NA	NA	20%	NA	70%
All key messages combined	a, c, d, e	a, c, d, e	a, c, d, e	a, d	a, d	a, c, d, e, f	a, d, g
Benchmark for all key messages combined	70%	50%	50%	70%	70%	60%	60%
TECHNIQUES – washing hands							
% who used correct hand washing technique (baseline method)	70%	60%	70%	70%	70%	70%	70%
% who used correct hand washing technique (international method)	70%	60%	70%	70%	70%	60%	60%

HIV/AIDS – Cross sectoral			
Indicators	**LOA target**	**MTE target (adults)**	**MTE target (children 13& up)**
Means of HIV/AIDS Transmission			
Percent of respondents that can state one can avoid acquiring HIV/AIDS		75%	60%
Percent of respondents that state one can avoid HIV/AIDS by abstaining from sex		40%	50%
Percent of respondents that state one can avoid HIV/AIDS by using condoms		40%	50%
Percent of respondents that state one can avoid HIV/AIDS by limiting sex to one partner		40%	50%
Percent of respondents that state one can avoid HIV/AIDS by avoiding unprotected sex with prostitutes		40%	50%
Percent of respondents that state one can avoid HIV/AIDS by avoiding unprotected sex with persons who have many sex partners		40%	50%
Percent of respondents that state one can avoid HIV/AIDS by remaining faithful to one partner		40%	50%
Percent of respondents that state one can avoid HIV/AIDS by avoiding unprotected sex with persons who inject drugs intravenously		40%	50%
Percent of respondents that state one can avoid HIV/AIDS by avoiding infected blood		40%	50%
Percent of respondents that state one can avoid HIV/AIDS by avoiding the use of syringes, razors, straight edges		40%	50%
Percent of respondents that state one can avoid HIV/AIDS by avoiding contact with blood		40%	50%
Percent of respondents that state that a pregnant woman can give the HIV virus to her child during pregnancy		60%	50%
Percent of respondents that state that a mother can give the HIV virus to her child during child birth		60%	50%
Percent of respondents that state that a mother can give the HIV virus to her child via breast feeding		60%	50%
General knowledge on HIV/AIDS			
Percent of adult respondents that have been tested for HIV		20%	N/a
Percent of respondents that state that the HIV virus can take up to six months to show up as positive on a blood test.		60%	60%
Percent of respondents that state that there are no cure for people who have HIV		60%	60%
Percent of PTA respondents that state that HIV/AIDS has been discussed at their PTA meetings		55%	M/a
Perception of Personal Risk			
Percent of respondents that state that you do not get HIV by shaking hands with someone who has HIV/AIDS		60%	60%
Percent of respondents that state that you do not get the HIV virus by sharing a bathroom/toilet with someone who has HIV/AIDS		60%	60%
Percent of respondents that state that you do not get the HIV virus by hugging someone who has HIV/AIDS		60%	60%
Percent of respondents that state that a woman can refuse to have sex with her husband if he has a sexually transmitted infection		70%	N/a
Percent of respondents that state that it is not OKAY if he husband/boyfriend has sex with his wife/girlfriend even if she said “no” to his sexual advances		70%	N/a
Percent of respondents that state that a man can refuse to have sex with his wife if she has a sexually transmitted infection		70%	N/a
Percent of respondents that think it is not okay for a man to have sexual relations outside of his marriage		70%	70%

Percent of respondents that think it is not okay for a woman to have sexual relations outside of her marriage		70%	70%
Percent of respondents that think it is not acceptable for a man/woman to have sexual relations in exchange for the payment of household bills or school fees, for example		70%	70%
Percent of children that state one can avoid HIV/AIDS by remaining faithful to one partner		N/a	50%
Stigma and discrimination			
Percent of respondents that state knowing someone with the HIV virus		40%	20%
Percent of respondents that state they are friends with someone infected with HIV, or suffering from AIDS		40%	20%
Percent of respondents that state that if a friend of theirs was diagnosed as HIV positive, they would continue your friendship with that person		70%	60%
Percent of respondents that state they would be willing to take care of a family member that is infected with the HIV virus in their own home		70%	60%
Percent of SSNI adult respondents that state that they would accept a child into the center that they know to be HIV positive		70%	N/a
Percent of adult respondents that state they do not believe that people who have the HIV virus deserved getting the disease because of their past behavior		70%	60%
Percent of adult respondents that state they do not believe that people who have the HIV virus deserved getting the disease because they are bad religious people		70%	60%

SAFETY NET

Indicators	BL Value	LOA target	MTE target
Management			
Percent of staff that can state two or more universal children's rights		90%	85%
Percent of center management staff that have attended a meeting in the last 6 months with their Ruche - independently from CRS		80%	20%
Hygiene conditions			
Percent of centers that were found to be clean and relatively free of trash		80%	50%
Percent of center kitchens that were found to be clean and free of trash		80%	50%
Percent of center kitchens without uncovered food out on the counters		90%	75%
Percent of kitchen food preparation areas found to be smooth/free of sticky substances		80%	50%
Percent of kitchen food preparation stations found to have no evidence of pests or rodents		85%	70%
Percent of kitchens with soap available at the closest water point to the kitchen		80%	50%
Percent of centers in which latrine/toilet areas found to be clean		80%	50%
Percent centers with doors on all of the latrines/toilets		80%	60%
Percent of centers in which all latrine/toilet doors close completely		80%	50%
Percent of centers in which latrines/toilets provide adequate superstructure		50%	30%
Canteen management			
Percent of centers with no food shortages in the center canteen in the last month		90%	70%
Percent of centers with financial withdrawal or deposit that is dated within the last 30 days in the bookkeeping ledger		80%	50%
School attendance, birth certificate and meals			
Percent of children that state they are currently going to primary school		95%	80%
Percent of children that state they are currently going to school o receiving any training		95%	80%
Percent of children with birth certificates (or equivalent)		95%	80%
Percent of children that state they ate SFB, cornmeal or lentils (put local preparation names) in the last 24 hours		95%	90%
Percent of children that state they ate something other than SFB, cornmeal or lentils (put local preparation names) in the last 24 hours		60%	30%

CIVIC EDUCATION – cross sectoral		
Indicators	**LOA target**	**MTE benchmark**
% who know that the state is founded on 3 principles – property, government, citizenry	50%	20%
% who know that "Deputes" are elected for two-year terms	50%	20%
% who know the name of the tribunal in their commune	80%	50%
% who know that political parties gain political office by winning elections	80%	50%
% who know they have the right to form an association or social group	80%	50%
% who know they have the right to form a political party	80%	50%
% who know that Senators can propose laws	80%	50%
% who believe that the state and the population are both responsible for taking care of the environment	80%	50%
% who know that a "majistra komenal" (Mayor) obtains his/her position by winning elections	80%	50%
% who know that KASECS obtain their position by winning elections	80%	50%
% who know that ASECS obtain their position by winning elections	80%	50%
% who know that another name "maman lwa peyi a" (the constitution) is “La Loi Mere”	50%	20%
% who know that there are three branches of government – Executive, Legislative and Judiciary	50%	20%

CHAPTER 3 – METHODOLOGY

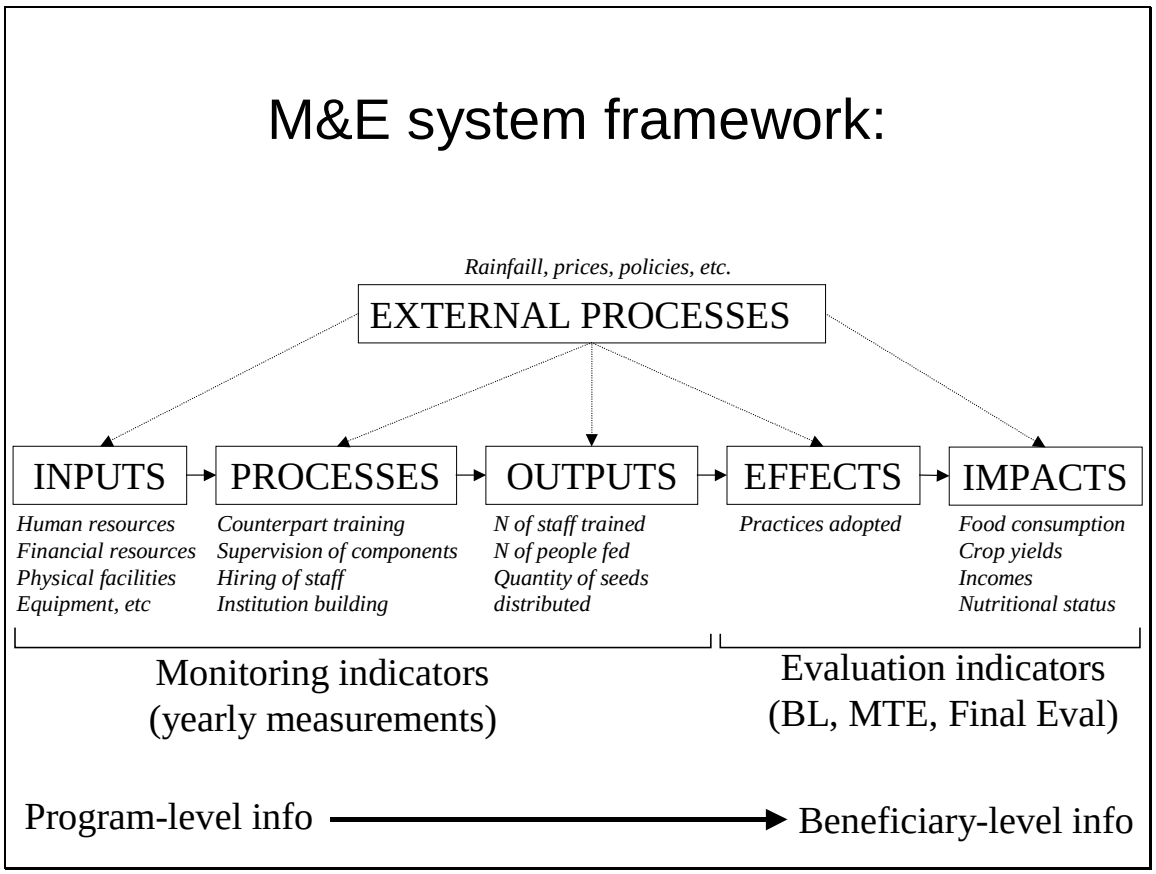
3.1. A Conceptual Model for Monitoring and Evaluation (M&E)

In an operational context, the role of the M&E system is to track and mirror the flow of actions that take place as project inputs are transformed into population-level impacts, and to verify that those impacts are indeed taking place. A good system will also inform project managers about the action to take if impacts are not occurring. To design the M&E, it is thus important to understand how the flow of activities is linked: conceptually, a project uses a set of *inputs,* and submits those to *processes* in order to generate *outputs*. *Outputs* in turn translate into *effects* at the target population level—*effects* which, in turn, are necessary to the materialization of the project's final *impact*. For instance: assume that a project wants to increase agricultural yields by offering farmers training in a new set of techniques[3]. To achieve this, the project lines up funds and technical specialists (*inputs*) and organizes a training course (*process*) in which it teaches farmers the selected techniques. The number of farmers trained constitutes the *output* of that activity. The number of farmers that effectively adopted the technique (a subset of those who were trained) are the *effect* of that activity. To the extent that adoption of the technique is essential to yield increase, then that *effect* must occur if the project is to achieve its desired *impact* (see Figure 1). The M&E must reflect this process, thus the logic of program design also underlies the logic of the M&E design, by reflecting all key project steps (*inputs, processes, outputs, effects, impacts*) in the M&E system, using objectively verifiable indicators.

Not all indicators to be used are of the same kind, however. Data relating to *inputs, processes* and *outputs* can be generated easily from routine project information (inputs such as the amount of money spent can be traced using ledger accounts; outputs such as the number of farmers trained can be obtained from attendance lists to the course; etc) and for those indicators, there is no need to do a survey. When it comes to *effects* and *impacts*, however, the project must go to the population in order to measure how many of the trained farmers actually adopted the technique. Being a decision that is highly personal to each farmer, this cannot be inferred from the project's book keeping records. A population-based data collection exercise is necessary to assess how many of the trained farmers adopted the technique or whether yields have increased or not.

From a logistical point of view, this distinction between sources of data (project-based versus population-based) is what distinguishes monitoring from evaluation: monitoring uses data from project records; evaluation uses data from the population (through a random survey, a census, etc). Population-based assessments being costlier than simple bookkeeping, project evaluations are occasional, rather than annual. Limiting the number of population-based queries, however, presents the project with the danger of not knowing whether the effects and impacts it is meant to achieve are indeed taking place: looking only at monitoring data, a project manager may fail entirely to detect that there is a problem with the adoption of the technique until it is too late to react. Say that our agricultural extension project is doing all it said it would, but that the unavailability of a crucial factor (e.g. labor, or capital) impedes farmers from adopting it. Unless a population-based evaluation is done during the life of the activity, the project will not know until its final evaluation that adoption rates are not as expected, thus jeopardizing its capacity to increase yields. Following that logic a central role of the mid term evaluation is to verify that the desired *effects* are indeed taking place. This is a central premise of this MTE model.

[3] We take for granted that the conceptual framework underlying the approach is sound; i.e. there is a cause-effect relationship between the technique promoted and eventual productivity increases. We do not discuss this here; but the issue was covered in the Baseline Survey Report where ample details are provided on the conceptual models used to guide intervention design in the CRS program.



Because effects are manifested at the level of the population, however, the need for a survey remains. To reduce its cost, Lot Quality Assurance Sampling is used. LQAS uses binomial distributions properties, which are more efficient than normal distributions at assessing population-level probabilities of dichotomous outcomes. The great advantage of LQAS is that it requires much smaller samples than traditional population-based surveys. For instance, assuming an unstratified, homogenous universe of infinite size, and accepting α and β errors each set at 10%, a simple random sample of n=19 is sufficient to judge whether performance has reached or not a predetermined performance benchmark on a given indicator (Valadez, 1996). One additional feature that makes LQAS attractive is the possibility to go beyond the simple "pass/fail" judgment to compute population-level point estimates for indicators of interest (e.g. vaccination coverage, disease prevalence, etc). This is done by dividing the entire project area into several "supervision areas" and by combining the data across those to compute the *proportion* of "pass/fail" responses over the entire project area. (Note that there must be at least four SAs to make this statistically valid. This increases the total sample by a factor of similar magnitude[4]; yet the potential advantages of the method in terms of cost will likely remain positive, as the new n will remain small compared to a traditional 30x30 cluster survey).

[4] For instance, if each SA has n=19, then the sample across four SAs will be four times that size, 76. The number of "passes" (say, 45) can then be simply divided by the total sample size (76) to yield a point estimate of 59.2% (45/76=.5921). Weighting the result from each SA by the size of its population increases the accuracy of that estimate. As always, confidence intervals should be placed around the point estimate to ensure that the sample means truly clears the benchmark.

3.2. DESIGN OF THE SURVEY (PHASE I)

3.2.a. Instrument Development

With the above M&E principles in mind, the team set out to develop the instruments used in this MTE. This included: selecting indicators; formulating the wording; setting benchmarks and identifying the samples. Those various steps are described in continuation.

i) Indicator Selection and Formulation

The starting point for this MTE was to identify the indicators to be tested. An initial list was provided by CRS' DAP Indicator Performance Tracking Table (IPTT). Following from what was said above, a particular emphasis was given to *effect-level* indicators. This initial list was then augmented by eliciting from CRS staff the data they needed to improve the management of their activities. To comply with LQAS' dichotomous requirement, all indicators in the resulting list were then worded to yield a pass/fail response. They were also worded to have the "desirable" outcome point as the "pass" answer (for example, answering "yes" to the question "Did the child have diarrhea in the last two weeks?" would point at a negative outcome. This is difficult to analyze in LQAS so the indicator associated with that question was re-cast as "Percent of children that did NOT have diarrhea in the last two weeks").

ii) Setting Performance Benchmarks

The second step was to set a performance benchmark for each indicator evaluated. We generally assumed that a project should see half of its effects materialized by the time it reaches its mid point. Suppose for instance that 30% of mothers in the project area knew how to prepare Oral Rehydration Salts (ORS) at the time of the Baseline. Through training, the project intends to augment that rate by 30% and bring it to 60%. Assuming a linear adoption rate, half of this effect (15%) should have occurred by the project's mid-point—45% thus becoming the benchmark against which the activity is assessed. Obviously, linear rates are not always expected: certain effects take longer to manifest themselves, in which case the growth rate in adoption may show a curvilinear pattern.

Also, particular activities may have started later, changing thus the expected growth curve. For those reasons, CRS staff and FANTA carefully considered each indicator before setting its benchmark[5]. Lastly, benchmarks were established at 5% cutoff intervals (15%, 20%, etc)[6]. The final set of indicators and benchmarks is listed in Appendix 2.

iii) Data Collection Questionnaires

As previously stated, the MTE IPBT served as the starting point for the development of the Phase I questionnaires[7]. While most of the indicators included in the IPBT translated into single questions, there were several indicators that required a series of questions in order to satisfy their informational requirements; this situation mostly took place within the MCHN sector on more complex issues such as exclusive breastfeeding.

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[5] Questions that were added to the original questionnaires did not have a baseline value. Therefore, the program team had to set benchmark values expected at the mid term evaluation for these new indicators. On the other hand, some mid-term benchmarks were intentionally left blank for those indicators that did not have baseline values. In such cases, the weighted coverage levels revealed in the MTE will serve as baseline values for these indicators.

[6] Decision rules for those intervals are readily available from the literature, but not for finer increments. To illustrate: say a baseline reveals a point estimate of 22.3%. The project hopes to change this by 40 percentage points and bring it at 62.3% during LOA. However, the mid point (42.3%) cannot be tested as there are no decision rules for that estimate–instead the project must chose whether to test against either 40% or 45%. This is a minor issue when numbers are large, but it can be inconvenient when desired changes are small (e.g. going from 10% to 15% over the LOA—what is the benchmark in such a case?). Fortunately, no such situations were confronted in this MTE.

[7] Many of the questions that were included in the MCHN questionnaires were taken from the Haiti and Madagascar Joint Baseline Surveys. This strategy allowed for the retention of the original formulation of the question (for comparison purposes), while providing the opportunity to upgrade the data collection instrument, so that the data can be collected for all indicators according to international standards (e.g. breast feeding).

Within each sector there were several questionnaires. The quantity of questionnaires depended upon the number of sampling groups; their composition reflected the characteristics of the target group to be sampled. For example, Directors of Social Safety Net Intuitions (SSNI) were asked questions regarding the administration of the centers and included questions for the data collector on the sanitary conditions of these centers. Young children, aged 8-13 years, which lived at the SSNIs, were posed questions about the food they were served there and their participation in educational activities.

Particular initiatives within the DAP program – such as civic education, HIV/AIDS education, and the promotion of proper hand washing techniques – were determined to have cross-sectoral relevance, and as such, questions relating to these initiatives were included in the other DAP sector questionnaires.

The first draft of the questionnaires was developed by FANTA and presented to CRS for their input and feedback. After substantial consideration, revision, and expansion by the CRS DAP staff, the MTE Team Leader and FANTA, a second draft was completed and translated into French and Creole[8]. These drafts were used in the training of the enumerators and field-tested. The final drafts of the questionnaires – which were ultimately used in the data collection – reflected the experiences of the MTE data collection team during field-testing.

3.2.b. Sampling

The greatest benefit of LQAS is its low sample size requirements. Compared to usual sampling technique (such as cluster sampling which usually requires around 900 interviews) LQAS can content itself with a sample of size n=19 (provided certain conditions are met). It is thus very economical. However, the leanness of LQAS is also its weakness: the size of the sample is so small that it prohibits disaggregating the data into subsets, making the simplest analytical techniques (cross-tabulations, means comparison) impossible—unless stratifying, i.e. deriving an independent sample for each group or region of interest. Although this creates serious potential for "sample inflation" (multiplication of samples to accommodate subsets of interests), it is likely that the final number of interviews across all samples will still be lower than what it would be if we used a simple random survey based on assumptions of normally distributed data.

When stratifying in LQAS, it is useful to distinguish between two types of strata: those based on geography ("supervision areas") and those based on target groups. Subdividing by Supervision Areas (SAs) involves dividing the entire catchment area into smaller management units. Say that a project operates in four provinces. The catchment is the entire country program, but if activities in each province are programmed independently, it makes sense to obtain a LQAS sample in each province to examine how the project performs in each province. Obviously, the collection of four samples will make the study costlier, as it will raise the total number of data points to 76 (assuming four samples of size n=19) but this will convey two major benefits to the study: first, it will be possible to see where (and where not) objectives are being met, pinpointing areas where improvements are needed. Second, it makes it possible to derive coverage estimates for the indicators under review—i.e. not only will we able to say that the sample "passed" or "failed" on a given test; we will also be able to use the percentage of units across the four samples that passed on that test as a basis to compute a coverage estimate. This adds an important analytical dimension to the survey, as will be shown later in the results section. Subdividing by Target Groups involves dividing the client population of an intervention into sets of individuals for whom expectations may differ. For instance, all school students are targeted to receive HIV/AIDS education, but their capacity to retain information may vary by age group (e.g., younger children may have lower understanding of "high risk sexual behaviors" than older ones); thus it makes sense to have different benchmarks for different age groups. As in supervision areas, dividing by target groups involves drawing a new sample for each group of interest. The advantage here is also twofold: first it allows setting different benchmarks for the same activity but for different groups. Second, it allows to pinpoint accurately

[8] The instructions to the data collectors on questionnaire administration were in French, while the actual questions to be posed to the interviewee were translated into Creole.

in which group the project fails to reach its objectives, and thus to focus attention on that particular set of people.

A final note on sampling: the method used to derive the desired sample size differs on the basis of the size of the universe. In situations where the universe size is infinite (i.e. >500 units) the binomial probability distribution can be used to derive sample sizes and decision rules. Where population sizes contain fewer than 500 units, however, the hyper-geometric distribution for cumulative probabilities must be used. We do not explain here why this is so, as this relates to the statistical properties of each distribution; but must inform that all our sample calculations took this rule of thumb into account.

i) Supervision Areas

The above section provided the rationale for the design of this Mid Term Evaluation. In the remainder of this chapter, we examine how those principles were concretely applied as we selected indicators, samples and supervision areas.

Before the sampling process could begin, CRS sector teams were tasked with organizing their program interventions into supervision areas. In the LQAS model, the minimum number of supervision areas necessary for aggregating the data to calculate weighted coverage estimates for program indicators is four. Each supervision area has its own participant list and thus the sampling was carried out based on that particular participant pool.

Where possible, the sector teams were encouraged to divide their supervision areas into universes of 500 units or more as this would allow sample sizes of 19, which according to the LQAS model, is sufficient to provide statistically representative data with acceptable confidence intervals. For those sectors with supervision areas with less than 500 units, it was necessary to undertake complex hyper-geometric calculations in order to determine appropriate sample sizes and corresponding benchmark decision rules.

- Sectors that were divided into four or more supervision areas, with 500 or more units each, included: Credit–Women and MCHN. The Education sector was also divided into four supervision areas but required hyper-geometric calculations to determine the sample size since it did not have 500 units.

- Sectors that had less than four supervision areas included: Agriculture, Credit–Colvol, SSNI, and Water and Sanitation. While Agriculture and Credit-Colvol each contained 500 units or more in their supervision areas, the SSNI and Water and Sanitation sectors did not and thus required hyper-geometric calculations to determine sampling size.

Table 2 presents a summary of the sampling for each sector investigated during the mid-term evaluation.

Table 2: Summary of sampling by sector

Sector	Supervision areas (SA)	Universe	Sample	# Groups/site	# Inter-views/SA	# Total interviews/ sector
MCHN [9]	**SA1**: Tiburon, Les Anglais, Chardonnieres	9,007	19	3 (mothers of children 0-6, 6-12 and 12-24 months)	57	285
	SA2: Port a Piment, Roche a Bateau, Coteaux	5,233	19	3	57	
	SA3: Aquin (+ La Colline and Vieux Bourg)	8,599	19	3	57	

[9] The baseline study was conducted in SA1 to SA4.The Grande Anse department was added as a separate SA since no baseline data had been collected in that department. Baseline results will be compared to aggregated results for the first four SAs.

Sector	Supervision areas (SA)	Universe	Sample	# Groups/site	# Inter-views/SA	# Total interviews/ sector
	SA4: Cotes de Fer, Fond des Blancs	12,172	19	3	57	
	SA5: Baradères, Nippes, Grande Anse	30,665	19	3	57	
CREDIT and MCHN (CHWs)	**SA1**: South Coast, Aquin, Cotes de Fer	508	19	1	19	48
	SA2: Grande Anse and Nippes	265	29	1	29	
CREDIT (women)	**SA1**: Tiburon, Les Anglais, Chandonnieres	555	19	1	19	76
	SA2: Port a Piment	528	19	1	19	
	SA3: Roche a Bateau, Coteaux	752	19	1	19	
	SA4: Aquin, Cotes de Fer	489	19	1	19	
Agriculture	**SA1**: Coteaux	>500	19	1	19	38
	SA2: Roche a Bateau	>500	19	1	19	
Education	**SA1**: La Colline, Vieux Bourg, Aquin, Ile a Vache	27	19	5 (PTA member, School director, teacher, female school child and male school child)	95	375
	SA2: Baraderes, Beaumont, Jeremie, Les Abricots	27	15	5 (idem)	75	
	SA3: Tiburon, Les Anglais, Chardonnieres, Port a Piment, Port Salut	49	26	5 (idem)	130	
	SA4: Fond des Blancs , Cotes de Fer	27	15	5 (idem)	75	
Safety Net	**SA1**: with HIV/AIDS training	71	29	6 (management, staff, female child 8-13, male child 8-13, female child >13, male child >13)	174	294
	SA2: without HIV/AIDS training	34	20	6 (idem)	120	
Water and Sanitation	**SA1**: School latrines	30	16	1	16	54
	SA2: School cisterns	21	13	1	13	
	SA3: Spring cappings	45	25	1	25	
					TOTAL INTERVIEWS	**1,110**

ii) Sampling Lists

The generation of sampling lists proved more time consuming than was originally anticipated. The varying benchmark levels for each universe size under 500 required quite a few complex calculations and fundamentally necessitated the creation of a whole new LQAS table for hyper-geometric distribution.

As the questionnaires were being refined, participant lists were being drawn up by CRS for use in the sampling. For the purpose of this exercise, a "participant" could be an individual (such as a member of a farmer *groupement),* an institution (such as a school), or a locality (from which a resident mother would be selected). Each type of "participant" group required separate sampling methodologies.

The universe and the number of participants being known for each area, the sampling was done by starting with a random number using the sampling interval required to obtain the total number of participants for that particular area.

The MCHN sector was evaluated at the population level and the sampling was drawn from the list of localities – and number of households by locality – using the maps produced by the Haitian Institute of Statistics.

For those sectors with individual participants, as was the case with Agriculture and Credit, the selection process was centralized and undertaken by CRS and FANTA, using a random number table, before the data collectors left for the field. Armed with the names of specific people, the data collectors visited the locality of residence of the individual, located her/him with the help of the community and/or local CRS volunteers, and carried out the interview.

Participant lists that were comprised of institutions that receive support form CRS, such as Education, SSNI, and Water and Sanitation, the selection process was two-fold. The selection of the institutions was centralized and undertaken by CRS and FANTA, using a random number table, before the data collectors left for the field. The selection of the actual respondents, however, was carried out by the data collectors in the field - on the day of her/his visit to the institution. Data collectors used random number tables and numbered cards to identify respondents with the desired profile for interviewing.

3.2.c. Training

Training of data collectors for Phase I was done between November 29 and December 5, 2004. Selection of enumerators and supervisors was done in three steps: before the training, after the theoretical training and after the field test.

During the first three-day training, questionnaires were reviewed question by question to ensure greater consistency in administration. Since each questionnaire was made up of different sections and because some sections were repeated in more than one questionnaire, the training was done by section: MCHN (health), hand-washing, colvols knowledge, water and sanitation, HIV/AIDS, micro-credit mothers, micro-credit colvols, education, agriculture, social assistance, civic education. The CRS manager responsible for each program first made a short presentation to explain the context of the study to the data collectors. Then, each question was discussed including the methodology on how to note the answer. Additional explanation was provided as needed. After having reviewed the questions for each sector, the group was divided into small groups to practice the questions. After each simulation, data collectors and supervisors shared the difficulties encountered with the whole group and clarification was provided whenever necessary. All enumerators were trained in all questionnaires except for the Safety Net sector for which only two data collectors and two supervisors were trained. At the end of the theoretical training three less qualified enumerators were eliminated for not having been fully successful in the aptitude test.

The field-testing of the questionnaires was done in the rural area of Palmiste-à-Vin. Except for the Safety Net sector, all questionnaires were tested in the field by small groups of data collectors coordinated by a supervisor. The whole group went to a school, an MCH center, a spring capping, a school latrine, and a farmer's plot of land. The MCH, credit mothers and credit colvols questionnaires were tested by small groups of two to three data collectors. For the other questionnaires, each participant had the opportunity to conduct an individual interview or individual observation. The composition of each group changed for each type of interview to allow the supervisors to know and assess each data collector. At the end of the each day, difficulties encountered during the field test were discussed and appropriate changes were included in the questionnaires accordingly. Two additional enumerators were eliminated at the end of the field test. With regards to the Safety Net questionnaires, two enumerators and two supervisors participated in the field-testing that was done in two orphanages in the area of Port au Prince once the whole group came back from Palmiste- à-Vin.

Based upon the number of interviews that needed to be carried out during Phase I, it was determined to divide the data collection team into seven teams--six composed of a team supervisor and three or four

data collectors and one made of two data collectors for the Safety Net Institutions. Phase I data were collected by 23 enumerators and 6 supervisors.

3.2.d. Field Work

The Phase I fieldwork took place between December 9 and December 23, 2004. The number of interviews to be done in one day, the time estimated to reach each interviewee and the number of sectors to be covered were the criteria used to determine the areas to be assigned to each team which varied between two to seven communes. Six teams were dispatched to the field along with a vehicle and a driver per team. Each team was made up of one supervisor and three or four enumerators. Before going to the field, each team received the complete list of people to be interviewed and sites to be visited for each locality in each commune. However, it was up to the Team Supervisor to determine the scheduling and assignment of interviews for the team. It was originally estimated that each enumerator could make 5 to 6 interviews per day if the work distribution by geographical areas was effectively done. This estimate was confirmed during the fieldwork. The Supervisor was also responsible for reviewing the questionnaires before their submission to the MTE Team Leader to make sure that they were filled out completely and correctly..

With regards to Safety Net questionnaires, two enumerators in the area of Port au Prince completed most of them. The remaining interviews were conducted by a team supervisor in the areas of Jérémie and Les Cayes.

As explained in the section 2.b.ii above, the selection of some respondents was done in the field by the survey team. With the LQAS sampling methodology where the name of the locality (for MCHN sector) and/or the name of the participants (credit mothers) were pre-selected, the enumerators had to walk long distances to reach most of the respondents. If a person was absent, the enumerator had to return a second time and sometimes a third time to be able to complete the questionnaire.

Special forms were provided to team supervisors to collect information on special cases or incoherencies encountered during the data collection and fieldwork. This detailed information was reported in the Phase I Team Leader's report and were taken into account in the data analysis.

The MTE Supervision Team comprised of the MTE Team Leader, a CRS staff person, and a FANTA staff person departed one day after the data collection team was dispatched to the field. The idea was that we would visit all of the different teams unannounced to check on their progress and assess their performance in the field. The supervisory visits were very useful for the entire team in that it provided the teams to raise questions or draw our attention to issues that were confronting them in the field. The supervision team would meet with one team at a time to answer questions and solve problems and share the exchanges and issues raised during visits with the previous team. In a five-day span, the supervision team visited all of the field teams and was able to solve the administrative or logistical problems that the teams were facing. The supervisory visits also allowed the Team leader to gain a more informed perspective on the data collection results in that she was able to investigate issues more deeply with the teams, ask questions, go out on interviews, etc. This ultimately allowed the Team Leader to provide feedback to CRS and FANTA.

3.2.e. Data Analysis

A local firm was contracted to enter the data using the double entry methodology. All data were sent to FANTA at the beginning of January 2005 for analysis.

Analyzing LQAS data is straightforward, as it only requires assessing whether the number of defective units exceeds or not the decision rule implied by the desired benchmark. For instance, say that a diarrhea prevention-BCC program wishes to test whether 50% of interviewed women have learned at least three methods of preventing diarrhea. Assuming a sample of 19 and alpha and beta errors set at 10%, no more than 12 of the 19 sampled mothers should fail in naming at least three correct ways of preventing diarrhea for the program to get a "pass" on this indicator. If more than 12 women fail the test, then the

entire program is also judged to "fail". The judgment of whether the program meets the test is thus made simply by counting the number of women who failed to answer the question. This is the most basic analysis done with LQAS data, and it was done here for all the indicators observed in the survey.

Dividing the population into four or more supervision areas, however, makes it possible to go beyond the simple LQAS analysis of pass/fail, and establish an overall prevalence point for an indicator by computing its ratio of "passes" to total sample (i.e. summing up the number of items that met the test across SAs and divide this by the total number of items sampled). For instance, say that 10 women met the test in SA1, 17 in SA2, 12 in SA3, and 9 in SA4; resulting in 48 "passes" overall. Given 19 women interviewed per SA, a total of 76 were interviewed in total. The prevalence point can be computed by taking the proportion of "passes" to the total, i.e. 63% (48/76)[10]. Second, since this prevalence point is a means, the confidence intervals (CI) around that mean can be derived; making it possible to state with confidence whether the means estimate (and its associated CIs) effectively "clears" the benchmark or not. Thus, not only do we know now which SA passed or failed the test, but we can state whether the program as a whole, and across all its SAs also passes the test. Third, a new benchmark can be devised using this new estimate, allowing to state which SA performed best against the newly estimated coverage. Whenever possible, such a breakdown by SA was done in this survey. An example of the resulting analyses is given in the following table:

Indicator	**BL Value**	**LOA target**	**MTE Target**	**WeightedAverage (CI)**	**LQAS judgment (overall)**	**Results: Actual performance per SA[11]**			
						SA 1	**SA 2**	**SA 3**	**SA 4**
% children given breastmilk only on day of birth	32.5 %	50%	40%	63.6% (11.0ppt)	Pass	Y Y	Y Y	Y Y	Y Y
% infants having received colostrums	53.0 %	95%	80%	72.5% (9.9ppt)	UD	B W	Y Y	Y Y	Y Y

The baseline value on the first indicator (% children given only breastmilk on day of birth) is 32.5%. The program expects to bring that proportion to at least 50% by the end of the DAP. The target mid-point chosen for the MTE is 40%[12]. The last four columns show that all four SAs "passed" on this 40% MTE benchmark (denoted by the top Y in each cell). Further, the overall coverage estimate reveals that the prevalence point across all SAs is 63.6% (with confidence intervals of +/-11.0 percentage points), i.e. it is well above the expected 40% so the program as a whole also gets a "pass". Finally, each SA is tested against the new benchmark set by the actual coverage estimate of 63.6% (rounded up again at the next 5% increment, i.e. 65%), with results denoted in the lower Y in each Results cell demonstrating that all SAs met that test for the first indicator.

Findings are different for the second indicator (% infants having received colostrums). From a baseline value of 53%, the project expects to bring this indicator to the 95% level by the end of the project. The chosen target benchmark for the MTE is 80%. Results by SA show that all but the first SA met the test for that indicator. However, the estimated coverage for the entire program is 72.5%, with a CI of 9.9 ppt. This means that the coverage estimate, even though below the benchmark, cannot be said with statistical confidence to be below the 80% benchmark, as the CI of 9.9 implies the means could be as high 82.4 (72.5+9.9). Whenever it cannot be said with certainty, as is the case here, that the coverage "clears" the benchmark one way or another, the analyst has to refrain from making a final judgment for the full program and classify its judgment as UD (undetermined). Lastly, all SAs are tested against the new

[10] Note that for further precision, each SA sample is weighted by the population size in its SA.

[11] "Y"= Yes, met the benchmark; "B"= Failed to reach the decision rule for the benchmark; "W"= Failed to reach the decision rule for the weighted average (rounded up at the nearest 5 percentage point increment); "UD" Unable to Determine = given the confidence intervals, we cannot state with certainty that the weighted average clears the benchmark. In such cases, judgments are made only at individual SA levels, not for the overall sample.

[12] For convenience, benchmarks for all indicators in this MTE were rounded at 5% increments. 40% is the rounded value that comes closest to this mid point between 32.5% and 50%.

benchmark provided by the 72.5% coverage estimate and it is found again that all of them pass the test, except SA1.

In sum, what the program manager can infer from those findings is that:

1) Things appear to be going as planned with regards to the first indicator: no corrective action is needed here at this point[13].
2) Things are also going relatively well with regards to the second indicator, except for SA1, where additional efforts will definitely have to be devoted to improve the perception of mothers concerning the offering of colostrums on the day of birth.

Such detailed and specific analyses can thus point out, not only whether the program overall is in the process of meeting its objectives, but also where objectives are being met and where not. This allows to orient the effort of corrective action to where it is truly needed which, in the end, should help the project reach its stated objectives in all covered areas.

3.3. LESSONS LEARNED – PHASE I

3.3.1 Lessons Learned – Phase I

3.3.a. Instrument Development

i) Indicator and Performance Benchmark Table (IPBT)

A certain amount of momentum was created in the formation of the questionnaires. This momentum led to the inclusion of questions that did not correspond to a specific indicator in the original IPBT; but were nonetheless necessary in order to link the different sections of the questionnaires. These questions translated into the creation of new indicators that were ultimately incorporated into a revised version of the IPBT. In other words, the IPBT, which was initially assembled to serve as the backbone for the questionnaires, later needed revision in order to reflect the complexities of the questionnaires it inspired in the first place. While this situation in itself is not problematic in a methodological sense, it did necessitate a further investment of time and energy on the part of CRS in the creation of new benchmarks and LOA values.

Perhaps greater attention to the development of more complete lists of program indicators at the beginning could have avoided such a procedural step backwards later. More focused questionnaire development could also have minimized the time necessary for the revision of the original IPBT as well; in other words, paying less attention to the maintenance of questionnaire "flow" and more attention to addressing the specific informational requirements of the indicators identified in the original IPBT.

ii) Setting Performance Benchmarks

MTE performance benchmarks were set by CRS program staff and FANTA. For most indicators with LOA targets already set, it was assumed that the project had reached half of its effects by the time of the mid term evaluation. However, for the questions added during the planning of the MTE, mid-term performance benchmarks were included for all new indicators. The strategy for setting up mid–term benchmarks differed from one sector to another.

Agriculture: both the LOA and the MTE targets were set before the MTE; however, since indicators were measuring the adoption of agricultural practices on project participants, the team realized afterwards that the benchmarks had been set too low,

[13] Unless program managers want to revise their goals upwards, as the initial objective on this indicator may have been too modest, in light of the fact that LOA objectives had already been reached by mid point.

MCHN: Respondents for the MCHN sector were divided into three groups according to the age of the child (0-6 months, 6-12 months and 12-24 months). No baseline data had been collected on mothers of children less than six months old and overall baseline values were used as reference to set the mid-term benchmarks for that age group. For the 6-12 and 12-24 groups, some additional analyses had to be done with the baseline data to be able to compare the results by age group and measure the progress done since the baseline.

For most of the other sectors (HIV/AIDS, micro-credit, education, safety net, water/sanitation, civic education), no baseline values were available. Even though mid- term targets were set based on past and current program experiences, the team realized afterwards that for some indicators, results were either far below or far above the expected targets. With the pass/fail LQAS methodology, the level of the benchmark is a key determinant and requires an in-depth reflection at the planning stage; especially in case no baseline value is available.

For sectors where the MTE result would be used as a baseline value, the subdivision of the catchment area into four supervision areas allowed for an extrapolation of the program coverage; a useful approach for calculating the baseline value. However, in the case of a single catchment area, the evaluation team was only able to discern whether the sample "passed" of "failed" the mid-term benchmark, an approach that is not as informative as one using program coverage as the baseline value.

Even though the CRS sector teams understood the process of setting the mid-term benchmarks during the planning process, they became more aware of their significance at the time of the analysis. Since the whole mid-term process was a pilot exercise, the whole team was "learning by doing". However, examples of results analysis at the planning stage would have contributed to a better understanding of the whole methodology including the decisions made regarding performance benchmarks.

iii) Data Collection Questionnaires

This MTE collected an enormous amount of information on the overall performance of the DAP. There were, nonetheless, a few unfortunate cases where the data collected were not useful, or needed to be disregarded entirely, due to poor question formulation or unclear instructions to the data collector. It is felt that the ambitious deadlines were largely to blame for these situations. The time frame provided for the development of a second draft of the questionnaires, their translation into both French and Creole, field-testing, further refinement and ultimate finalization was less than three weeks. Such a short space of time did not allow for the adequate review of all of the questionnaires by parties less closely involved in the process, or for their translation into English – the only common language of the MTE supervisory team.

For some sectors, the questions did not cover some important issues that could have been covered by the MTE. This is the case for the agriculture and the safety net sectors where numerous opportunities to measure project progress were missed.

In a related issue, a system should have been put in place to monitor the inclusion of certain questions relating to such cross-sectoral topics as HIV/AIDS. Questions on HIV/AIDS knowledge, practice, and attitudes were included in virtually all of the MTE questionnaires for all sectors and sampling groups; however, not all of the relevant questions found their way into the questionnaires. Greater consistency in the inclusion of HIV/AIDS questions would have provided increased utility in terms of the manipulation of the data for comparison purposes across sectors and samples.

The LQAS method is based on dichotomous outcomes (yes/no, pass/fail), and every effort was made to simplify the questionnaires in order to elicit such responses. Many of the issues investigated in Phase I, however, were quite complex and as such, necessitated more than one question in order to get at the desired data. In such situations, a single question may not have had specific relevance to a particular indicator, but when it was included in a larger data set, it gained its relevance and indeed, critical inclusion.

The creation of data sub-sets was also an issue in the development of the questionnaires. As LQAS is based on sample sizes of 19, any decrease in the sampling numbers creates sub-sets. Sub-sets undermine the statistical attractiveness of the LQAS methodology because they change the sample size and thus, the benchmark decision rules; and depending upon the actual responses, hyper-geometric calculations may be necessary.

3.3.b. Sampling

i) Supervision Areas

Ideally, most sectors would have preferred to divide their catchment area into four supervision areas. However, the evaluation team had to estimate the cost/benefit of multiplying the sample by four. In some cases, the number of units was too small to be divided by four (for example, 21 school cisterns). In other cases, such as agriculture, the program had been working with only two associations, the association being the unit of analysis for the programmatic component.

For both MCH and Education programs, the supervision areas corresponded the programmatic areas. This strategy became very useful for programming purposes since it allowed the analysis of program performance to be done by programmatic area and for recommendations to be specific to each geographic area.

With more than two thousand participants in the mothers' credit program, the subdivision into four supervision areas was not entirely done according to programmatic areas. The subdivision was done to reach at least 500 units in each area. Therefore, the conclusions drawn for each supervision area are sometimes difficult to interpret since a single area might include more than one programmatic area. If a problem exists in a specific area, it could go unnoticed if the area was associated with other areas where the problem does not exist.

Taking into account the benefits conveyed by sampling four supervision areas, the evaluation team would strongly recommend using this methodology as often as the number of units and the cost of the study would permit. Ensuring, whenever possible, that the programmatic area corresponds with the supervision area is also highly recommended.

ii) Sampling Lists

Perhaps the most problematic issue that arose in the drawing up of sampling lists had to do with the selection of Alternates. Not enough Alternates were identified previous to the fieldwork for the sectors where lists had been drawn with the names of the participants (women credit and colvol credit) . This resulted in valuable time being spent by the field staff communicating by telephone with CRS in Port-au-Prince and the redrawing of the lists for the selection of more Alternates. The need for Alternates was one that had been recognized early on in the process; what was not anticipated was many would be needed.

In a survey that is under such tight time constraints as this one, the data collector does not usually have the luxury of returning to a site another day in order to interview a specific person. Though the data collectors put forth an honest effort to locate the pre-selected respondents on the day of their arrival, it was not always possible to find them, thus requiring the substitution of that person with an Alternate. There were instances where the data collector could return at another time to interview the pre-selected respondent, but usually it was not possible.

A greater amount of time should have been spent in assembling the participant lists for the micro-credit sectors in order to ensure their relevance to the data requirements. All micro-credit sampling lists had to be redrawn because the participant lists were outdated, incomplete, or otherwise inaccurate.

The most obvious example of the inappropriate participant lists was the SSNI sector. For the HIV/AIDS sampling, SSNIs were divided into two supervision areas – SA1 was comprised of SSNIs that had

received HIV/AIDS trainings, while SA2 had not received such training. For each SSNI, the data collector was tasked with interviewing six people, including two girls and two boys (aged 8-13 years old and 13 years and up). Shortly after beginning the data collection, it became quite clear why certain of the SSNIs in SA2 had never received HIV/AIDS trainings; namely because they were centers for "special populations" like physically or mentally handicapped children, orphaned infants, etc. There were also single-sex centers and centers for young adult males. The populations in these centers thus precluded the satisfaction of the required number of completed samples. As a matter of fact, less than 75% of the necessary interviews of males took place at the centers of SA2, rendering the obtained data ineffectual. Identification of "alternates" sites would have solved some of the problems encountered with the SSNI sector. However, the comparison between SA1 and SA2 with regards to HIV/AIDS training would not have been appropriate since the two groups were different.

3.3.c. Training

The time allocated for the training was too short. Even though all enumerators had previous experience in surveys and questionnaires, this methodology was new to all of them. Many showed difficulties in filling the double negative questions that were found to be confusing. Changes were made during the field test questionnaires later on before the teams left for the actual fieldwork. Enumerators should have had more time for field testing to uncover problems related to phrasing sentences and inconsistencies with instructions provided to them. Since supervisors were responsible for reviewing the questionnaires in the field, additional training would have been important to help them identify the potential inconsistencies that had to be corrected later on by the CRS/FANTA team supervisors.

The period for the field test was also too short. Some interviews were done in small groups and each enumerator did not have the opportunity to complete some of the questionnaires by himself/herself.

In her report covering the data collection period, the team leader reported a series of notes relative to the questionnaires. Those inconsistencies were corrected either in the field or before the data entry. In case the same questionnaires are used for a similar survey in the future, it would be important to include all such comments in a revised version of the survey.

3.3.d. Field Work

The selection of alternates was one of the most problematic issues that arose in the field. This was largely a problem with Credit-Women and SSNIs. Three alternates per Supervision Area had been selected for the Credit-women sector. But, it became readily apparent that Caritas, the institution that manages the credit program for CRS, had not provided updated list of participants. It was also revealed that men had received loans and that there were some people that had taken out multiple loans in other people's names. Some of these multiple loan recipients were leaders within the community.

No major problems were encountered for sectors where the sampling list was made up of the names of localities or sites. However, with names of participants, enumerators had to visit some households more than once if the person was absent, The difficulties were greater for the Credit women sector where the sampling list provided by the partner was no updated and some participants, who had been identified for the survey, had ended up quitting the credit program. Supervisors had to contact the evaluation point person at the CRS central office who rapidly did the sampling of the alternates again. Urgent decisions had to be made very rapidly since the change in the sampling interval directly affected the identification of all the alternates. Without effective means of communications such as the telephone, this change would not have been done in a timely manner and this would have caused a significant delay in the field work implementation for that sector.

3.3.e. Data Analysis

The primary analysis of LQAS data is notoriously simple, as it involves essentially measuring whether the number of "passes" equals or exceeds the number needed to meet the benchmark; and from that

comparison, apply a pass/fail judgment at the program level. Some complexity is added when doing a secondary analysis of the data by SA to derive point estimates, confidence intervals etc; as was done here. Yet this pilot showed that, once the key principles are understood, this secondary analysis is likewise a straightforward process: CRS staff could easily and correctly perform the primary and secondary analyses by sector, once basic training had been done by FANTA. This augurs well for the replicability of the methodology, and is a good lesson learned that confirms the ease of use of LQAS in general.

3.4 Qualitative Assessment – Phase II

As described in section 1.2 above, Phase II investigated the bottlenecks identified during Phase I using qualitative methodology.

3.4.a. Identification of Problem Areas

After Phase I results had been analyzed, each CRS program sector team met with the FANTA team and the team leader to review and discuss results for all indicators measured during Phase I. During that process, the team focused on indicators that seemed to be lagging in performance and discussed if they merited further investigation.

Problem areas were identified in four major sectors: MCH, Women credit, Colvol credit and School latrines. In addition to those four sectors, the CRS education team proposed to investigate during Phase II some key issues pertaining to education that were not addressed during Phase I.

After having identified the areas to be investigated in each sector, the team proposed the potential source of information for each area. The team leader who was the main person responsible for conducting the Phase II of the MTE compiled those comments and proposed a Phase II plan to the CRS/FANTA team including objectives, areas of investigations, methodology, locations and sources where to look for each information.

Since most of the sectors identified for Phase II had covered four different supervision areas during Phase I, the team was able to propose specific supervision areas for Phase II, more specifically areas where the results had been less performing. After having summarized all the issues, it was decided to conduct most of the Phase II in Port a Piment and Aquin areas.

3.4.b. Selection of Methodology for Constraints Analysis

Qualitative methods used for Phase II of the MTE included focus group and key informant interviews. Focus groups were conducted with groups of mothers in the credit program, mothers with children 12-24 months old and not participating in the credit program, colvols, school directors, teachers and members of Parents Teachers associations. Key informants interviews were performed with field based CRS and partner staff, persons responsible for health centers and other key leaders in the communities.

The team leader prepared a detailed logistical plan with number of meetings, number and types of participants for each meeting and methodology for selecting participants in each of the two areas identified for Phase II. Since the MCH and the credit programs were targeting the same participants, many focus groups and key informant interviews covered both sectors.

3.4.c. Field Work

The CRS field coordinator left for the field a few days before the team leader to schedule all the interviews and focus groups according to the plan prepared by the team leader. A total of 13 focus groups (7 in Port a Piment and 6 in Aquin) and 9 key informant interviews (4 in Port a Piment, 4 in Aquin and one CRS staff) were conducted during Phase II. All these interviews and meetings took place during a two-week period and were conducted by the team leader who has a long experience in qualitative

survey methodology. Notes from the meetings were taken by a CRS staff and compiled on a daily basis by the team leader.

3.4.d. Results Analysis

The team leader compiled the results from all meetings and interviews for each sector. The report was prepared according to the list of objectives originally identified by the CRS/FANTA team during the Phase II planning stage. Results of Phase II findings are presented in Chapter 5.

Since Phase II evaluation was implemented as a follow up investigation for Phase I, findings specific to Phase II and recommendations to improve project performance are combined with those of Phase I to ensure a comprehensive and integrated report for each sector.

3.5 Lessons Learned – Phase II

3.5.a Identification of Problem Areas

Since this evaluation methodology was new to most of the team, the CRS staff did not rapidly understand the process for identification of problem areas for Phase II. Similar to the Phase I, some program staff wanted to investigate numerous issues. Time and cost constraints were important factors taken into consideration while planning Phase II. With the assistance of FANTA staff and the team leader, the CRS team was able to finalize a list of important issues to be investigated during Phase II.

Some sectors did not identify any issues to be examined during Phase II. However, the education team proposed to investigate new issues pertaining to education that were not addressed during Phase I. Issues such as causes of students' school dropout and use and assessment of training materials provided by CRS. This change in Phase II planning affected the timing for the fieldwork. It is recommended that the complete set of performance indicators for each sector be identified at the beginning of the study.

3.5.b Selection of Methodology for Constraints Analysis

With regards to the credit mothers program, the original plan for Phase II included the areas where problems had been identified. Field experience showed that conducting additional interviews with key informants in areas where the credit program has been successful revealed to be a highly informative process. While providing valuable explanations why the program has been successful in some areas and not in others, this information also contributed to a better understanding of the difficulties encountered in problematic areas.

3.5.c Field Work

Since the composition of the group will influence the dynamic of the focus group, the selection of the participants is a very important issue. The selection should not be done by local people involved in program activities. The process must be supervised by an external person who should follow the rules and criteria set by the team leader.

It is also important to take the time to understand the mentality of the people living in the area targeted by the study before conducting qualitative research in a that area. This can be done through informal interviews with local leaders or other people living in that community.

3.5.d Results Analysis

One positive result that came out of the Phase II results analysis is the variety of program sectors that were covered within a same group. The wide range of groups and participants who were interviewed was

also identified as a strong point. This methodology facilitated the results analysis process because it provided a wide range of information from which the most significant elements were withdrawn.

CHAPTER 4 – MTE RESULTS BY SECTOR – PHASE I

4.1. Agriculture

The main goal of most of CRS' agricultural interventions is to increase farming output. What is achieved, vis-à-vis this goal, depends on the program's objectives. If farming efficiency is pursued, such as increasing the volume of production per area planted, then an indicator relating to crop yields is appropriate. If the objective is to improve household food security, the success of the intervention can be measured as an increase in total farm production that, once converted into a common yardstick such as monetary value or kilocalories, links the nutritional and economic needs of a farming household to its agricultural output.

Programs that aim at improving agricultural performance typically target the factors that influence farm output. As there was no "off the shelf" conceptual model which lay out the factors accounting for the performance of farming in developing countries, the DAP Baseline survey team, with the technical assistance of FANTA, designed its own model by making agricultural performance a function of three broad categories of factors, namely: 1) land characteristics; 2) farm characteristics; and 3) institutional and economic context.

1. **Land characteristics** were defined as a function of the quality and quantity of the land available to the producer, the productive investments made and farming practices used on that land, and exogenous factors related to the agroecology.

2. **Farm characteristics** included household wealth and access to family labor, farm size, technical knowledge and education of the farmer, and gender of the household head.

3. **The institutional/economic context**, finally, referred to the input and output markets, access to inputs, output prices, access to credit, means of transport, and access to information.

The CRS/DAP agriculture project is implemented by a branch of Caritas Cayes, a long-term CRS partner. The goal of this project is to increase access to food for 1,500 smallholders farming families in the targeted food insecure areas by 2006. The specific objectives are to:

- Increase the availability of beans and plantains for 1,500 families on 375 hectares of hillside land through biological soil conservation/fertility recovery methods, and provision of improved seeds.
- Improve revenues and the availability of animal protein for 1,500 families through chicken and pig-raising.
- Increase revenues via the DAP-assisted commercialization of two agricultural products of 1,500 participating families.

4.1.a Analysis of Results - Agriculture

The MTE focused on land characteristics, one of the broad factors that influence farm production. Other indicators focused on the perception related to gender within the small farmers' associations.

Since the beginning of the DAP, the agriculture project targeted two farmer association groups consisting of approximately 500 farmers each. One association was in Roche a Bateau (SA1) and the other in Coteaux (SA2). The MTE surveyed 19 farmers from each Association, or, supervision area as they were designated.

i) Land Characteristics

In an effort to address poor soil quality, the agriculture project has been relying on small farmer productive associations to replicate the trainings they have received in natural resource management in their own communities. Members applied the techniques they learned in biological soil conservation, soil preparation and fertility recovery to the production of beans and plantains (on .25 hectares of their land),

and expanded their production potential through the grafting of 15-25 fruit trees. In addition, each participating farmer received grass and plantain cuttings, beans seeds, as well as further training and technical assistance support from Caritas staff and CRS agriculture extension agents..

Both SAs (Roche a Bateau and Coteaux) successfully met the benchmark targets for all indicators associated with land characteristics, including: the 80% benchmark which was set for "the percent of beneficiaries who apply the techniques aiming at improving land characteristics"; the 60% benchmark for "the percent of beneficiaries who apply appropriate planting techniques standards"; and the 40% benchmark for "the percent of beneficiaries who have at least 50 trees planted." Those results, in particular, are excellent in that by their continuous application, the quality of the soil in farmer plots should significantly improve throughout the life of the DAP and beyond.

Table 3 indicates the results of the MTE on the indicators related to "land characteristics."

Table 3: Agriculture - Land Characteristics

Indicator	MTE Target	SA1[14]	SA2
Land Characteristics			
Percent of farm association member plots that use Level A/courbe de niveau techniques	75%	Pass	Pass
Percent of farm association members that have a dry and cool place for seed storage	80%	Pass	Pass
Percent of farm association member plots that use either green fertilizer or compost	70%	Pass	Pass
Percent of farm association member plots that use the promoted planting density standards for beans	60%	Pass	Pass
Percent of farm association member plots that use the promoted planting density standards for plantains	60%	Pass	Pass
Percent of farm association member plots with one or more recommended anti-erosion system	80%	Pass	Pass
Percent of plots visited with one or more anti-erosion systems in place ("ramp pay", "clayonnage", or live barrier).	75%	Pass	Pass
Percent of farm association member plots that have at least 50 trees planted on them	40%	Pass	Pass

ii) Gender within farmers' associations

The second set of indicators investigated focused on the perceptions related to gender within the small farmer associations. Three indicators were measured in this regard, namely: 1) Percent of farm association members that report the inclusion of women was a guiding principle in the formation of their association; 2) Percent of farm association members that think that women should be allowed membership in the group, and 3) Percent of farm association members that can state at least one concrete benefit of the active involvement and membership of women. SA1 and SA2 both met the benchmark for these three indicators (80-90%), suggesting that women have achieved equal status within the association structure and that their participation in the association is viewed positively. The results for these indicators relating to gender are highlighted in table 4.

[14] Pass = Met the benchmark Fail = failed to meet the benchmark

Table 4: Agriculture – Gender within farmers' associations

Indicator	MTE Target	SA1	SA2
Percent of farm association members that report the inclusion of women was a guiding principle in the formation of their association	90%	Pass	Pass
Percent of farm association members that think that women should be allowed membership in the group	80%	Pass	Pass
Percent of farm association members that can state one concrete benefits for the active involvement and membership of women	80%	Pass	Pass

4.1. b. Conclusions and Recommendations – Agriculture

As all of the farmers surveyed in the MTE have participated in the agricultural initiatives implemented by Caritas and supported by CRS, project staff has since realized that the MTE targets were probably set at too low a level. Had the performance benchmarks been set higher, thus making it more challenging for the farmers to pass on the indicators, weaknesses in the project may have been revealed and hence, reinforced.

The adoption of the techniques promoted by both institutions is seen as critical to the reduction of food insecurity within the participating association member families and indeed, their communities. Even though the objectives that were targeted by the MTE (land characteristics and perceptions relating to gender) were satisfactorily met, the adoption of those factors remains crucial to reducing food insecurity. As such, the project should not wait until the end of the DAP to start measuring such impact-level indicators as: the percent of in crop yield increase per hectare among targeted farmers (beans and plantains); the average number of months of household food reserve stocks; and increases in livestock holdings among farmer households (pigs and chickens). In areas where the project started in 2002, these indicators could start being measured in 2006, through their steady integration into regular project monitoring activities. Other issues, related to changes in the economic situations of the farmers, could also be integrated into the regular monitoring systems. .

In short, the agriculture project seems to be performing according to the standards set in the MTE, which lends support to the continuation of project activities as currently structured and implemented by Caritas and CRS support staff.

4.2. MICRO-CREDIT

The 2002 Baseline evaluation identified a strong link between household wealth and the nutritional status of children. The height for age (stunting) and weight for age (underweight) indicators showed the most substantial difference in nutritional status by SES (Socio-economic status) level. As stated in the 2002 Baseline report:

> *"The relationship suggests that households with more domestic assets have better nourished children. Taken as a proxy for wealth, the benefits of having more domestic assets can be hypothesized. Greater wealth may mean increased access to food resources and improved ability to provide diverse high quality foods, such as the more expensive nutrient-rich animal products. Given those preliminary associations, it seems that well-targeted interventions to increase household wealth, such as improved access to credit for women, or, income-generating activities to the worst-off households, when coupled with effective information, education and behavior changes messages, could ultimately improve the nutritional status of children".* [15]

[15] Report of the 2002 Joint Baseline Survey in the Targeted Areas of the PL-480, Title II Programs in Haiti, by Gilles Bergeron and Megan Deitchler, FANTA Project, Washington, October 2003

Based upon these critical findings, CRS introduced a micro-credit component into its MCHN program in an effort to increase household resource levels. The credit component has been implemented on two levels - at the level of CHWs and Rally Post participants - and contributes to the overall strategic objectives of the MCHN program, namely:

- SO1 - to improve the health and nutritional status of children, pregnant and lactating women; and
- SO2 - to increase the availability and accessibility to quality health and nutrition services.

The "village banking" approach is used for both groups of credit recipients, but the organizational structure is somewhat different. CRS partner institutions Caritas Cayes and Caritas Jacmel implement the community micro-credit program. The CHW micro-credit program, however, is currently under the direct supervision of CRS – but responsibility for it is gradually being transferred to the two Caritas offices.

Though the 2002 Baseline survey did not include a specific evaluation of the micro-credit program, the CHW program has been reviewed in other previous DAP evaluation exercises: namely the final evaluation of the VACS (Voluntary Agencies Child Survival) in 1996, and in the mid-term and final evaluations of the 1996-2001 DAP. All of these evaluation exercises have revealed positive findings, with the micro-credit program proving to be an incentive for the CHWs, while at the same time, contributing to the sustainability of the MCHN program.

No formal evaluation has ever been undertaken of the rally post credit program, however. Regular performance reviews have been performed (analyzing reimbursal and arrears rates, for example), but this has never been done on a formal and comprehensive level.

With the objective of testing Baseline finding, that there is a link between household asset and nutrition levels, the MTE targeted direct beneficiaries of the micro-credit at the community level. Issues such as loan management, the levels of solidarity within the banking groups, and changes in their household wealth, were investigated for both groups of credit recipients - CHWs, and village bank participants. Additional issues were also tested with the groups at the community levels, such as their participation in rally posts, the recipient selection process and their literacy/numeracy status.

No specific impact indicators have been set for the micro-credit component since the purpose of this program is to contribute to the overall impact indicators set for the MCHN program. Therefore, the results of this MTE will provide valuable information on the effects of the program on the credit recipients and will assist in identifying necessary steps towards achieving the strategic objectives of the overall health program by the end of the DAP.

4.2.a Analysis of Results - Community Credit Program

The micro-credit program targeting community participants reaches an estimated 2,000 people and is being implemented in the south coast areas of Cotes de Fer and Aquin. At the community level, participants are grouped around the rally-post activities. The credit program requires that at least 70% of the credit recipients be rally post participants. Previous experience in small business is also a requirement since the purpose of the loan is to strengthen an existing business. The group elects a Steering Committee of three to five people who attend a training provided by the program's implementing partners, Caritas les Cayes and Caritas Jacmel. The Steering Committee is responsible for the management of the overall loan portfolio, as well as the disbursal of loans to the members of the village banks. Even though women are prioritized participants, other members, including men, from the same community (especially those with many years of experience in small business) are also eligible. The principle of group solidarity in the repayment and management of the loans is fundamental to the success of this village banking structure.

For the purposes of the MTE, the credit program area was divided into four supervision areas, with approximately 500 clients each. Such a division allowed for four sampling groups of 19 and the ability to aggregate the results in order to derive coverage estimates for the tested indicators. Results for the

participants in the credit program presented in the table below are separated under six main headings: 1) Participation in rally posts, 2) Participant selection process, 3) Loan management, 4) Group solidarity, 5) Literacy/Numeracy skills, and 6) Changes in household wealth.

i) Credit Recipient Participation in Rally Posts

One of the main criteria of this credit program is that at least 70% of loan recipients be participants in the monthly rally posts that are conducted by the CHWs. While the SAs performances on this benchmark are encouraging--all of the supervision areas passed both the 70% benchmark and weighted coverage estimate of 76% (Table 5) --we are unable to definitely state whether or not the benchmark was met, due to the fact that there are such wide confidence intervals around the means of this indicator (+/- 9ppt[16]). Nevertheless, these results seem to indicate that Caritas Les Cayes and Caritas Jacmel are implementing the credit recipient selection process appropriately and consistently across their coverage areas.

Similar results were found for the second indicator - percent of credit participants who have participated in a rally-post since they joined the credit program–all of the supervision areas passed the 50% benchmark. In this instance, however, it seems that SA2 (Port a Piment) is not performing at the same level as the other supervision areas, as it failed to meet the weighted aggregate for that indicator.

Even though having a child less than five years old is not a requirement for participation in the credit program, all of the SAs, with the exception of SA2, met the 70% MTE benchmark that was set for this indicator.

Table 5: Credit Recipient Participation in Rally Posts

Indicator	BL Value	LOA target	MTE Target	WA (CI)	LQAS[17] judgment (overall)	Actual performance per SA[18]			
						1	2	3	4
Participation in rally-posts									
% of credit participants who participated in a rally-post before they joined the credit program	NA	NA	70%	76.0% (9.5ppt	UD	YY	YY	YY	YY
% of credit participants who have participated in a rally-post since they joined the credit program	NA	NA	50%	51.5% (11.1ppt)	UD	YY	YW	YY	YY
% of credit participants who have children less than 5 years old	NA	NA	70%	56.6% (11.2ppt)	Fail	YY	BY	YY	YY

ii) Selection Process

Participants were asked if they felt that the selection processes for receiving a loan and selecting a steering committee were carried out in a fair and democratic way. Judging from their answers presented in Table 6, it appears that credit recipients believe this to be so, as benchmarks were satisfactorily met in all four of the SAs for both indicators: 96.5% for the indicator on loan recipient selection and 93.2% for Steering Committee selection. Only SA4 failed to meet the weighted aggregate for these indicators, though the difference in the performance levels in this SA as compared to the others is small.

[16] ppt= percent point

[17] "Pass": the Weighted average is greater than the MTE target; "Fail": the Weighted average is less than the MTE target; "Unable to determine": the Weighted average is different from the MTE target but because the range of the confidence interval overlaps with the MTE target, we are unable to definitively state it the MTE target was met or not.

[18] SA1: Tiburon, Chardonnieres / Rendel and Les Anglais; SA2: Port a Piment; SA3: Roche a Bateau and Coteaux; SA4: Aquin and Cotes de Fer

Table 6: Credit Recipient Selection Process

Indicator	BL Value	LOA target	MTE Target	WA (CI)	LQAS judgment (overall)	Actual performance per SA			
						1	2	3	4
Selection process									
% of credit participants who feel the selection process for receiving micro-credit loans is fair and democratic	NA	NA	75%	96.5% (3.8ppt)	Pass	Y -	Y -	Y -	Y -
% of credit participants who feel that the Steering Committee was selected in a fair and democratic manner	NA	NA	80%	93.2% (4.9ppt)	Pass	Y Y	Y Y	Y Y	Y W

iii) Management of Loans

Five questions were asked to credit recipients to get a sense of how they were doing with the management of their loan. Three of them met the mid-term expectations in all SAs, indicating that the participants feel they are able to manage their loan and their business efficiently (Table 7). However, whereas three SAs met the benchmark and the weighted aggregate performance level for the percentage of credit participants who made a profit from their business activities last month, SA2 (Port a Piment) failed to meet both the benchmark and the WA for that indicator, which suggests that the loans may not be being managed as well in this supervision area as compared to the others.

The results for the last indicator in this sub-heading (percent of credit participants who never had a problem paying back any of the monthly loan payments) differ from one SA to the other. The overall benchmark was not met (weighted aggregate – 67.2 %, +/- 9.4%), yet two SAs (SA1 and SA3) met the benchmark.

Table 7: Credit Recipient Management of Loans

Indicator	BL Value	LOA target	MTE Target	WA (CI)	LQAS judgment (overall)	Actual performance per SA			
						1	2	3	4
Management of Loans									
% of credit participants who would like to continue in the credit program	NA	NA	85%	89.2% (6.4ppt)	UD	Y Y	Y Y	Y Y	Y Y
% of credit participants who think they are capable of managing their loan well	NA	NA	70%	96.3% (4.0ppt)	Pass	Y Y	Y Y	Y Y	Y Y
% of credit participants who think they are capable of managing their business efficiently	NA	NA	60%	95.1% (4.8ppt)	Pass	Y -	Y -	Y -	Y -
% of credit participants who made a profit from their business activities last month	NA	NA	80%	74.5% (8.8ppt)	UD	Y Y	B W	Y Y	Y Y
% of credit participants who have never had a problem paying back any of the monthly loan payments	NA	NA	80%	67.2% (9.4ppt)	Fail	Y Y	B W	Y W	B Y

iv) Group Management and Solidarity

Two indicators measured the level of solidarity among their credit groups, in terms of the groups' history of financial assistance to potential defaulters within their group, and their perceptions of the management capacity of the Steering Committees. As all four of the SAs met the benchmark for these two indicators, it appears that group solidarity levels are at the level that was expected by Mid-Term. It should be noted,

however, that SA2 (Port a Piment), once again, does not meet the weighted aggregate performance levels for all SAs, indicating that performance is less obvious there than elsewhere.

Table 8: Group Management and Solidarity among Credit Recipients

Indicator	BL Value	LOA target	MTE Target	WA (CI)	LQAS judgment (overall)	Actual performance per SA			
						1	2	3	4
Group Solidarity									
% of credit participants whose groups has assisted a fellow group member when she/he had a problem paying back her/his loan	NA	NA	35%	46.4% (10.9ppt)	Pass	YY	YW	YY	YY
% of credit participants who think their group's steering committee does a good job managing the micro-credit program	NA	NA	80%	91.4% (5.9ppt)	Pass	YY	YW	YY	YY

v) Literacy / Numeracy / Understanding Bank Books

Three indicators were included to measure the literacy and numeracy levels of group members (Steering Committee members were not included). Benchmarks for these three indicators were set low (30% and 20%) since it was expected that the members who are not part of the Steering Committee are less literate. All four SAs met the benchmark set for them (Table 9): 55.4% know how to sign their names, 65.5% feel confident in their addition and subtraction skills and 41% of credit participants have read the financial agreement with the steering committee. However, SA2 does not meet the WA for the indicator on addition and subtraction skills.

In order to understand their loan transactions, all participants should be able to understand how their bank book works. Unfortunately, all four SAs failed to meet that indicator benchmark. Therefore, the project should reinforce the training programs on the understanding of the bank books and make sure that the messages get to all group members and not only the Steering Committees members.

Table 9: Credit Recipient Literacy / Numeracy / Understanding of Bank Books

Indicator	BL Value	LOA target	MTE Target	WA (CI)	LQAS judgment (overall)	Actual performance per SA			
						1	2	3	4
Literacy / numeracy / understanding their bank book									
% of credit participants who know how to sign their name	NA	NA	30%	55.4% (11.2ppt)	Pass	YY	YY	YY	YY
% of credit participants who feel confident in their addition and subtraction skills	NA	NA	30%	65.5% (10.6ppt)	Pass	YY	YW	YY	YY
% of credit participants who report not having any difficulty in understanding how their bank book works	NA	NA	85%	43.3% (11.1ppt)	Fail	BY	BY	BW	BW
% of credit participants who have read the financial agreement with the steering committee of the group in order to get their loan	NA	NA	20%	41.0% (11.0ppt)	Pass	YY	YY	YY	YY

vi) Changes in Household Wealth

With the objective of testing the Baseline findings, indicators were included in the MTE to test whether credit loans contribute to the increased wealth and health of the household. Unfortunately, findings on these specific issues were inconclusive (Table 10). Most of these issues will have to be addressed in the Phase II.

First, the percent of credit participants whose school aged children all went to school remained unchanged before and after joining the credit program (75.6% and 76.9%). Second, with the hypothesis that the credit program would contribute to better child nutrition, benchmarks for the other two indicators - percent of credit participants who spend more money on food than before they received their loan and the percent of credit participants who feel they have more money to spend on things such as clothing, medical care and school fees/costs than before they received their loan, - were both set very high (75% and 70%). All four SAs failed to meet the benchmark for both of these indicators. The hypothesis that access to credit contributes to increased food expenditures, clothing, medical care, transportation, and school fees, thus failed to be confirmed. This issue will have to be addressed through a qualitative study during Phase II.

It is also difficult to understand the findings for the indicator; namely that 88.8% reported never having to borrow money from other sources in order to pay back their loan, and the indicators dealing with expenditures - 35% stated that they did not spend more money on food than before, and 55.7% who do not spend more money on things such as clothing, medical care, school fees.

Similarly, in SA4, results showed that the respondents did not reach the weighted average for never having to borrow money from another source; nor did they meet the benchmark for not having had any difficulty paying back their loans. What these results suggest is that participants in this supervision area, when compared to the other SAs, are having some trouble paying back their loans and are resorting to borrowing money from other people in order to do so. Further investigation as to the reasons for these results will be necessary.

Moreover, 22.5% of participants think that the amount of their loan was enough to improve their business activities as they would have liked. The incoherence between these two findings and the first indicator (88.8% who never had to borrow money from other sources) should also be looked at during Phase II of the evaluation.

Table 10: Changes in Household Wealth of Credit Recipients

Indicator	BL Value	LOA target	MTE Target	WA (CI)	LQAS judgment (overall)	Actual performance per SA			
						1	2	3	4
Changes in Household Wealth									
% of credit participants who never had to borrow money from another source since they received their loan	NA	NA	65%	88.8% (6.8ppt)	Pass	YY	YY	YY	YW
% of credit participants who spend more money on food than before they received their loan	NA	NA	75%	35.3% (10.7ppt)	Fail	BW	BY	BY	BY
% of credit participants who feel they have more money to spend on things such as clothing, medical care and school fees/costs than before they received their loan	NA	NA	70%	55.7% (10.0ppt)	Fail	BW	BW	YY	YY
% of credit participants who think the amount of their loan was enough to improve their business activities as they would have liked	NA	NA	50%	22.5% (9.4ppt)	Fail	BY	BY	BY	BY
% of credit participants whose school aged children all go to school	NA	NA	60%	75.6% (9.5ppt)	Pass	YY	YW	YY	YY

% of credit participants whose school ages children were all going to school before they joined the credit program	NA	NA	40%	76.9% (9.4ppt)	Pass	Y Y	Y Y	Y Y	Y Y

4.2.b. Conclusions and Recommendations – Community Credit Program

Even though some targets set for the credit program were met (group management, solidarity amongst members, selection processes, literacy and numeracy levels, etc.), some issues need to be reinforced by the project staff while others need to be explored in more depth through a qualitative study.

In addition to the results of the survey, other issues were reported during the implementation of the MTE survey (see section on survey implementation). For example, in SA1 and SA2 particularly, there were issues related to the lists of credit program participants provided by the managing partner, Caritas. Once the survey had begun, it was revealed that not all of the people on these lists were, in fact, credit recipients; suggesting that there had been some improprieties somewhere in the selection processes in these SAs. This revelation required the drawing up of the sampling lists for these SAs, once again, in order to identify eight substitute participants that were needed to complete the 19 interviews required.

CRS will need to work more closely with its partner, Caritas Cayes, in order to ensure that the participant lists are up-to-date and that the selection guidelines for receiving credit are being adhered to correctly.

Compared to the other three SAs, the area of Port a Piment is of most interest since this supervision area performed at a lower level than the other three SAs. Together with its partners and field staff, CRS should plan to undertake a careful analysis of its programs in that area. Phase II results should guide CRS in planning this analysis.

With regards to the micro-credit program, CRS should recommend to Caritas that it reinforce the training programs for recipients on how their bankbooks work. Caritas should also improve its strategies for disseminating its programmatic messages, so that all of the group members get them – not just the Steering Committee members.

CRS needs to better understand why participants in the credit program have not been spending more money on food since they received their loans. It would be best to undertake the qualitative study in SA2 (Port a Piment) where the project failed to reach the targets set for the MTE.

4.2.c. Analysis of Results - Community Health Worker (Colvol) Credit Program

All CHWs attached to the same health center are regrouped into one or two groups according to the number of CHWs and their geographical distribution. Previous experience in small business is not a requirement since their primary responsibility is the organization of the monthly community rally post. Their loan is managed as a group and the solidarity principle is again fundamental. According to the program rules, for a CHW to participate in the credit program, he/she should have a regularly functioning rally post. The credit component was added to the MCHN program in 1989, at the time that CHWs were introduced into the program structure. CHWs do not receive remuneration for their activities and the credit program is seen as a means of providing these individuals with an incentive to continue their important work.

For the purpose of the MTE, CHWs were divided in only two groups: the first group covering all of the CHWs of the South Coast and Cotes de Fer / Aquin, where the Baseline had been done; and the second group covering the CHWs from the Grande-Anse / Nippes, areas where the Baseline had not been done.

i) Management of Loan

Four different questions were asked to get an indication of how the CHWs have been managing their loan. Results presented in Table 11 show that all of the indicators met their mid-term expectations (75%) in both SAs, indicating that the participants felt that they are able to manage their loan and their businesses efficiently.

Table 11: CHWs - Management of Loans

Indicator	BL Value	LOA target	MTE Target	Actual performance per SA[19]	
				SA1[20]	SA2[21]
Management of their loan					
% of colvols who think they are capable of managing their loan well	NA	NA	75%	Pass	Pass
% of colvols who think they are capable of managing their business efficiently	NA	NA	75%	Pass	Pass
% of colvols who made a profit from their business activities last month	NA	NA	60%	Pass	Pass
% of colvols who have never had a problem paying back any of the monthly loan payments	NA	NA	70%	Pass	Pass

ii) Group Solidarity

CHWs were asked if their groups had ever assisted a fellow group member when she/he had a problem paying back her/his loan. Both SAs met the benchmark of 40% (Table 12), indicating that there is a strong sense of group solidarity among the CHWs.

Table 12: CHWs Group Solidarity

Indicator	BL Value	LOA target	MTE Target	Actual performance per SA	
				SA1	SA2
Group solidarity					
% of colvols whose groups has assisted a fellow group member when she/he had a problem paying back her/his loan	NA	NA	40%	Y	Y

iii) Changes in Household Wealth

With regards to the indicators chosen to measure the changes in household wealth, results for CHWs are similar to those observed with the credit participants at the community level. Both SAs met the MTE benchmark set at 80% for CHWs whose school aged children all go to school and 65% for CHWs whose school aged children were all going to school before they joined the credit program (Table 13). The 60% benchmark was also met for the percent of colvols who never had to borrow money from another source since joining the credit program.

[19] Y": Yes, met the benchmark; "B": Failed to reach the decision rule for the benchmark
[20] SA1 included all of the areas covered by the project since 2002 (South Coast, Aquin and Cotes de Fer)
[21] SA2 included the areas that were not covered by the Baseline and where activities have continued since 2002, but with limited support from CRS (Grande Anse and Nippes).

Based upon the link that was proposed by the Baseline survey, that increased income would translate into higher nutrition levels for children, the MTE sought to test the following indicators: 1) Percent of credit participants who spent more money on food than before they received their loan; and 2) Percent of credit participants who felt that they had more money to spend on things such as clothing, medical care and school fees/costs than before they received their loan. The benchmarks for these indicators were set at high levels - 80% and 60% respectively. MTE results revealed that both SAs failed to meet the benchmark for the first indicator (more food), but passed the benchmark for the second one (use money for other things). Therefore, the hypothesis that the credit program contributes to increased food expenditures was not confirmed in this survey. This issue will have to be addressed through a qualitative study in Phase II of the MTE.

Table 13: CHWs Changes in Household Wealth

Indicator	BL Value	LOA target	MTE Target	Actual performance per SA	
				SA1	SA2
Changes in household wealth					
% of colvols who never had to borrow money from another source since they received their loan	NA	NA	60%	Pass	Pass
% of colvols who spend more money on food than before they received their loan	NA	NA	80%	Fail	Fail
% of colvols who feel they have more money to spend on things such as clothing, medical care and school fees/costs than before they received their loan	NA	NA	60%	Pass	Pass
% of colvols who think the amount of their loan was enough to improve their business activities as they would have liked	NA	NA	50%	Fail	Fail
% of colvols whose school aged children all go to school	NA	NA	80%	Pass	Pass
% of colvols whose school aged children were all going to school before they joined the credit program	NA	NA	65%	Pass	Pass

iv) Credit Program as an Incentive to work as CHW

An interesting finding was revealed regarding the perception of the CHWs on their dual roles as volunteer health promoters and credit recipients. Whereas at least 50% of CHWs stated that the credit program is an incentive for them to work as volunteers, at least 60% stated that they would continue their work as CHWs even if the credit program were discontinued (Table 14). This seem to indicate that, in general, CHWs appreciate the benefits that they experience within their communities as a result of being a CHW, but that the credit program is not so much an incentive to continue working as a CHW, but rather an added bonus or reward of sorts.

Table 14: CHWs – Credit Program as Incentive

Indicator	BL Value	LOA target	MTE Target	Actual performance per SA	
				SA1	SA2
Credit program as an incentive to work as CHWs					
% of colvols who think the micro credit loan program is an incentive to work as a colvols	NA	NA	50%	Y	Y
% of colvols who would continue to work as a colvol even without the micro credit program	NA	NA	60%	Y	Y

4.2.d. Conclusions and Recommendations – Community Health Worker (Colvol) Credit Program

Most of the targets related to loan management, group solidarity and credit program being an incentive for their work as a CHW were met. However, even though CHWs have more money to spend on things such as clothing, medical care and school fees, target for one of the most critical of the benchmarks was not met – the indicator that tested whether CHWs spent more money on food now, as compared to before receiving the loans. This issue surfaced for credit recipients at the community level as well, and will need further investigation in order to validate or invalidate the positive link between increased income and nutritional status, set forth in the Baseline report.

4.3. Water and Sanitation Program

Water and Sanitation services are key to the development process and to the improvement of the quality of people's lives. Safe water and good sanitation are essential to the protection of community health, by limiting the transmission of infectious diseases, especially among children and other vulnerable groups, by ensuring the maintenance of a sanitary home environment and improving the nutritional status of its inhabitants. Such services also contribute to the enhancement of human dignity and economic opportunity.

The CRS Water and Sanitation project is committed to addressing the myriad of issues that surround the evolution and adoption of appropriate technologies and behaviors and does so within the framework established by CRS' strategic plan and the regional Health and Water Sanitation strategy. This approach has enabled CRS and its partners to strengthen community structures such as: Parent Teachers Associations (PTA) and Community Water committees, health center representatives, and Community Health Workers (CHW). By utilizing local resources for construction work and community-based project management, the project builds the capacities of the target communities to identify, develop, implement and maintain their own future water and sanitation projects, thereby contributing to the long-term sustainability of such initiatives. Actively involving the target communities in all aspects of project development fosters a sense of community ownership and confidence in their abilities to transform their own lives.

While improved water supply and sanitation facilities are important, they will not necessarily have a health impact in and of themselves, unless proper hygiene practices in food preparation, basic sanitation, and correct hand washing techniques, are also adopted. The information given to community members should be locally relevant, realistic and complete and should also take into account local circumstances. The communication process needs to be open and evolving in order to promote positive behavioral changes.

Children being agents of change, the school is an excellent channel to pass important messages related to health, water and sanitation; as a means of keeping children healthy, improving the quality of the learning environment, and influencing the pupil's family members' behaviors, as well as those within their communities.

In Haiti, one of the biggest challenges to sustainable development goals is the growing number of families without access to adequate waste disposal and water provision in both poor urban and rural areas. Important water and sanitation-related findings were reported in the 2002 DAP Baseline survey: the prevalence of diarrhea was found to be statistically lower in households with a latrine/toilet, with a protected water source and where the distance to water source was less than half an hour away. Knowledge about how to prevent diarrhea and correct hand washing techniques were also associated with lower diarrhea prevalence.

4.3.a. Analysis of Results

In the MTE, the focus was on the water and sanitation infrastructures themselves (which were built in the south coast of Haiti, from Tiburon to Port Salut), as well as their use and maintenance. The survey covered four components of the CRS Water and Sanitation project, namely:

- Capped springs in communities where rally posts are implementing MCHN activities
- Latrines in schools participating in the Education program

- Water cisterns in schools participating in the Education program
- Garbage disposal in schools participating in the Education program

Information on the distance to the water source and the type of water was also collected by the MCHN questionnaires and is presented in that section.

i) School Cisterns

Seven indicators related to the condition and maintenance of water cisterns were assessed. Results presented in Table 15 show that MTE targets were met on all those indicators, suggesting that the school cisterns are generally properly cared for and protected.

Table 15: Condition and maintenance of water cisterns

Indicator	MTE Target	LQAS judgment (overall)
Percent of cisterns with walls intact	70%	Pass
Percent of cisterns without standing water	80%	Pass
Percent of cistern faucets equipped with a handle	90%	Pass
Percent of cisterns without a leak/drip	70%	Pass
Percent of cisterns with water flowing from the faucet	70%	Pass
Percent of wash basins without garbage or debris	65%	Pass
Percent of wash basins without animal feces within 10 meters	65%	Pass

ii) School Latrines

Another set of indicators investigated in the MTE related to the condition of the school latrines at the time of the survey, their usage and maintenance. Of the 10 indicators that were tested, only five met the MTE performance benchmarks (Table 16), namely:

- Percent of latrines that were found to be clean
- Percent of latrines free of visibly soiled paper
- Percent of latrines with functioning doors,
- Percent of latrines located at an appropriate distance from a water source, and
- Percent of latrines located at an appropriate distance from the school.

The remaining failed to meet their performance benchmarks. Those included:

- Percent of latrines where all latrine doors were closed upon arrival
- Percent of latrines with doors equipped with working inside locks,
- Percent of latrines with seat covers in all stalls,
- Percent of latrines with all latrine covers down, and
- Percent of latrines that had at least one broom available.

These results show that the project had mixed results in both its behavioral and technical goals for the latrines. Hygiene practices are deemed as critical as the condition and maintenance of the latrine. Also, a latrine has to be well maintained in order to be in good condition. Results suggest that maintenance is a major issue. It should be addressed in Phase II of the MTE, and in the second half of the DAP.

Table 16: Condition and maintenance of school latrines

Indicator	MTE Target	LQAS judgment (overall)
Percent of latrines found to be clean (no trash lying on the floor, no feces visible)	60%	Pass
Percent of latrines free of visible soiled toilet paper or other used paper	60%	Pass
Percent of latrine sites visited where all latrine doors were closed upon arrival	60%	Fail
Percent of latrines with functioning doors	80%	Pass
Percent of latrines with doors equipped with working inside locks	65%	Fail
Percent of latrines with seat covers in all stalls	60%	Fail
Percent of latrines with all latrine covers down	50%	Fail
Percent of latrines that had at least one broom available	40%	Fail
Percent of latrines located at an appropriate distance from water source	70%	Pass
Percent of latrines located at an appropriate distance from the school	70%	Pass

iii) Trash disposal

When the project builds a school latrine, it also provides garbage cans to the school, and teaches proper garbage disposal methods. The survey data indicates that trash cans were easily accessible to school children in at least 80% of the cases, but that the schools failed to use the trash disposal system properly (Table 17). Both the Water and Sanitation and the Education projects will need to emphasize the importance of proper garbage disposal practices in the future if schools are going to improve their overall performance on basic sanitation indicators by the end of the DAP.

Table 17: Trash disposal

Indicator	MTE Target	LQAS judgment (overall)
Percent of sites with trash can easily accessible to school children	80%	Pass
Percent of schools without garbage lying around	70%	Fail
Percent of trash disposal areas with acceptable levels of garbage in them (where the level of trash in the garbage pit was below the level of the ground or surrounding wall)	70%	Fail

iv) Capped Springs

Twenty-five capped springs were visited during the MTE. The indicators that were measured focused on evaluating the quality and maintenance of both the capped spring and water point fountain areas. Three indicators were also included to measure behavior changes associated with the capped spring, those being obtained by interviewing a community member who happened to be in the capped spring area at the time of the data collector's visit.

Among the eight infrastructure indicators set for the capped spring area, five met the MTE performance targets whereas three did not (Table 18). An encouraging finding relates to the efforts made for the reforestation of the spring surroundings. On the other hand, the survey documented unacceptable levels of garbage lying around capped spring areas, and a recurrent absence of drainage canals surrounding three sides of the spring structure. The project should emphasize to users the importance of maintaining the area clean, and keeping the drainage canals clear and free. Perhaps the community water committee should be retrained.

Twelve indicators were tested with regards to the water point area, only one of which did not meet the MTE target, namely the presence of debris around the water point. All other indicators met their targets. Such results are encouraging, and show that the Water Committees are maintaining the capped spring

structures and are disseminating effectively important key hygiene and health messages. That most interviewed community members stated knowing someone on the local Water Committee demonstrates a visible presence and level of activity on the part of the Committees. Overall, these results show strong community involvement in water and sanitation issues. The positive results associated with the technical aspects of the spring cappings also point at the quality of their construction, done by the local masons.

Finally, all three of the behavior change indicators met their MTE performance targets: at least 20% of the individuals surveyed stated that their household members regularly purify the water they obtain from the capped spring; 60% or more responded that their household has experienced less diarrhea since the construction of the spring; and at least 70% state that they use more water now that the capped spring is in place. These encouraging results are presented in the table below.

Table 18: Capped springs- condition and maintenance

Indicator	MTE Target	LQAS judgment (overall)
Spring capping area		
Percent of spring capping free of garbage or debris	65%	Fail
Percent of spring capping with walls intact	70%	Pass
Percent of spring capping covered by lid	70%	Pass
Percent of spring capping with lid firmly in place	70%	Pass
Percent of spring capping surrounded by a canal on three sides	70%	Fail
Percent of spring capping canals that are at least 20cm deep	70%	Fail
Percent of spring capping with front area free of standing water	80%	Pass
Percent of spring capping surroundings protected by vegetation	50%	Pass
Water point/fountain area		
Percent of water point/fountain areas free of garbage or debris	65%	Fail
Percent of water point/fountain surroundings free of standing water	80%	Pass
Percent of water point faucet or fountain pipe with water flowing	75%	Pass
Percent of water point/fountain where there are no animals within 5 meters	80%	Pass
Percent of water point/fountain where there are no animals feces within 5 meters	80%	Pass
Percent of communities with a spring capping that have a committee to manage the system	65%	Pass
Percent of respondents who state knowing at least one member of the spring capping committee	65%	Pass
Percent of respondents who state they have never seen the system run dry	60%	Pass
Percent of respondents who state they have never seen the system broken or damaged	60%	Pass
Percent of respondents who state they have never seen people doing their laundry at the water point/fountain	60%	Pass
Percent of respondents who state they have never seen people watering their animals at the water point/fountain	65%	Pass
Percent of respondents who state they have never seen people bathing at the water point/fountain (DN)	60%	Pass
Behavior changes		
Percent of respondents who state that their family treats the water with bleach before drinking it	20%	Pass
Percent of respondents who state that their family has less diarrhea since the construction of the spring capping	65%	Pass

Indicator	MTE Target	LQAS judgment (overall)
Percent of respondents who state using more water since the construction of the spring capping	70%	Pass

v) Distance to Water Source and Type of Source (mothers of the MCHN program)

Indicators related to the distance to water source and the type of water source (protected versus not protected) were tested by collecting information from the 285 mothers selected for the MCHN program (19 mothers in each SA for each child's age group: 0-6, 6-12, 12-24 months). Two of these indicators had been collected in the Baseline survey, and could thus be compared to the MTE results.

It appears that households had to travel farther for water at the time of the MTE than they did in 2002 when the Baseline was carried out (Table 19). In 2002, 74.2% of mothers reported that their water collection took 30 minutes or less. In 2004, that number had lowered to 48.5% across the supervision areas. As a matter of fact, only SA2 (Port a Piment, Roche a Bateau, Coteaux) met the 75% benchmark for this indicator; while SA1, SA3 and SA4 all failed to do so.

With regards to the quality of the water source, 50% of households fetch their water from a protected water source at Mid-Term, as compared to the 56.2% that did so at the time of the Baseline. SA2, SA3 and SA4 all met the benchmark for this indicator. SA1 is the only supervision area that did not meet the 55% benchmark nor the weighted average for this indicator indicating that the coverage of the capped springs were lower in this SA than in the others.

Since the beginning of the DAP in 2002, 45 springs have been capped on the south coast (SA1 and SA2). Of these, 29 were built in SA1 (12 in Tiburon, two in Les Anglais, seven in Chardonnieres and eight in Rendel). Why this SA failed on the coverage indicator when it received the majority of the project's resources is perhaps that the area is more scarcely populated than SA2. Perhaps the water projects implemented in SA1 do not reach as many households as in the other SAs for this reason. This should be confirmed by the project monitoring data. .

Important water and sanitation related findings were reported in the 2002 DAP baseline: the prevalence of diarrhea was found to be statistically lower in households using a protected water source (34.3%) compared to an unprotected source of water (24.1%). The same study did not show the same significant difference with the distance to water.

Therefore, these findings do not necessarily show that the sanitation program should intensify spring capping projects in SA1, but rather that cost effectiveness studies should be undertaken, taking into account the affected populations, before such spring capping projects are undertaken.

Table 19: Distance to water source

Indicator	BL Value	LOA target	MTE Target	WA (CI)	LQAS judgment (overall)	Actual performance per SA			
						1	2	3	4
Distance to water source, all age groups (aggregates)									
Percent mothers reporting water collection taking 30 minutes or less	74.2 %	NA	75%	48.5 % (6.4%)	Fail	BY	YY	BY	BW
Percent of mothers that fetch their water from a protected water source	56.2 %	NA	55%	50.0 % (6.7%)	Unable to determine	BW	YY	YY	YY

4.3.b. Conclusions and Recommendations – Water and Sanitation

i) School Cisterns

The hardware seems to be intact and functioning well with regard to the availability of water and the maintenance of school cisterns. Knowledge on maintenance of those thus seems appropriate.

In order to ensure the sustainability of the school cisterns, the CRS/Education field-based staff should continue to ensure that the cisterns are always well maintained by encouraging the target communities and PTAs to continue their good work and to make sure that the school children continue their correct behavior with regard to the cistern.

ii) School Latrines

Targets measuring the cleanliness of the school latrines were met. However, targets set for maintenance issues were not met for some indicators. In order to get the project on the right track, in terms of its achieving its LOA targets, the CRS/WS project will collaborate closely with CRS/Education project with respect to the maintenance of the school latrines, and to keep them clean. Minimum standards should be imposed for the purchase of materials for the construction of these facilities (such as locks, seat covers, etc). The CRS/Education staff should also reinforce school sanitation efforts by encouraging PTAs to establish appropriate organizational structures, cleanliness committees, and guidelines concerning proper, safe, and sanitary waste disposal procedures, as well as outlining the proper usage and maintenance of school sanitation facilities.

A qualitative study will be undertaken to understand why school latrines maintenance is a problem. As improper hygiene practices and the lack of proper sanitation practices have negative consequences on the health of students and school staff alike, further study is needed to understand: why school latrines are not being well maintained; who is responsible for the cleaning the latrines; why these responsibilities are not being carried out; and why there is no system to keep latrines in good condition.

iii) Capped Springs

CRS/WS must continue to support the Water Committees in the construction and maintenance of the capped spring structures and environs. It must also work through these committees to better educate the local communities in how to better care for the capped spring and water points. Such small-scale public health campaigns can also be integrated into MCHN activities and the messages promoted by the CHWs, which may assist in further disseminating proper hygiene information. The Water and Sanitation project will also undertake cost effectiveness surveys in order to select the most appropriate sites for construction of the capped springs in the future. This will facilitate the establishment of more efficient program monitoring and evaluation systems that will, in turn, ensure greater coverage of water services.

4.4. EDUCATION

The Food Assisted Education (FAE) component of the DAP operates in the South, South East, and Grande Anse Departments. All FAE schools benefit from and participate in: a) a School Canteen; b) Health Hygiene and Nutrition interventions (trainings, activities, de-worming); c) Quality of Education activities, to improve school management and teaching; and d) Community Participation activities, mainly via the strengthening of Parent-Teacher Associations (PTAs). The program targets 156 primary schools (of which 145 are FAE schools), and reaches an estimated 48,000 school children.

The sampling methodology covered four supervision areas, and five categories of respondents: PTA Members; School Directors; School Teachers; female pupils; male pupils.

4.4.a. Analysis of Results

i) PTA Committee Members

Results presented in Table 20 indicate that PTA members regularly organize and attend their quarterly meetings, and participate in the school health activities and in the small projects that support their school. Data also indicate that in all SAs, PTA members do attend the trainings organized by CRS. Program staff should continue emphasizing the importance of PTA Members' involvement in school activities in order to build upon and strengthen these positive behaviors.

Table 20: PTA Committee Members- Education Program

Indicator	MTE Benchmark	SA1[22]		SA2		SA3		SA4	
		BMK	WC	BMK	WC	BMK	WC	BMK	WC
Per cent of PTA members that attended at least one PTA meeting in the last 4 months.	50%	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass
Per cent of PTA members stating participation in a school health-related activity in the past 6 months	60%	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass
Per cent of PTA members stating participation in a PTA small project in the past 12 months	30%	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass
Per cent of PTA members stating participation in a training event given by CRS for PTA members	80%	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass

ii) School Directors

Data indicates that the majority of directors is satisfied with the training and support that they have received from CRS (Table 21). Some emphasis should be given by program staff to sensitize schools directors on the importance of health, hygiene, and nutrition education, to enlist their support and leadership for this activity. SA2 Directors might not have yet received such trainings, as this supervision area is relatively new in the program; which could explain why this supervision area failed on this particular indicator.

Table 21: School Directors – Education Program

Indicator	MTE Benchmark	SA1		SA2		SA3		SA4	
		BMK	WC	BMK	WC	BMK	WC	BMK	WC
Per cent of School Directors that have ever received managerial or administrative training from CRS while an employee of their school	80%	Pass	Pass	Pass	Fail	Pass	Pass	Pass	Pass
Per cent of School Directors that feel that the training they received improved the overall quality of their management or administration	40%	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass
Per cent of School Directors that received Health, Hygiene, and Nutrition training from CRS since being director at their school.	80%	Pass	Pass	Fail	Fail	Pass	Pass	Pass	Pass

iii) School Teachers

Results indicate that teachers participate in and are satisfied with trainings provided by CRS. Similarly, teachers in all supervision areas felt that the trainings they received helped improve the overall quality of their teaching (Table 22). However, Teachers in SA2 (as School Directors in this zone) failed to pass the benchmark for Health, Hygiene and Nutrition training. This may be due to the training calendar for such training interventions, and the fact that SA2 is relatively new to the program.

[22] SA1 : La Colline d'Aquin, Aquin, Vieux Bourg d'Aquin, Ile a Vache, SA2: Baraderes, Beaumont, Jeremie, Les Abricots, SA3: Tiburon, Port a Piment, SA4: Fond des Blancs et Cotes de Fer

Table 22: School teachers – Education Program

Indicator	MTE Benchmark	SA1		SA2		SA3		SA4	
		BMK	WC	BMK	WC	BMK	WC	BMK	WC
Percent of Teachers that ever received pedagogical or teacher training from CRS while an employee of their school	75%	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass
Percent of Teachers that feel the training they received improved the overall quality of their teaching	40%	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass
Percent of Teachers that received any Health, Hygiene, and Nutrition training from CRS while teaching at their school.	75%	Pass	Pass	Fail	Fail	Pass	Pass	Pass	Pass

iv) Female Students

Benchmarks were met on all indicators related to the School Canteen: both male and female students stated having received a meal the last day that they were at school (Tables 23 and 24). They also state appreciating the quality of these meals and mention they eat all the food given to them at school. Only in a few cases are weighted coverages not met (by female students in SA1 who are less emphatic in having meals regularly served; and by male students in SA3 who seem less appreciative of the quality of the meals). In order to address the latter issue, greater emphasis could be placed in this SA at the level of the School Canteen staff on providing children with a greater variety of meals.

Table 23: Female Students – Education Program

Indicator	MTE Benchmark	SA1		SA2		SA3		SA4	
		BMK	WC	BMK	WC	BMK	WC	BMK	WC
Percent of female students who received a meal the last day they were at school	80%	Pass	Fail	Pass	Pass	Pass	Pass	Pass	Pass
Percent of female students who state that the quality of that meal was good	50%	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass
Percent of female students who state generally eating all the food given to them at school.	80%	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass

v) Male Students

Table 24: Male students- Education Program

Indicator	MTE Benchmark	SA1		SA2		SA3		SA4	
		BMK	WC	BMK	WC	BMK	WC	BMK	WC
Percent of male students who received a meal the last day they were at school	80%	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass
Percent of male students who state that the quality of that meal was good	50%	Pass	Pass	Pass	Pass	Pass	Fail	Pass	Fail
Percent of male students who state generally eating all the food given to them at school.	80%	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass

Benchmarks were met on all indicators related to the School Canteen: both male and female students stated having received a meal the last day that they were at school. They also state appreciating the quality of these meals and mention they eat all the food given to them at school. Only in a few cases are weighted coverages not met (by female students in SA1 who are less emphatic in having meals regularly served; and by male students in SA3 who seem less appreciative of the quality of the meals). In order to

address the latter issue, greater emphasis could be placed in this SA at the level of the School Canteen staff on providing children with a greater variety of meals.

4.4.b. Conclusions and Recommendations - Education

Overall, results for this sector are positive, with the sampling groups passing most of the benchmarks that were set for their corresponding indicators. School Directors, PTA members and Teachers all seem to be participating in the training events that have been offered to them by CRS, as well as in other activities aimed at improving the staff performance and staff-parent relations. The only instance where the benchmark was not met for these sampling groups took place in SA2 and related to Health, Hygiene and Nutrition training. As SA2 is new to the program and those trainings, CRS will need to provide greater support for such events in the future if LOA goals for this indicator are to be met in that area.

This MTE exercise did not examine school retention rates for children even though this is one of the most important goals of the Education project. The reason for this is that this information already exists within CRS monitoring documentation for this sector. While survival rates can be calculated relatively easily, the reasons why students drop out of school are not as readily apparent from school attendance records. Therefore, CRS will need to further investigate why children leave school early in order to develop appropriate strategies for combating this trend.

4.5. Maternal Child Health and Nutrition (MCHN)

The overall objective of the DAP's Maternal and Child Health and Nutrition (MCHN) program is to improve the health and nutritional status of children under-five, pregnant and lactating women by 2007. Refer to Chapter 2 and Appendix 1for a more detailed presentation of the program.

The CRS/MCHN program is implemented in different departments of the Southern Peninsula: South Coast, Aquin and Cotes de Fer (South East), Grande Anse and Nippes. The original DAP proposed by CRS did not include the Grande Anse/Nippes department and no Baseline data had been collected for this department; although additional resources provided on a yearly basis by USAID had allowed CRS to continue interventions in that department. Consequently, CRS decided to include the Grande Anse department in the Mid-Term Evaluation (MTE); but not to include the results in the aggregated results. The departments where the Baseline was conducted were divided into 4 supervision areas for the MCHN sector; the aggregated results of which were compared with those of the Baseline survey, when this was possible.

Indicators used in the Baseline study were included in the MTE as appropriate and applicable; using the same formulation. It is important to note that cluster sampling was used in the Baseline study whereas the Mid-Term evaluation used LQAS. It is not ideal to mix methods, but both surveys are meant to be representative of the overall population. Thus we have good ground to claim for the comparability of results between those two points in time.

The MTE results for the MCHN sector are presented in seven general sections:

- Breastfeeding and infant feeding practices
- Diarrhea and diarrhea management
- Child immunization and vitamin A
- Prenatal and postnatal care
- Participation in program activities: rally posts and health clinics
- Health knowledge of the Community Health Workers
- Hand washing knowledge and practices

4.5.a. Analysis of Results – Breast Feeding and Infant Feeding Practices by Age Group

Appropriate infant and child feeding practices are essential to the health and nutritional status of children. Current international guidelines for infant and child feeding recommend that children be exclusively

breastfed from birth up until six months of age. Breastfeeding should be initiated within one hour of delivery and nutrient-rich colostrum should be fed to the infant. Beyond six months of age and through two years or older, the infant should continue to be breastfed frequently, and on-demand. Good hygiene and proper food handling techniques, including avoiding the use of feeding bottles, should be practiced. Starting at six months, complementary foods, in addition to breast milk, should be provided. In general, the number of daily complementary feeds and quantity of food provided at each feed should increase with the age of the child. For the average healthy breastfed infant, meals of complementary foods should be provided two to three times per day for children 6-9 months of age and three to four times per day for children 9-12 months and 12-24 months. In addition, nutritious snacks should be offered to children 6-24 months one to two times per day, as desired. Once complementary feeding is initiated, adequate food group variety is important to ensure that the child's minimum nutrient requirements are met. The nutrient content of complementary foods should be high for all age groups. Meat, poultry, fish or eggs should be eaten daily, or as often as possible. Vitamin A rich fruit and vegetables should be eaten daily, and adequate lipid content should be included in the child's diet[23]. Data on those various aspects of infant and child feeding practices were collected in the Baseline survey, and then again in the Mid-Term evaluation. For the purpose of this analysis, we compare the results from both sets of data, as well as the benchmarks that were established for the project's mid-point.

i) Breastfeeding and Infant Feeding Practices among Mothers of Children 0-6 Months of Age

As stated earlier, children should be exclusively breastfed from birth up until six months of age. Breastfeeding should be initiated within one hour of delivery and nutrient-rich colostrum should be fed to the infant. Beyond six months of age and through two years or older, the infant should continue to be breastfed frequently, and on-demand; and diet diversity should be increased. CRS' behavior change interventions were designed to increase the number of mothers that adopt those practices. The data in Table 25 examines how the program has performed in its nutrition-related BCC interventions to date.

At the time of the Baseline, thirty percent of all infants 0-6 months old received only breastmilk on the day of birth. Project managers expected that the BCC activities promoting this practice would succeed in increasing the percent of mothers who give only milk on the day of birth to forty percent by the Mid-Term, and to fifty percent by the end of the project (LOA). As the MTE data shows, the project has already exceeded its LOA expectations since 63% of mothers gave only breastmilk to their infants on the day of birth. This rate of progress is excellent. Similarly, the percent of mothers that breastfed their infant within one hour of birth was, at Baseline, 6.2%; to be increased to 20% percent by Mid-Term, and 50% percent by LOA. The Mid-Term target was satisfactorily met (34.2%), placing CRS in a good position to fulfill its LOA goal on this indicator.

Looking at the performance of the various SAs, the benchmarks were met in all five SAs for both indicators; likewise the target set by the weighted average was also met everywhere. As CRS' performance on these two indicators may be characterized as "successful", no changes to its BCC program operations in those areas is warranted at this time, as they appear to be having the desired effect in all SAs.

The weighted average for the indicator on giving colostrum to newborns is 72.5% +/- 9.9 ppt at Mid-Term. As the confidence interval range overlapped with the MTE target of 80%, we are unable to definitively state whether or not the MTE target was actually met for this indicator. We can, however, highlight that three of the four SAs cleared the MTE benchmark, which suggests that the program is making adequate progress in promoting this practice in the majority of its impact areas. The only exception to this trend is SA1, where CRS failed to meet its target. This signals to project managers that the field staff in this SA will need to pay special attention to colostrum-related messages henceforth if they are to reach their LOA targets. Otherwise, the project should continue implementing its activities in the three other SAs as before, since the results there seem to be in line with program expectations.

[23] This text is borrowed from Bergeron and Deitchler, 2002.

The other two indicators, namely, the percent of infants currently breastfed and the percent of infants exclusively breastfed were measured according to two methods: the Baseline method and the international method. The difference between these two methods in calculating rates of exclusive breastfeeding lies largely in the period of reference. In the Baseline method, mothers were asked when particular foods were introduced into the child's diet; any food other than breastmilk that is given to the child before the child reaches 6 months disqualified that child from being considered "exclusively breastfed from 0 to 6 months". In contrast, the international method focuses only about what the child ate within the last twenty four hours: if the child was given anything besides breastmilk in the preceding day, then that child was not considered exclusively breastfed and disqualified from passing on that indicator. The MTE results for the two methods were found to be nearly identical, with 51.3% according to the Baseline method, and 51.4% by international method). Mid-Term expectations were met in all SAs; though SA3 failed to meet the performance level set by the weighted average. When looking at the "Percent of infants exclusively breastfed, using the international method", the project also achieved its MTE objectives.

ii) Breastfeeding Practices among Mothers of Children 6-12 Months of Age

Except for exclusive breastfeeding rates (which do not apply to children older than 6 months) the same indicators used for infants aged 0-6 months were also used for infants 6-12 months of age. CRS' interventions seem to have had the desired effects with regards to offering newborns only breastmilk on the day of birth. The overall results for the practices of giving breastmilk within the first hour of birth, providing colostrum, and maintaining breastfeeding cannot be determined as the confidence intervals for these indicators lay around 10%. The results did, however, highlight weakly performing supervision areas. For the practice of early initiation of breastfeeding (i.e. breastmilk within 1 hour of birth), for example, SA2 was shown to be the weakest performing area. For receiving colostrum, we saw that SA1 (which failed to reach the benchmark for 0-6 months) now satisfied the benchmark; while SA2, SA3 and SA5 all failed to reach it. These results suggest that this practice is a bit shaky in its adoption rate; therefore, the messages should be reinforced in all sites on this behavior.

Table 25: Breast Feeding and Infant feeding Practices among Mothers

Indicator	BL Value	LOA target	MTE Target	WA[24] (CI)	LQAS judgment (overall)	Actual performance per SA[25]				
						Areas covered by Baseline[26]				GA
						1	2	3	4	5
Breast feeding and Infant feeding practices 0-6 months of age										
Percent of children given breastmilk only on day of birth	32.5 %	50%	40%	63.6% (11.0ppt)	Pass	Y Y	Y Y	Y Y	Y Y	Y -
Percent of infants breastfed within 1 hour of birth	6.2%	16.2 %	20%	34.2% (10.6ppt)	Pass	Y Y	Y Y	Y Y	Y Y	Y -
Percent of infants having received colostrums	53.0 %	95%	80%	72.5% (9.9ppt)	UD	B W	Y Y	Y Y	Y Y	Y -
Percent of infants currently breastfed	95.8 %	95%	95%	100.0% (--)	Pass	Y -	Y -	Y -	Y -	Y -
Percent of infants exclusively breastfed (BL method)	16.8 %	26.8 %	20%	51.3% (10.3ppt	Pass	Y Y	Y Y	Y W	Y Y	Y -

[24] The weighted average was computed using only data from SAs 1 through 4, i.e. from the areas where the Baseline study had been carried out. Data from SA5 was not included into the weighted average as this area (Grande Anse department), was not originally included in the DAP and the Baseline study, as was already explained. .

[25] "Y"= Yes, met the benchmark; "B"= Failed to reach the decision rule for the benchmark; "W"= Failed to reach the decision rule for the weighted average (rounded up at the nearest 5 percentage point increment); "UD" (Unable to Determine) = given the confidence intervals, we cannot state with certainty that the weighted average clears the benchmark. In such cases, we do not make a judgment for the overall sample. We look instead only at individual SA performance. "-": not applicable

[26] SA1= Tiburon, Les Anglais et Chardonnières, SA2 = Port a Piment, Roche a Bateau et Coteaux, SA3 = Aquin (La Colline, Aquin, Vieux Bourg d'Aquin), SA4 = Fond des Blancs et Cotes de Fer, SA5 = Nippes et Grande Anse

Indicator	BL Value	LOA target	MTE Target	WA[24] (CI)	LQAS judgment (overall)	Actual performance per SA[25]				
						Areas covered by Baseline[26]				GA
						1	2	3	4	5
				)						
Percent of infants exclusively breastfed (Int'l method)	NA	26.8 %	20%	51.4% (10.3ppt)	Pass	Y Y	Y Y	Y W	Y Y	Y -
Breast feeding and Infant feeding practices, 6-12 months of age										
Percent of children given breastmilk only on day of birth	NA	NA	40%	70.6% (9.6ppt)	Pass	Y Y	Y Y	Y W	Y Y	Y -
Percent of infants breastfed within 1 hour of birth	NA	NA	20%	21.4% (9.6ppt)	UD	Y Y	Y W	Y Y	Y Y	Y -
Percent of infants having received colostrums	NA	NA	80%	71.5% (10.0ppt)	UD	Y Y	B W	B W	Y Y	B -
Per cent of infants 6-12 months currently breastfed	98.5 %	98.5 %	95%	95.3% (4.3ppt)	UD	Y -	Y -	Y -	Y -	Y -
Percent of infants 6-12 months fed the appropriate # of Complementary Feedings (CF) in last 24 hrs	55.6 %	60.6 %	60%	20.6% (9.3ppt)	Fail	B -	B -	B -	B -	B -
Percent of infants 6-12 months given all 3 food groups (as described by CRS messages) in last 24 hours	-	-	80%	60.0% (11.4ppt)	Fail	B Y	Y Y	B Y	B Y	Y -
Breast feeding and Child feeding practices, 12-24 months of age										
Percent of infants 12-24 months currently breastfed	60.0 %	70.0 %	65%	73.0% (10.1ppt)	UD	Y Y	Y Y	Y W	Y Y	B -
Per cent of infants 12-24 months fed the appropriate # of CF in last 24 hrs	41.1 %	46.1 %	45%	23.3% (11.6ppt)	Fail	B Y	B Y	B W	Y Y	B -
Per cent of infants 12-24 months given all 3 food groups (as described by CRS messages) in last 24 hours	-	-	80%	66.8% (10.1ppt)	Fail	B W	Y Y	Y Y	Y Y	B -

Since complementary foods are to be introduced at 6 months of age, two new indicators were added to this age group, namely (1) the frequency of feeding, and (2) the diversity of foods offered to the child. Unfortunately, the project failed to meet its objectives on both counts. With regards to feeding the appropriate number of complementary foods to the child, the data suggests that mothers in the CRS area not only failed to reach the benchmark in all SAs, they regressed from the situation at Baseline: the proportion of mothers offering the appropriate number of daily complementary feeding to their 6-12 month old children fell from 55 percent at Baseline, to 20.6 percentage points at the Mid Term. Therefore the messages about the appropriate frequency of complementary feedings should be reinforced in all of the SAs. Further investigation into the causes of this steep regression will need to be investigated more closely, in order to develop a programmatic strategy for addressing this serious drop in performance.[27].

CRS' educational messages also focus on the importance of giving all three food groups to children 6-12 months of age; the three food groups including body builders/protein, body protectors/fruits and vegetables, and energy providers/sugar, oil, starch, cereals. Since no information had been collected on this at Baseline, the MTE target was arbitrarily set at 80%. Results showed that only 60% of the 6-12 month old children received those three food groups the day before the survey was carried out; and that

[27] For instance, do the economic and political difficulties that have affected Haiti in the last 15 months explain this apparent degradation of the capacity of mothers to offer food with the appropriate frequency?

the problem was mostly in SAs 1, 2 and 4, who all failed to reach the 80% MTE benchmark for this indicator.

iii) Breastfeeding Practices among Mothers of Children 12-24 Months of Age

The situation described above for the 6-12 month olds is replicated in the 12-24 months age group: at the aggregate level (weighted average), the program failed to reach its targets, both in terms of the frequency and the diversity of the diet. It should be noted, however, that the dietary diversity indicator failed only in SA1 and SA5; it met both the benchmark and the target set by the weighted average in all of the other groups. For that age group, therefore, it appears that messages about dietary diversity should be reinforced in SA1 and SA5; while messages about feeding frequency should be reinforced in all SAs. It is important to note that SA5 is the Grande Anse area where program activities have not been implemented as intensively as in the other four supervision areas. At the same time, however, SA1 includes the area of Port a Piment, where low program coverage, participation and effectiveness have been observed in most of CRS supported programs over the last two years.

4.5.b. Conclusions and Recommendations – Breastfeeding and Infant Feeding Practices

The rate of progress for two important breast feeding indicators - giving breast milk only on day of birth and infants breastfed within one hour of birth- is excellent and CRS should continue its same BCC strategies, as they appear to be having the desired effect in all SAs.

However, the following three key practices have not been adopted as widely as expected by mothers in the CRS intervention areas: (1) giving colostrum to infants; (2) providing the adequate number of daily complementary feeds to children between 6 and 24 months; and (3) providing children 6-24 months with the appropriate dietary diversity. According to the conceptual framework used by CRS, the adoption of these practices is crucial to reducing malnutrition rates and therefore, CRS should strive to better understand the constraints that may impede mothers from adopting these important practices in the future.

SA1 and SA5 are areas where the program was shown most often to fail to meet the targets for the infant and child feeding indicators of focus for this study. The program should reinforce its training program in the Grande Anse area (SA5) in order to reach the same results as in the other areas. SA1 is a complex issue and the overall situation of low program participation will be addressed as a whole - in coordination with the other program sectors.

4.5.c. Analysis of Results - Diarrhea and Diarrhea Management

"Appropriate prevention and treatment of infection and disease are essential to protect a child's nutritional status. As described in the applied conceptual framework, children's health and nutritional status are closely related. In the presence of infection and disease, appetite as well as the absorption and utilization of nutrients may diminish. Similarly, children who are malnourished are not as resistant to illness, disease and infection. Children's health status is therefore both an underlying causal factor, and a related outcome of malnutrition."[28]

i) Diarrhea Prevalence

Results on the prevalence of diarrhea as well as information on the types of treatment and practices provided by the caretakers during childhood diarrhea are presented in Table 26**.**

[28] This text is from Bergeron and Deitchler, Report on the DAP Baseline study, 2002

The weighted average for children without diarrhea was 66.5% for children less than 6 months old, 61.7% for children 6-12 months old and 52.4% for children 12 to 24 months old. The overall result for the 6 to 24 month olds was 57.0%.

Even though most of the SAs passed the benchmark and the weighted average for this indicator, the data revealed unequal performance levels across the SAs. For example, SA3 failed to meet the benchmark and weighted average for 0-6 month olds, SA2 failed for 6-12 month olds, while SA1 failed for 12-24 month olds. When combining the last two age groups (namely, the 6-24 month olds), SA1, SA2 and SA5 all failed to pass the benchmark. However it seems that diarrhea prevention messages have made progress in SA4 (Cotes de Fer and Fond des Blancs), as this supervision area passed the benchmark for diarrhea prevention for all age groups.

Table 26: Diarrhea and Diarrhea Management

Indicator	BL Value	LOA target	MTE Target	WA (CI)	LQAS judgment (overall)	Actual performance per SA				
						Areas covered by Baseline				GA
						1	2	3	4	5
Diarrhea and diarrhea management, 0-6 months of age										
% infants without diarrhea in last two weeks	80.1	85.1	80%	66.5% (10.2ppt)	Fail	YY	YY	BW	YY	Y-
Diarrhea and diarrhea management, 6-12 months of age										
Percent infants without diarrhea in last 2 weeks	60.1	65.1	65%	61.7% (11.0ppt)	UD	YY	BW	YY	YY	B-
Diarrhea and diarrhea management, 12-24 months of age										
Percent infants without diarrhea in last 2 weeks	61.2	66.2	65%	52.4% (11.1ppt)	Fail	BW	YY	YY	YY	Y-
Diarrhea and diarrhea management (for children who had had diarrhea during the last two weeks), 6-24 months of age										
Percent children without diarrhea in last two weeks	64.5% (6-35.9 months)	69.5%	65%	57.0% (7.9ppt)	Fail	BW	BY	YY	YY	B-
Percent children who were given ORS for diarrhea	37.4%	60%	50%	53.0% (12.9ppt)	UD	YW	YY	--	YY	Y-
Percent children with diarrhea who were given increased liquids during diarrhea	44.6%	NA	50%	43.1% (12.0ppt)	UD	YY	YW	--	YY	Y-
Percent children with diarrhea who were given the same or more food	27.4%	NA	40%	40.4% (12.8ppt)	UD	YY	YY	--	YW	Y-
Percent children receiving continued feeding during diarrhea	15.2%	25.2%	20%	16.8% (10.0ppt)	UD	YY	YY	--	YY	Y-

Indicator	BL Value	LOA target	MTE Target	WA (CI)	LQAS judgment (overall)	Actual performance per SA				
						Areas covered by Baseline				GA
						1	2	3	4	5
Percent children with diarrhea receiving additional food after diarrhea episode	36.4 % Y	46.4 % Y	40% -	38.1% (12.5ppt) -	UD -	Y Y	Y Y	- -	Y Y	Y -

ii) Diarrhea management

Questions on diarrhea management were tabulated only for children who had had diarrhea during the last two weeks. Therefore, in order for the number to be sufficient for the analysis, the results on diarrhea management were aggregated using the data collected on the last two age groups, namely for children 6-24 months, for SA1, SA2 and SA4. Too few children had diarrhea in SA3 to be included in this tabulation.

The recommended treatment for diarrhea involves three components: 1) Providing ORS for the child during diarrhea 2) Providing increased fluids to the child during diarrhea and 3) Providing the same or more quantity of food to the child during diarrhea. In addition, children should receive additional food after the diarrhea episode has passed.

Only 37.4% of children were given ORS during diarrhea at the time of the Baseline. LOA expectations for that indicator are 60% and the benchmark at the MTE was 50%. At Mid-Term, the data showed that 53% of children who had had diarrhea during the last two weeks were given ORS during diarrhea. This rate of progress is excellent and places CRS in a good position to fulfill its LOA goal for that indicator. It also supports the continuation of its BBC program on the use of ORS, as it appears to be having the desired effect.

With regards to the four indicators measuring increased intake of fluids and food during diarrhea, the range of the confidence interval overlapped with the MTE targets so it is not possible to state definitively whether or not MTE targets were met. It can, however, be concluded that the program has made adequate progress in promoting appropriate diarrhea management in that all of the SAs cleared the benchmark for these indicators.

Judging from the overall results, it seems that significant progress has been made in terms of the percentage of children who were given the same or more food during diarrhea: 27.4% at the time of the Baseline and 40.4% at Mid-Term. With regards to the percent of children with diarrhea who were given increased liquids during diarrhea, the progress was not as significant, however.

Another important indicator, namely increased feeding during diarrhea, was computed by combining the proportion of children who were given both increased liquids and same or more food during diarrhea. Even though all SAs passed the benchmark, only 16.8% of children with diarrhea were given both increased liquids and same or more food during diarrhea at the time of the Mid-Term.

"During episodes of diarrhea, the growth of a child may falter, due to the child's impaired ability to absorb and utilize nutrients. The period following recovery from diarrhea represents an important opportunity during convalescence, or "catch-up growth" can occur. Once diarrhea has ceased, increased feeding is therefore recommended, and may enable a child to return to his/her prior health and nutrition status, rather than to remain at a deteriorated level".[29] At the time of the Mid-Term, all SAs passed the benchmark of 40% set for that indicator.

4.5.d. Conclusions and Recommendations - Diarrhea and Diarrhea Management

[29] This text is from Bergeron and Deitchler, Report on the DAP Baseline study, 2002

Diarrhea prevalence among children 6-24 months old failed to pass the benchmark in SA1 and SA2. For programmatic purposes, project managers should instruct the staff working in those two areas to pay special attention to diarrhea prevention messages.

Among the three components recommended for the treatment of diarrhea, the use of ORS has increased significantly since the time the Baseline was conducted: 53% of the children 6-24 months old who had had diarrhea during the last two weeks were given ORS during diarrhea at the time of the Mid-Term evaluation compared to 37.4% at the time of the Baseline. The increased use of ORS can possibly be explained by the increased access to ORS through a social marketing program set up by all of the CHWs in collaboration with PSI (Programme de Sante et Information).

With regards to the other two components of the recommended treatment for diarrhea (same or more food and increased liquids) all SAs passed the benchmark with more than 40% of the children with diarrhea receiving additional liquids and the same or more food. This result places CRS in a good position to reach the LOA targets for those indicators.

When comparing the results of the Mid-Term with those from the Baseline, the progress was more significant for the indicator measuring the amount of food given to the child during diarrhea than the indicator on increased liquids. Even though all SAs passed the benchmark of 20% set for the indicator combining both components of the treatment (continued feeding: increased liquids and same or more food), CRS staff and CHWs should continue to emphasize the BCC messages on the importance of applying simultaneously all three components of appropriate treatment of diarrhea: ORS, increased liquids and same or more food.

Finally, results also showed that messages related to the giving of additional food to the child after the diarrhea episodes have been successful in CRS targeted areas.

4.5.e. Analysis of Results – Health Cards, Child Immunizations and Vitamin A Supplementation

The CRS program encourages mothers to have a health card and birth certificate for their children. Information on the possession of health cards and birth certificates was collected for all age groups, while data on vitamin A supplementation was collected for only two age groups: 6-12 and 12-24 months old. Current guidelines for Vitamin A capsule supplementation in developing countries recommend that children aged twelve months to five years of age receive 200,000 IU, as a single dose, every four to six months. The information on Vitamin A supplementation was collected by recall.

Immunization status was collected on children 12-24 months of age, using the standards developed by the Demographic Health Survey. For the purposes of this MTE, being fully immunized required that each of the following vaccinations were received: BCG, Measles, three DPT and three doses of polio, not including polio at birth (Haiti DHS 2000). Children receiving these vaccinations (according to the recommended immunization schedule) are able to achieve full immunization by one year of age.

i) Health Cards for Children 0-6 months

Results on health cards and immunization for the age groups are presented in Table 27.

The Mid-Term target for the percent of children having a health card or a birth certificate was set at 90% for all three age groups. For the 0-6 month old children, the weighted average for that indicator was 85.8% (+/- 7.8ppt) at Mid-Term. Because the range of the confidence interval overlapped with the MTE target for this indicator, we are unable to definitively state if the MTE target was met or not. We can, however, conclude that three SAs (SA1, SA3 and SA4) cleared the benchmark, suggesting that the program has made progress in those SAs in promoting the importance of the health card. Project and partner staff working in SA2 (including Port a Piment) should pay special attention to this message, as the 90% performance target was not reached in this area. The low performance in SA2 for the younger children can be explained by the decreased participation at rally posts, which has been observed in the area of Port a Piment over the last few months. As fewer mothers have been taking advantage of the

growth monitoring services offered at the rally post level, fewer mothers have been obtaining health cards for their children.

ii) Health Cards and Child Immunizations in Children 6-12 Months of Age

The MTE results for the number of children aged 6-12 months with health cards or birth certificates indicated that the program has been performing well in all of the SAs – as all SAs cleared the benchmark with an overall average of 96.6%. Similar improvements were seen with Vitamin A supplementation. At the time of the Baseline, 45.7% of all children 6-12 received a Vitamin A capsule within last six months. Program staff and partners expected that this indicator would increase to 60% by the Mid-Term, and 80% by the end of the project. As the data showed, the LOA expectations have already been met by Mid-Term, as 82.8% of children have received a Vitamin A capsule in the last six months. This rate of progress is excellent.

Table 27: Health cards, Child Immunizations and Vitamin A Supplementation

Indicator	BL Value	LOA target	MTE Target	WA (CI)	LQAS judgment (overall)	Actual performance per SA				
						Areas covered by Baseline				GA
						1	2	3	4	5
Child Immunization and Vitamin A, 0-6 months of age										
Percent children with health card or birth certificate with date recorded	NA		90%	85.8% (7.8ppt)	Unable to determine	Y Y	B W	Y Y	Y Y	B -
Child Immunization and Vitamin A Supplementation, 6-12 months of age										
Percent children 6-12 months with health card or birth certificate with date recorded	NA		90%	96.6% (4.1ppt)	Pass	Y -	Y -	Y -	Y -	Y -
Percent children receiving Vitamin A capsule in last six months	45.7 %	80%	60%	82.8% (7.8ppt)	Pass	Y Y	Y Y	Y W	Y Y	Y -
Child Immunization and Vitamin A Supplementation , 12-24 months of age										
Percent children 12-24 months with health card or birth certificate with date recorded	NA		90%	84.4% (7.9ppt)	UD	B Y	Y Y	Y Y	Y Y	Y -
Percent children receiving Vitamin A capsule in last six months	46.4 %	80%	60%	90.9 (5.7ppt)	Pass	Y W	Y Y	Y Y	Y Y	Y -
Percent children fully immunized (3 doses polio)	26.7 %	36.7 %	35%	63.5% (11.1ppt)	Pass	Y W	Y Y	Y Y	Y Y	Y -

iv) Health Cards, Child Immunizations, and Vitamin A Supplementation in Children 12-24 Months of Age

On average, 84.4% of 12-24 month olds have a health card or birth certificate with their date of birth recorded. Except for SA1, all SAs met the benchmark, set at 90%. Program staff based in SA1 (Tiburon, Les Anglais, Chardonnieres) should therefore examine the possible reasons for their lower performance, and emphasize to mothers the importance of the health cards for children of this age group.

Data on Vitamin A supplementation was also collected for children 12-24 months. At the time of the Baseline, 46.4% of all children aged 12-24 months had received a Vitamin A capsule in last six months. Program staff and partners expected that this indicator would increase to 60% by the Mid-Term and to 80% by the end of the project. As the data showed, LOA expectations were largely met by Mid-Term, as

90.9% of children had received a Vitamin A capsule during the last six months. This rate of progress is excellent.

Information on the immunization status of children aged 12-24 months old was collected and revealed that 63.5% of children in this age group were fully immunized at the time of the MTE. This rate of progress is excellent, as the LOA target for this indicator was 36.7%. This success can largely be contributed to three national immunization campaigns that have been undertaken by the Ministry of Health (with WHO support) during the last two years.

4.5.f. Conclusions and Recommendations – Health Cards, Child Immunizations, and Vitamin A Supplementation

We believe that joint action between CRS and the Ministry of Health has been instrumental in increasing the level of Vitamin A supplementation and full immunization of children over the last three years. Since the beginning of the DAP, CRS has been providing support to the Ministry of Health by transporting vaccines from their main warehouse in Port au Prince to CRS' regional warehouse in Les Cayes. CRS has also contributed to the improvement of the cold chain by supplying new refrigerators to five health centers located in the project area. Because of the shortage of staff at the health center level, and the limited number of CHWs who can provide immunization services, CRS staff provides assistance in immunization services whenever they are doing supervision visits. The positive results highlighted above can also be explained by an increased awareness on the part of parents on the importance of child immunization. Project staff reported that in many areas, parents are now asking for those services.

For programmatic purposes, project staff should pay special attention to the possession of health cards for children 0-6 months of age in SA 2 (Port a Piment, Roche a Bateau and Coteaux) and for 12-24 month olds in SA1 (Tiburon, Les Anglais and Chardonnieres).

4.5.g. Analysis of Results – Pre-natal and Post-natal Care

"During pregnancy, the health of the developing fetus is directly linked to the health and nutrition status of the mother. Women's dietary intake, for example, influences the availability of certain nutrients to the developing fetus. Women deficient in vitamins or minerals are unable to provide the required quantity of nutrients to the infant, resulting in negative outcomes for the growth and development of her child. Poor maternal health acts in a similar way to cause negative consequences for the infant. Any infection or disease that puts the health of the mother at risk also puts the health of the unborn infant at risk. In developing countries, maternal death during pregnancy or in childbirth usually means death for the infant also.

Several practices can contribute to reducing maternal, peri-natal, and neo-natal deaths, and poor pregnancy outcomes in developing countries. Interventions related to access and use of pre- and post-natal care and improvement of women's nutritional status are all recognized as important to protecting maternal and infant health and nutrition"[30].

"Quality pre-natal care offers important preventative health benefits to the mother and infant. Pre-natal care provides health workers an opportunity to identify and treat illness, communicates health messages, and allows for early detection of potential pregnancy complications. In addition, interventions for protection against iron deficiency anemia and neonatal tetanus can be provided to women during pre-natal visits. The availability and use of these services were collected during the Baseline study. The same information was collected during the Mid-Term, therefore, measuring the progress done on the issues on pre and post natal care"[31].

[30] This section is borrowed from Bergeron and Deitchler, Joint Baseline report, 2002
[31] Ibid.

"Almost all births in Haiti take place at the home of the mother and less than 10% of births take place at a health institution. More important than delivery location may be the presence of a trained birth attendant at the time of delivery. The presence of a trained health worker during delivery increase the likelihood that neonatal and post-partum infection will be prevented, and that referral to emergency health care will be made, when appropriate. Further, health messages are shared when a trained health worker is present at birth; the relationship between the health worker and the mother can be established and important infant feeding and care guidance can be impressed"[32]

"The post-natal care visit is an important opportunity to initiate follow up with the mother and her newborn. The visit allows the health worker to monitor the health of the mother and her infant, as well as to provide additional guidance to the mother on proper feeding and care of the child"[33].

The MTE collected data on the timing and location of the post-natal visit and if there was a consultation with a trained health worker. Results are presented for the three age groups of children. One can assume that mothers of children aged 0-6 months are those who are still receiving some post-natal care. On the other hand, mothers of children aged 12-24 months old at the end of 2004 received their pre- and post- natal care during 2002 and 2003.

At the time of the Baseline, information on pre- and post-natal care was not collected for mothers of children less than six months old. Therefore, Mid-Term results for the 0-6 months old are compared with Baseline results for mothers of all children 6-59.9 months. For the other two age groups, Baseline results are available by age group. On the other hand, LOA program targets have been set for all age groups combined and the table below presents the same targets for all three age groups.

i) Pre- and Post-Natal care for Mothers of Children 0-6 Months of Age

Results presented in Table 28 show that 91.6% of mothers of 0-6 months old children had a health card. For the indicator concerning mothers' complete immunization status during last pregnancy (two maternal tetanus toxoid vaccinations), the confidence interval overlapped with the MTE target of 70%; therefore, we are unable to definitively state if the MTE target was met or not. We can, however, conclude that all of the SAs cleared the benchmark, suggesting that the program has been making adequate progress in all of the SAs with regards to immunization of pregnant women.

Similar results were reported for the utilization of prenatal services. In all of the SAs, at least 80% of mothers had 3 or more prenatal visits with a trained provider. Therefore, the result of 78.2% for the CRS coverage area is excellent. During the Baseline survey, the overall result for mothers of children of all age groups combined (6 to 59.9 months) was 79.6%. This high value observed at the time of the Baseline can explain why the progress done at mid-point was not significant.

Significant progress was also noted in the percent of mothers who received pre-natal care from a trained provider before the third trimester of their pregnancy. At the time of the Baseline, 81.4 % of mothers (for all age groups) visited their trained provider before their third trimester; by Mid-Term, this percentage increased to 95.6%.

The percent of mothers who had a trained health provider assist in their delivery has nearly doubled since the Baseline survey was carried out (from 32.3% in 2002 to 68.0% in 2004). The MTE benchmark for that indicator was set at 70%, and all of the SAs cleared the MTE benchmark. Among the mothers who gave birth at home, 60.2% gave birth with a trained health provider present. This result showed significant progress since the Baseline in 2002 when only 23.8% of all mothers who had given birth at home had a

[32] Ibid.
[33] Ibid.

trained health provider present. Note, however, that SA1 seems to be performing at a lower level than the other three SAs with regards to this indicator.

At the time of the MTE, the percent of mothers who gave birth in a health facility was still very low (6.5%). As explained above, where the mother delivers is not as important as having a trained birth attendant present at the time of delivery It is interesting to note that only SA3 (Aquin) met the benchmark of 35% set for the MTE. This is likely due to the fact that all four health facilities located in this supervision area are health centers and/or hospitals, and provide these types of maternity services. Access may therefore explain the low proportion of facility-based deliveries.

The Baseline results revealed that postnatal care was not much of a priority for women, in that only 19.1 % of mothers surveyed made at least one postnatal visit with a trained health provider within 45 days of delivery. This priority has obviously changed, however, in that 56.2% of mothers had made at least one post-natal visit at the time of the MTE. This rate of progress is excellent when compared to the MTE performance benchmark, which was at 25%. There was one exception to this general trend, namely that SA3 (Aquin), which has not performed as well as the other SAs in regards to post-natal care.

Interestingly enough, data from SA5 revealed a similar increase in post-natal care. This trend can be explained by the fact that CRS has continued its support of pre- and post-natal services in this area, including food supplementation for pregnant and lactating women as a major activity.

Table 28: Pre- and Post-Natal Care: Mothers of Children 0-6 months old

Indicator	BL Value	LOA target	MTE Target	WA (CI)	LQAS judgment (overall)	Actual performance per SA				
						Areas covered by Baseline				GA
						1	2	3	4	5
Pre-Natal and Post-Natal Care, 0-6 months of age										
Percent mothers who have a health card	58.7%[34]	NA	80%	91.6% (6.5ppt)	Pass	Y Y	Y Y	Y Y	Y Y	Y -
Percent mothers who received at least 1 tetanus shot	83.8% (all age groups)	NA	70%	92.4% (6.4ppt)	Pass	Y Y	Y Y	Y Y	Y Y	Y -
Percent women fully vaccinated against tetanus during last pregnancy (received 2 shots or was already fully vaccinated)	63.8% (all age groups)	73.8% (all age groups)[35]	70%	77.1% (9.8ppt)	UD	Y Y	Y Y	Y Y	Y Y	Y -
Percent mothers with at least 3 prenatal visits with a trained	79.6% (all age	84.6% (all age	80%	78.2% (9.5ppt)	UD	Y Y	Y Y	Y Y	Y Y	Y -

[34] Information of mothers of children less than 6 months old were not collected at the Baseline; those Baseline results are those of mothers of children 6-59.9 months old all combined

[35] LOA results for pre and post natal care are only available for three indicators and were originally set for mothers of children of all age groups combined (6-59.9 months old)

Indicator	BL Value	LOA target	MTE Target	WA (CI)	LQAS judgment (overall)	Actual performance per SA				
						Areas covered by Baseline				GA
						1	2	3	4	5
provider	groups)	groups)								
Percent of mothers who received pre-natal visit with trained provider before third trimester of pregnancy (7 months)	81.4% (all age groups)	NA	80%	95.6% (5.0ppt)	UD	Y Y	Y Y	Y Y	Y Y	Y Y
Percent of mothers who had a trained health provider assist the delivery	32.3 % (all age groups)	37.3% (all age groups)	70%	68.0% (10.7ppt)	UD	Y Y	Y Y	Y Y	Y Y	Y -
Percent mothers who gave birth at home with a trained provider present	23.8% (all age groups)	NA	60%	60.2% (11.0ppt)	UD	Y W	Y Y	Y Y	Y Y	Y -
Percent of mothers who gave birth in a health facility	9.7% (all age groups)	NA	35%	6.5% (5.2ppt)	Fail	B -	B -	Y -	B -	B -
Percent of mothers who made at least one postnatal visit with a trained provider within 45 days of delivery	19.1 % (all age groups)	24.1% (all age groups)	25%	56.2% (11.4ppt)	Pass	Y Y	Y Y	Y W	Y Y	Y -

ii) Pre- and Post-Natal care for Mothers of Children 6-12 Months of Age

For mothers of children aged 6-12 months, Mid-Term results were compared with those of the Baseline for that specific group (Table 29). Results were similar to those of mothers of younger children presented in the previous section. Results presented in the table below show that 85.8% of mothers of 6-12 months old children had a health card and that all SAs cleared the benchmark.

For the indicator on complete immunization status during last pregnancy (two maternal tetanus toxoid vaccinations), the range of the confidence interval overlapped with the MTE target; therefore, we are unable to definitively state if the MTE target was met or not. We can, however, conclude that all SAs cleared the benchmark, except SA5, suggesting that the program has been making adequate progress in the first four SAs with regards to immunization of pregnant women. At the time of the Baseline study, only 49.1% of mothers of children 6-12 months old were fully vaccinated against tetanus during their last pregnancy.

Similar results were reported for the utilization of prenatal services. The first four SAs cleared the benchmark for the percent of mothers who had at least three prenatal visits with a trained provider. SA5 did not meet the benchmark for this age group, however. During the Baseline survey, the overall result for the joint evaluation (the four Cooperating Sponsors) was 65%. With a survey done at the population level in the CRS intervention area, the result of 78.5% of mothers with at least three prenatal visits with a trained provider for CRS area is excellent. The high value of 83.8% observed at the time of the Baseline could explain the lack of further progress achieved by Mid-Term

More substantial progress was noted for the percent of mothers who had pre-natal visit with a trained provider before the third trimester of pregnancy. At the time of the Baseline, the result was 78.5 % whereas by Mid-Term, this percentage increased to 88.6% for mothers of children aged 6-12 months old. All SAs cleared the benchmark for this indicator - except the Grande Anse.

The percent of mothers who had a trained health provider assist in the delivery has doubled since the time the Baseline study was carried out (from 31.0% in 2002 to 63.7% in 2004). All SAs cleared the

benchmark for that age group. However, SA1 and SA2 did not meet the weighted average suggesting that these two areas have been performing at a lower level than the other two SAs with regards to the assistance of a trained health provider at delivery. Among the mothers who gave birth at home, 65.2% gave birth with a trained health provider present. This is excellent progress, as the Baseline value was only 18.4%. All of the SAs cleared the benchmark set for this indicator, but both SA1 and SA2 seem to be performing less well when compared to the other two SAs in that they did not meet the weighted average.

At the time of the MTE, the percentage of mothers of children 6-12 months old who gave birth in a health facility was still very low (13.0%) but the rate is still higher than that for mothers of younger children (6.5%). It is interesting to note that SA3 (Aquin) and SA4 (Cotes de Fer) met the benchmark of 35% set for the MTE.

Results of the Baseline study showed that post-natal care was not an area of concern for mothers of children 6-12 months old in that only 18.7 % of them made at least one post-natal visit with a trained health provider within 45 days of delivery. As the MTE target for this indicator was set at 25%, the data suggests that CRS has been performing very well in that the Mid-Term result was 47.7%. As with the previous age group, SA3 (Aquin) has not been performing as well the other SAs.

For mothers of children aged 6-12 months old, results observed in SA5 were not as positive as those observed in the younger age group for the same indicators. SA5 failed on three important indicators: complete vaccination during pregnancy, three prenatal visits with a trained health provider and a pre-natal visit with a trained provider before the third trimester of pregnancy. We can assume that mothers who recently gave birth have better pre- and post-natal care practices than those who gave birth one year ago.

Table 29: Pre- and Post-Natal Care: Mothers of Children 6-12 months old

Indicator	BL Value	LOA target	MTE Target	WA (CI)	LQAS judgment (overall)	Actual performance per SA				
						Areas covered by Baseline				GA
						1	2	3	4	5
Pre-Natal and Post-Natal Care , Mothers of Children 6-12 months of age										
Percent of mothers who have a health card	59.5 %	NA	80%	85.8% (8.3ppt)	UD	YY	YY	YY	YY	Y-
Percent of mothers who received at least 1 tetanus shot	71.4 %	NA	70%	92.7% (5.7ppt)	Pass	YY	YY	YY	YY	Y-
Percent of women fully vaccinated against tetanus during last pregnancy (received 2 shots or was already dully vaccinated)	49.1 %	73.8% (all age groups)	70%	74.5% (10.2ppt)	UD	YY	YY	YY	YY	B-
Percent of mothers with at least 3 prenatal visits with a trained provider	83.8 %	84.6% (all age groups)	80%	78.5% (9.4ppt)	UD	YY	YY	YY	YY	B-
Percent of mothers who received pre-natal visit with trained provider before third trimester of pregnancy (7 months)	78.5 %	NA	80%	88.6% (7.4ppt)	Pass	YY	YY	YY	YY	B-
Percent of mothers who had a trained health provider assist the delivery	31.0 %	37.3% (all age groups)	40%	63.7% (10.7ppt)	Pass	YW	YW	YY	YY	Y-
Percent mothers who gave birth at home with a trained provider present	18.4 %	NA	60%	65.2% (11.4ppt)	Unable to determine	YW	YW	YY	YY	Y-
Percent of mothers who gave birth in a health facility	14.5 %	NA	35%	13.0% (7.3ppt)	Fail	B-	B-	Y-	Y-	B-

Indicator	BL Value	LOA target	MTE Target	WA (CI)	LQAS judgment (overall)	Actual performance per SA				
						Areas covered by Baseline				GA
						1	2	3	4	5
Percent of mothers who made at least one postnatal visit with a trained provider within 45 days of delivery	18.7 %	24.1% (all age groups)	25%	47.7% (11.5ppt)	Pass	Y Y	Y Y	Y W	Y Y	Y -

iii) Pre- and Post-Natal Care for Mothers of Children 12-24 Months of Age

Results presented in Table 30 show that only 68.6% of mothers of children 12-24 months had a health card. SA1 and SA2 did not meet the benchmark; nor did SA5. For the indicator on complete immunization status during last pregnancy (two maternal tetanus toxoid vaccinations), the range of the confidence interval overlapped (65.0% +/-11.0ppt) with the MTE target of 70%; therefore, we are unable to definitively state if the MTE target was met or not. We can definitively state, however, that all SAs except SA1 cleared the benchmark for the indicator.

Similar results were reported for the utilization of prenatal services. All SAs, except SA1 and SA5, cleared the benchmark for the percent of mothers who had at least three pre-natal visits with a trained provider. During the Baseline survey, the result for that age group was 78.5% and the overall result for the joint evaluation (the four Cooperating Sponsors) was 65%. Therefore, the result of 83.2% at the MTE for CRS area showed excellent progress. This high value observed by CRS at the time of the Baseline (78.5%) can explain why the progress achieved by Mid-Point, 83.2%, has only been a slight improvement.

As with the other two previous groups, more substantial progress was noted for the percentage of mothers who had a pre-natal visit with trained provider before the third trimester of their pregnancy. At the time of the Baseline, the result was 78.5 % and this percentage increased to 87.8% at the time of the Mid-Term evaluation.

The percent of mothers who had a trained health provider assist in their delivery significantly increased from 32.1% at Baseline to 54.8% at mid term. All SAs cleared the MTE benchmark (set at 40%), although SA1 revealed a weaker performance in comparison to the other SAs. Among the mothers who gave birth at home, 60.9% had gave birth with a trained health provider present. This is excellent progress compared to the Baseline result, which was 24.3% for that same indicator.

At the time of the MTE, the percent of mothers who gave birth in a health facility was 12.2%. Here again, SA3 (Aquin) met the benchmark of 35% set for the MTE, but not the other SAs. Likely, the fact that all four health facilities located in Aquin are health centers and/or hospitals that provide delivery services helps explain the good performance of this SA, as compared to the others.

Results of the Baseline study had indicated that post-natal care was an area of concern, as only 18.1% of mothers of children 12-24 months had made at least one post-natal visit to a trained health provider within 45 days of delivery. The MTE target was set at 25%. The rate of progress for that indicator is excellent since the percent increased from 18.1% to 52.0% at the time of the Mid-Term evaluation, clearing the benchmark with a comfortable margin in all areas. We note however that SA3 (Aquin) performed at a lower level than the other SAs on this indicator.

In SA1, SA2 and SA5, mothers of children aged 12-24 months failed to clear the benchmark for health cards and both SA1 and SA5 also failed to clear the benchmark for the recommended number of pre-natal visits (three) with a trained provider.

Table 30: Pre- and Post-Natal Care: Mothers of Children 12-24 months old

Indicator	BL Value	LOA target	MTE Target	WA (CI)	LQAS judgment (overall)	Actual performance per SA

						Areas covered by Baseline				GA
						1	2	3	4	5
Pre-Natal and Post-Natal Care , 12-24 months of age										
Percent of mothers who have a health card	60.6 %	NA	80%	68.6% (10.5ppt)	Fail	B Y	B Y	Y Y	Y Y	B -
Percent of mothers who received at least 1 tetanus shot	80.3 %	NA	70%	81.7% (8.8ppt)	Pass	Y W	Y Y	Y Y	Y Y	Y -
Percent of women fully vaccinated against tetanus during last pregnancy (received 2 shots or was already dully vaccinated)	57.9 %	73.8% (all age groups)	70%	65.1% (11.0ppt)	UD	B W	Y Y	Y Y	Y Y	Y -
Percent of mothers with at least 3 prenatal visits with a trained provider	78.5 %	84.6% (all age groups)	80%	83.2% (8.0ppt)	UD	B W	Y Y	Y Y	Y Y	B -
Percent of mothers who received pre-natal visit with trained provider before third trimester of pregnancy (7 months)	78.5 %	NA	80%	87.8% (6.8ppt)	Pass	Y W	Y Y	Y Y	Y Y	Y -
Percent of mothers who had a trained health provider assist the delivery	35.3 %	37.3 % (all age groups)	40%	65.6% (10.3ppt)	Pass	Y W	Y Y	Y Y	Y Y	Y -
Percent mothers who gave birth at home with a trained provider present	24.3 %	NA	40%	60.9% (11.4ppt)	Pass	Y W	Y Y	Y W	Y Y	Y -
Percent of mothers who gave birth in a health facility	11.3 %	NA	35%	12.2% (7.2ppt)	Fail	B -	B -	Y _	B -	B -
Percent of mothers who made at least one postnatal visit with a trained provider within 45 days of delivery	18.1 %	24.1% (all age groups)	25%	52.0% (11.0ppt)	Pass	Y Y	Y Y	Y W	Y Y	Y -

4.5.h. Conclusions and Recommendations - Pre- and Post-Natal Care for Mothers of Children 0-24 months

Generally speaking, CRS has met most of its pre- and post – natal care Mid-Term targets; and has performed particularly well on indicators dealing with immunization during pregnancy, the number of prenatal visits, and the pre-natal visit with trained provider before the third trimester of pregnancy. This indicates that the majority of the mothers in the project intervention area have adopted the promoted health practices with regards to pre- and post-natal care.

The improved performance in the percentage of mothers delivering their baby with a trained health provider present (even at their homes) can be explained by the recent intensification of training programs for Trained Birth Attendants by the project. However, even though all SAs met the benchmark for this indicator, SA1 and SA2 showed lower performance levels than the other SAs. Project staff based in those areas should increase these types of training programs and encourage mothers to use the services of well-trained TBAs.

Results are more successful for mothers of younger children (0-6 months old) than for those of older children (6-12 and 12-24 months). This suggests that more recent exposure to program activities may be associated with better performance levels. This link may be further supported by the fact that most of the mothers of older children (12-24 months old), who have had less exposure to the program as their child grows, failed to pass the benchmark for the possession of a health card.

Better performance on the percentage of mothers who gave birth in a health facility in SA3 (Aquin) can be explained by the greater number of health facilities offering such services in that area. On the other hand, although the Aquin area met the benchmarks for the percent of women who made at least one post-natal visit to a trained health provider within 45 days of delivery for all three age groups, it performed at a lower level than the other SAs with respect to the post-natal care indicators. This may be explained by the fact that supplementary feeding programs (at pre- and post-natal clinics) were suspended for more than one year in the most important health facility located in that area (Hospital of Aquin). This suspension was due to poor "food monitoring" which was associated with personnel changes within institution's management.

With regards to SA5, mothers of the youngest group of children met all the benchmarks set for the other SAs (with the exception of the benchmark set for the indicator: "Percent of mothers giving birth at a health facility"). These positive results can be explained by the fact that support to pre- and post-natal services (food supplements for pregnant and lactating women) in the Grande Anse was never interrupted since the beginning of the DAP, thanks to supplemental resources made available by USAID during FY03 and FY04.

4.5.i. Analysis of Results - Participation in Program Activities - Rally Posts and Health Clinics

This section looks at the participation of mothers in different program activities, both at the community and the health facility levels. Since the Mid-Term evaluation was done at the population level, results for these indicators provided critical information on program coverage for specific interventions and activities.

One of the most important program activities evaluated in the MTE was the rally post, an activity carried out at the community level by Community Health Workers to provide such preventative services as: nutritional surveillance, health education, and the distribution of vitamin A and deworming medicine. Immunization services are also offered at the rally post level, although their provision depends on the presence of trained CHWs, qualified to provide such services.

As part of the MTE, data were collected on the level of participation in rally post activities, including Mother's Clubs, as well as the perceptions of mothers on the levels of knowledge and expertise of their local CHW. Mother's participation in the food supplementation programs was also explored, as this plays an important role in maintaining/improving the nutritional status of beneficiaries (rations are used as a nutritional treatment in the recuperation of malnourished children and as a nutritional supplement for pregnant and lactating women participating in the pre- and post-natal clinics). All CRS MCH food supplementation programs are carried out at the health facility level. The program starts at the second trimester of the pregnancy and ends when the child is 12 months old. Food supplementation programs are integrated into the pre- and post-natal clinics not only for nutritional purposes but also as a means of encouraging beneficiaries to take advantage of the available health services.

As food is delivered on a monthly basis, every mother should complete a series of 17 visits to the health facility where she receives quality health services for both her baby and herself. This distribution program is identified as a "preventive model". Food supplementation is also used in the "curative model" which focuses on managing moderate and severe malnutrition cases that are referred at the community level by the CHWs through the reference/counter reference system. Since the Mid-Term evaluation was carried out at the population level and the LQAS methodology required that all questions be applicable to all interviewees, information on the recuperation program was not included in this particular survey; thus, all questions related to food supplementation were related to the pregnancy and lactation periods. Mothers of children 0-12 months should have received food supplements beginning in the second trimester of their pregnancy and should still be participating in the food supplementation program for lactating women.

i) Rally Posts and Mothers' Clubs

The results presented in Table 31 indicate that 75.5% of children 0-6 months old had participated in a rally post in the month preceding the survey. However, as the confidence interval was so large (+/- 9.7ppt) it is not possible to definitively state whether the MTE target of 80% was met or not. We can, however, conclude that SA1, SA2 and SA4 cleared the 80% benchmark, while SA3 and SA5 did not;

suggesting that the program coverage for community rally posts has been adequate in the first three SAs but not so in SA3 (Aquin) and SA5 (Grande Anse) for children of that age group. Similar results were observed for the participation of the mother herself at the rally post: SA3 and SA 5 failed to meet the benchmark whereas the other three supervision areas met the 70% MTE target.

With regards to the participation of the mothers in educational sessions held at the rally post, mothers of 0-6 month old children failed to meet the benchmark set at 70%. The weighted average for this group was 52.2%. SA1, SA3 and SA5 did not meet the 70% benchmark. Results for SA5 (Grande Anse) can be explained by the fact that project activities at the community level did not receive the same level of institutional support as in the other supervision areas since the beginning of the DAP. However, the results for SA3 (Aquin) were particularly alarming in that their performance on this indicator was significantly lower than in the other SAs; thus the program needs to better understand the constraints that have impeded eligible mothers from participating in the educational session s at the rally posts.

For mothers of children 6-12 months of age, the rally post participation rates were similar to those of mothers of younger children, in that:

- 75.6% of children aged 6-12 months participated in a rally post the month preceding the survey. With the exception of SA3, all SAs cleared the benchmark suggesting that the program's coverage for the community rally post has been adequate in all but SA3 (Aquin).

- Similar results were observed for the participation of the mother herself in the rally post: SA3 failed to meet the benchmark whereas the other four SAs met the 70% MTE target for participation.

- Mothers of 6-12 months old children also failed to meet the benchmark set at 70% for their participation in the educational sessions held at the rally post. Though SA1, SA2, SA4 and SA5 all cleared the benchmark, SA3 (Aquin) did not. SA3's performance was so poor that it brought the program's overall coverage estimates down to 57.4%; SA3 failed to meet both the MTE target and the overall weighted average for this indicator. Once again, efforts need to be made to better understand why participation rates in the rally posts are so low in the area of Aquin.

Attendance rates at rally posts were less positive for the mothers of children 12-24 months old. Overall, only 68.1 % of children and 62.5% of mothers participated in a rally post in the month before the survey was undertaken. With the exception of SA4, no SA met the established benchmarks for all three of the participation indicators. These results can be explained by the fact that mothers often stop attending post-natal clinics once their child has received all the necessary immunizations or once the child has reached approximately one year of age. There were some successful results - in SA4 (Cotes de Fer), for example, where the refresher course scheduled for all CHWs in all areas before the end of the DAP had recently been complete. That area shows an increased mother's attendance rates in the rally posts there. Surprisingly, some positively deviant results were found in SA3 (Aquin) where two indicators also met the established benchmarks. This issue will also be looked at during the Phase II of the MTE.

The results on the participation in Mothers' Club activities were much better than expected as 40.2% of the mothers of children 0-6 months of age were reportedly members of a local Mothers' Club. All SAs passed the 25% benchmark, including SA5 where other projects such Haitian Health Foundation implement similar activities. For the mothers of 6-12 and 12-24 month olds, all of the SAs passed the benchmark even though the confidence interval of the overall averages (29.9% +/- 10.0ppt and 29.0 +/- 10.4 ppt) overlapped with the 25% target.

Table 31: Participation in Program Activities: Rally Posts and Mothers' Clubs

Indicator	BL Value	LOA target	MTE Target	WA (CI)	LQAS judgment (overall)	Actual performance per SA	
						Areas covered by Baseline	GA

						1	2	3	4	5
Participation at program activities: rally post and mothers' club/0-6 months of age										
Percent of children who have participated in a Rally Post in the last month	NA	90%	80%	75.5% (9.7ppt)	UD	Y Y	Y Y	B W	Y Y	B -
Percent of mothers who have participated in a Rally Post in the last month	NA	80%	70%	65.0% (10.5ppt	UD	Y Y	Y Y	B W	Y Y	B -
Percent of mothers who participated in an educational session at a Rally Post in the last month	NA	80%	70%	52.2% (11.1ppt)	Fail	B Y	Y Y	B W	Y Y	B -
Percent of mothers who are members of a Mothers Club	NA	50%	25%	40.2% (11.1ppt)	Pass	Y Y	Y Y	Y Y	Y Y	Y -
Participation at program activities: rally post and mothers' club/6-12 months of age										
Percent of children who have participated in a Rally Post in the last month	NA	90%	80%	75.6% (9.6ppt)	UD	Y Y	Y Y	B W	Y Y	Y -
Percent of mothers who have participated in a Rally Post in the last month	NA	80%	70%	70.0% (10.1ppt)	UD	Y Y	Y Y	B W	Y Y	Y -
Percent of mothers who participated in an educational session at a Rally Post in the last month	NA	80%	70%	57.4% (11.4pp)	Fail	Y Y	Y Y	B W	Y Y	Y -
Percent of mothers who are members of a Mothers Club	NA	50%	25%	29.9% (10.0ppt)	UD	Y Y	Y Y	Y Y	Y Y	Y -
Participation at program activities: rally post and mothers' club/12-24 months of age										
Percent of children who have participated in a Rally Post in the last month	NA	90%	80%	68.1% (9.8ppt)	Fail	B Y	B W	B Y	Y Y	B -
Percent of mothers who have participated in a Rally Post in the last month	NA	80%	70%	62.5% (10.3ppt)	UD	B Y	B W	Y Y	Y Y	B -
Percent of mothers who participated in an educational session at a Rally Post in the last month	NA	80%	70%	54.4% (11.4ppt)	Fail	B Y	B W	Y Y	Y Y	B -
Percent of mothers who are members of a Mothers Club	NA	50%	25%	29.0% (10.4ppt)	UD	Y Y	Y Y	Y Y	Y Y	Y -

ii) Perceptions of Mothers about Community Health Workers' Knowledge and Skills

Five questions were asked of the mothers to measure their perceptions of the Community Health Workers' knowledge of health issues, ability to perform his/her tasks and communicate specific health messages.

For mothers of children 0-6 and 6-12 months old, all of the SAs met the performance benchmarks for these perception-related indicators (Table 32). This was a very positive result since it reflects mothers' respect and recognition of the CHW as a valuable health resource at the community level.

Among mothers of 12-24 month old children, data results showed that CHWs in SA2 (Port a Piment, Roche a Bateau and Coteaux) need to improve their communication with mothers particularly with

regards to their child's weight. This SA failed to meet both the target and the performance benchmark for this indicator.

Table 32: Participation in Program Activities: Perceptions of Mothers on CHW's Knowledge on Health Issues and Communication Skills

Indicator	BL Value	LOA target	MTE Target	WA (CI)	LQAS judgment (overall)	Actual performance per SA				
						Areas covered by Baseline				GA
						1	2	3	4	5
Participation at program activities: **Rally-post: perception of mothers on CHW's knowledge on health issues /0-6 months of age**										
Percent mothers who think educational sessions provide practical information	NA	NA	70%	85.6% (7.4ppt)	Pass	Y Y	Y W	Y Y	Y Y	Y -
Percent mothers who think immunization provided by the Health facility is valuable	NA	NA	95%	96.7% (2.5ppt)	Unable to determine	Y -	Y -	Y -	Y -	Y -
Percent mothers who think growth monitoring services that Colvol provides are useful	NA	NA	95%	98.7% (2.5ppt)	Unable to determine	Y -	Y -	Y -	Y -	Y -
Percent mothers who know if child's weigh increased or decreased in the last month	NA	NA	70%	65.2% (11.1ppt)	Unable to determine	Y Y	Y Y	Y Y	Y Y	B -
Percent mothers who think information provided by Colvol is easy to understand	NA	NA	75%	84.9% (7.9ppt)	Pass	Y Y	Y Y	Y W	Y Y	Y -
Per cent mothers who think colvols are knowledgeable about nutrition information	NA	NA	80%	90.0% (6.9ppt)	Pass	Y Y	Y Y	Y Y	Y Y	Y -
Participation at program activities: **Rally-post: perception of mothers on CHW's knowledge on health issues /6-12 months of age**										
Percent mothers who think educational sessions provide practical information	NA	NA	70%	85.5% (7.2ppt)	Pass	Y Y	Y W	Y Y	Y Y	Y -
Percent mothers who think immunization provided by the Health facility is valuable	NA	NA	95%	98.2% (3.5ppt)	UD	Y -	Y -	Y -	Y -	Y -
Percent mothers who think growth monitoring services that Colvol provides are useful	NA	NA	95%	98.6% (2.6ppt)	Pass	Y -	Y -	Y -	Y -	Y -
Percent mothers who know if child's weigh increased or decreased in the last month	NA	NA	70%	79.9% (9.2ppt)	Pass	Y Y	Y Y	Y Y	Y Y	Y -
Percent mothers who think information provided by Colvol is easy to understand	NA	NA	75%	90.3% (7.0ppt)	Pass	Y Y	Y Y	Y Y	Y Y	Y -
Per cent mothers who think colvol are knowledgeable about nutrition information	NA	NA	80%	93.4% (5.7ppt)	Pass	Y Y	Y Y	Y Y	Y Y	Y -
Participation at program activities: **Rally-post: perception of mothers on CHW's knowledge on health issues /12-24 months of age**										
Percent mothers who think educational sessions provide practical information	NA	NA	70%	80.7% (8.3ppt)	Pass	Y Y	Y W	Y Y	Y Y	Y -

Indicator	BL Value	LOA target	MTE Target	WA (CI)	LQAS judgment (overall)	Actual performance per SA				
						Areas covered by Baseline				GA
						1	2	3	4	5
Percent mothers who think immunization provided by the Health facility is valuable	NA	NA	95%	95.9% (4.2ppt)	UD	Y -	Y -	Y -	Y -	Y -
Percent mothers who think growth monitoring services that Colvol provides are useful	NA	NA	95%	97.3% (3.6ppt)	UD	Y -	Y -	Y -	Y -	Y -
Percent mothers who know if child's weigh increased or decreased in the last month	NA	NA	70%	74.1% (9.6ppt)	UD	Y Y	B W	Y Y	Y Y	Y -
Percent mothers who think information provided by Colvol is easy to understand	NA	NA	75%	90.4% (6.4ppt)	Pass	Y W	Y Y	Y Y	Y Y	Y -
Per cent mothers who think colvol are knowledgeable about nutrition information	NA	NA	80%	89.9% (6.8ppt)	Pass	Y Y	Y Y	Y Y	Y Y	Y -

iii) Participation of Mothers in Food Supplementation Program during Pregnancy

Results in Table 33 show that 82.5% of mothers of children 0-6 months received food supplementation during their pregnancy. Whereas SA1, SA2 and SA4 all passed the 80% benchmark for this indicator, both SA3 (Aquin) and SA5 (Grande Anse) did not.

In contrast to the previous group, 100% of mothers of children 6-12 months in all SAs received food supplements during their last pregnancy. This is an excellent result, considering that sampling for the Mid-Term evaluation was done at the overall population level. It indicates a high program coverage and an effective referral/counter referral system.

Among mothers of children 12-24 months, finally, 72.5% received food supplementation during their last pregnancy. We note that all of the first four SAs met the benchmarks set for the food supplementation indicators, but SA5 did not do so. As said earlier, SA5 (Grand Anse) was initially scheduled for gradual phased out. Practically, this meant that food deliveries should have continued in that area even though activities were not fully supervised by CRS during 2002-2003. Analysis of the Commodity Office monitoring data may provide insights into the irregularity of the deliveries in the Grande Anse during that period.

Table 33: Participation in program activities: health facility- food supplementation

Indicator	BL Value	LOA target	MTE Target	WA (CI)	LQAS judgment (overall)	Actual performance per SA				
						Areas covered by Baseline				GA
						1	2	3	4	5
Participation at program activities: health facility- food supplementation/0-6 months of age										
Percent of mothers who received food supplementation during last pregnancy	NA	80% (MTE was 70)	80%	82.5% (8.5ppt)	UD	Y Y	Y Y	B W	Y Y	B -
Percent mothers how report receiving rations regularly each month during pregnancy	NA	NA	80%	41.0% (11.0ppt)	Fail	B Y	B Y	B W	B Y	B -
Percent of mothers who received food supplementation regularly since birth of child	NA	NA	80%	29.3% (10.0 ppt)	Fail	B Y	Y Y	B Y	B Y	B -

Indicator	BL Value	LOA target	MTE Target	WA (CI)	LQAS judgment (overall)	Actual performance per SA				
						Areas covered by Baseline				GA
						1	2	3	4	5
Percent mothers reporting receiving the correct ration from the health center	NA	NA	95%	55.9% (11.3ppt)	Fail	BY	BY	BW	BY	B-
Participation at program activities: health facility-food supplementation/6-12 months of age										
Percent of mothers who received food supplementation during last pregnancy	NA	80%	80%	100.0% (0.0ppt)	Pass	Y-	Y-	Y-	Y-	Y-
Percent mothers how report receiving rations regularly each month during pregnancy	NA	NA	80%	34.7% (10.1ppt)	Fail	BY	BY	BW	BY	B-
Percent of mothers who received food supplementation regularly since birth of child	NA	NA	80%	19.8% (7.9ppt)	Fail	BY	BY	BY	BY	B-
Percent mothers reporting receiving the correct ration from the health center	NA	NA	95%	54.3% (11.0ppt)	Fail	BY	BY	BW	BY	B-
Participation at program activities: health facility-food supplementation/12-24 months of age										
Percent of mothers who received food supplementation during last pregnancy	NA	80%	70%	72.5% (9.6ppt)	UD	YW	YY	YY	YY	B-
Percent mothers how report receiving rations regularly each month during pregnancy	NA	NA	80%	30.3% (10.3ppt)	Fail	BY	BY	BY	BY	B-
Percent mothers reporting receiving the correct ration from the health center	NA	NA	95%	49.4% (11.4ppt)	Fail	BY	BY	BY	BY	B-

iv) Regularity of Food Supplementation during Pregnancy (Pre-Natal Clinic)

Three related indicators measured the regularity of the food supplementation program in the MCHN program. The data indicated that only in SA2 did the program clear the expected 80% benchmark for regularity of food rations during post-natal visits. In all other SAs, mothers of children 0-6 months of age reported not receiving their food rations in a consistent manner during their last pregnancy: overall, only 41% of mothers received rations on a regular basis during their pregnancy. A similar picture emerges with regards to the second and third groups (mothers of children 6-12 months, and mothers of children 12-24 months): as reported earlier, 100% of mothers of 6-12 months participated in the food supplementation program during their pregnancy; yet, only 34.7% mentioned receiving their rations on a regular basis. All of the SAs failed to meet the 80% benchmark for this indicator in that group. Likewise, the indicator for women of 12-24 months old children failed to meet the associated benchmark in all SAs as well, as only 30.3% of women overall received a food supplement during their last pregnancy (the mother of a child aged 12-24 months in December 2004 was pregnant during the period April 2002 and April 2003). For the three age groups, therefore, and except for SA2 among mothers of children 0-6 months, no SA passed the established MTE benchmarks for the regularity of food supplementation during their last pregnancy.

v) Regularity of Food Supplementation after Childbirth (Post-Natal Clinic)

Mothers of children less than 12 months old are expected to participate in the post-natal clinic and receive food supplementation regularly. Results, however, showed that only 29.3% of mothers of children 0-6 months and 19.8% of mothers of children 6-12 months received regular food rations during their post-

natal visits.

vi) Correct Rationing at Health Center

On average, only half of the mothers reported having received the correct ration and ration size during their visits at the health center: 55.9% for mothers of 0-6 month old age group; 54.3% for mothers of 6-12 month olds; and 49.4% for mothers of 12-24 month olds. However, it is difficult to accurately interpret these results on the correct ration size as some mothers included the lack of a ration (no food available at the time of the visit) as one way to report an "incorrect" ration. It is recommended that this issue be looked at through a qualitative study during the Phase II of the Mid-Term evaluation regardless, as the performance levels were low enough to merit further investigation.

4.5.j. Conclusions and Recommendations - Participation in Program Activities - Rally Posts and Health Clinics

Mother's Clubs seem to be popular in the CRS program area, as attested by the MTE survey results. The project should therefore continue its support of these clubs and encourage the creation of new clubs as well.

Rally post participation is an important performance indicator for the program as this is where mothers receive education on health, nutrition, childcare, and pre- and post -natal care practices. Low participation rates in the area of Aquin are of concern, however, and will be investigated in detail in Phase II of the MTE. Since the hospital of Aquin experienced leadership problems in the last few years, focus groups with mothers will be held in that area of SA3 separately. Similar focus groups with mothers (preferably those of children older than 12 months) will also be held in another center also located in Aquin (La Colline d'Aquin for example) for comparison purposes. In addition, focus groups will be conducted with CHWs to explore the factors influencing mothers' low participation in rally posts; and key informant interviews will be completed with the person responsible for the health facility, as well as with the person coordinating the CHWs activity at the center level. Groups in Aquin and La Colline d'Aquin will be met separately.

Since a similar issue was observed in SA2 (Port a Piment), focus groups will be conducted with the same focus topics of enquiry as in the SA3 area of Aquin. This strategy is being followed in order to more fully investigate the reasons for the low participation of mothers of children older than 12 months in the rally posts.

On mothers' perceptions of the CHWs knowledge and performance, the overall results were encouraging. However, project staff in SA2 should look into the reasons why fewer mothers in this SA feel that the educational sessions provide practical information, as compared to the other SAs. This finding is consistent across all mother's groups in that SA.

Issues related to the regularity of food supplementation in MCHN program can be explained by the insecurity and unstable political situation (difficulties in transporting food from Port au Prince to the CRS regional office in Les Cayes and from the warehouses to the distribution centers, scarcity of spare parts for truck maintenance, etc.) that has prevailed throughout Haiti over the last two years. However, the CRS Commodity Management Staff will be notified of our findings and will be encouraged to increase their efforts to improve the regularity of the deliveries to MCH centers, to ensure that these centers do not experience interruptions in their pre- and post-natal clinic operations or disruptions in food supplementations to clinic participants, who rely on the food.

The results for the food component of the MCHN program were considered unsatisfactory by program staff in that food supplementation is a key contributing factor to increasing the usage of quality health care services by pregnant and lactating women and their children. Food supplementation is among the crucial project activities that directly contribute to the achievement of the DAP objective, which is to improve the health and nutritional status of children under-five, pregnant and lactating women by 2007.

Conclusions and recommendations on the issue of the correct ration size received by the participants will be presented in the Phase II section of this report.

4.5.k. Knowledge, Skills, and Participation of Community Health Workers

A network of about 1,000 Community Health Workers (CHW) carries out most health outreach activities of the MCHN program. These individuals are in charge of holding monthly meetings at rally posts, where community health education sessions are offered to caregivers and such services as growth monitoring, immunization, provision of vitamin A and deworming medicines are provided to children less than 5 years of age. To be able to undertake these responsibilities, CHWs are trained by project staff at the beginning of the DAP and participate in monthly continuing education sessions, provided by the staff at the area health facility.

The knowledge of CHWs was not assessed in the Baseline survey and no impact indicators were established for this aspect of CRS' program. However, given the key role played by CHWs in transmitting knowledge at the community level, it is clear that the success of CRS' BCC strategy relies to a great extent on the knowledge of the CHWs and their capacity to transmit that knowledge. To assess those issues, the MTE tested both the CHW's perception of their own capacity and their real capacity through a set of questions. Furthermore, the capacity of CHWs to deliver services is also associated with the existence and availability of materials and supplies.

The indicators developed for CHWs therefore focused on four main areas: a) Perception of own Knowledge, b) Actual Tests of Technical Knowledge, c) Availability of Supplies and Material Needed for the Monthly Rally Posts, and d) Participation in Monthly Meetings. For the purpose of those questions the CHWs were divided in two groups: the first group consisted of areas covered during the Baseline survey; while the second group encompassed those in the Grand Anse – the department that was not included in the Baseline.

i) Perceptions of Knowledge - CHWs

A set of six indicators were used to measure the CHWs perception of their own level of knowledge and skills related to their work in the rally posts, namely:

- Ability to provide quality health services
- Ability to provide nutritional messages
- Ability to provide maternal health messages
- Ability to correctly measure a child's weight
- Ability to record that child's weight on the growth card
- Ability to provide immunizations.

The benchmark was set at 90% for the first five of these indicators and it was met for all five of them in both SAs (Table 34). However, CHW do not feel they have the ability to provide vaccination services, even though the benchmark had been set at a lower level (60%) for this indicator. This is an interesting but unsurprising finding since CHWs have not received any training from CRS in this area. CRS may decide to train CHWs to provide vaccines in the future, but this will depend largely on the local Ministry of Health officials' point of view.

Table 34: CHWs' Perceptions of Knowledge and Skills

Indicator	MTE Target	Actual performance per SA[36]	
		SA1[37]	SA2[38]
Percent of Colvols who feel totally confident in their skills to provide quality health services to their communities	90%	Pass	Pass
Percent of Colvols who feel confident in their ability to provide nutritional messages to their communities	90%	Pass	Pass
Percent of Colvols who feel confident in their ability to provide maternal health messages to their communities	90%	Pass	Pass
Percent of Colvols who feel confident in their ability to measure a child's weight	90%	Pass	Pass
Percent of Colvols who feel confident in their ability to record a child's weight on the Road to Health cards	90%	Pass	Pass
Percent of Colvols who feel confident in their ability to provide immunizations	60%	Fail	Fail

ii) Technical Knowledge - CHWs

Results on indicators testing the technical knowledge of CHWs were mixed (Table 35). While knowledge appears to be strong in some technical areas, it seems to be weak in others. For example:

- Vitamin A
  One question asked about the symptoms related to Vitamin A deficiency, and CHWs in both supervision areas met the 90% benchmark on this indicator, thus demonstrating that they possess this knowledge.

- Diarrhea management & ORT
  A benchmark of 80% was set, and reached in both SAs, for indicators related to CHWs' technical knowledge of diarrhea management. These results showed that CHWs have good knowledge on the use of ORT and the correct feeding practices during episodes of diarrhea. In addition, a 90% benchmark was met by CHWs in both SAs for the supporting indicator: "CHWs who feel the trainings they received in social marketing of ORT was useful in their work with the mothers in the community (see part C of the Table below)."

- Knowledge on breastfeeding and infant feeding
  As previously stated, CHWs are the key actors in the transmission of messages to program participant. Consequently, they must be aware of certain critical topics such as appropriate breastfeeding and infant and child feeding practices.

  When tested on specific indicators, the MTE results showed that at least 70% of CHWs in both SAs knew that fever should not prevent mothers from breastfeeding their children. However, when tested on the number of times a one-year-old child should be fed each day, CHWs failed to clear the benchmark of 60% in both supervision areas. This is a very important indicator and critical to the success of the program with regard to the BCC strategy, so failure to meet the benchmark for this knowledge is unsatisfactory.

Table 35: CHWs' Technical Knowledge

[36] Y": Yes, met the benchmark; "B": Failed to reach the decision rule for the benchmark. No prevalence estimates were derived since we had only two groups, or SAs; which provides an insufficient number of cases to calculate robust estimates.
[37] SA1 included all areas covered by the project since 2002 (South Coast, Aquin and Cotes de Fer)
[38] SA2 included areas that were not covered by the Baseline and where activities continued since 2002 with a minimum CRS support (Grande Anse and Nippes)

Indicator	MTE Target	Actual performance per SA	
		SA1	SA2
Percent of Colvols who can identify the vitamin deficiency which causes bad vision (Vitamin A)	90%	Pass	Pass
Percent of Colvols who know how many times a day a one-year old child should be given something to eat	60%	Fail	Fail
Percent of Colvols who state that it is okay for a mother to breastfeed when she has a fever	70%	Pass	Pass
Percent of Colvols who can recognize the symptoms of scabies when given a description of the condition	75%	Fail	Fail
Percent of Colvols who know that a child with a weight for age below -3 standard deviations should be referred to a health center immediately	95%	Fail	Fail
Percent of Colvols who mention using at least one Adult Participatory Learning technique during their educational work	95%	Pass	Fail
Percent of Colvols who feel that the trainings they received in the social marketing of ORT has been useful to their work with mothers in their communities	90%	Pass	Pass

- Use of participatory learning methods during education session
  Participatory learning is one of the best adult learning techniques, so CHWs are encouraged to use them in their educational sessions at the rally post. Though CHWs in both SAs have been trained in these techniques during this DAP cycle, CHWs in SA2 did not perform as well as their colleagues in SA1. A 95% benchmark was set for the percent of CHWs that use at least one participatory training technique – SA1 met this benchmark whereas SA2 did not.

- Criteria of reference for malnourished children
  The growth chart is the main tool that helps CHWs make referral decisions in cases of marasm. In the case of kwashiorkor, the presence of edema should guide the decision. Basically, all children diagnosed <3 SD deviations should be referred to the health facility. All of the CHWs have been instructed and trained in identifying the criteria for the referral of a child to the health facility for better management of malnutrition. As the referral system was set up to quickly address acute malnutrition cases, it is critical that CHWs recognize the warning signs of these conditions.

  The benchmark for CHWs ability to identify the criteria for immediate referral to health centers was set at the highest level permitted by the LQAS methodology, namely 95%. The benchmark was set so high because CHWs need to be well aware of the criteria. In order to properly test the CHWs knowledge of the referral protocol, the question that was posed to them on this issue was phrased in a somewhat complicated, yet realistic manner. The survey results revealed, however, that the CHWs in both SAs were unable to answer the question appropriately, as to the immediate need for referral of any <-3SD malnourished child, and thus did not pass the 95% benchmark for this indicator.

iii) Availability of Necessary Materials and Supplies for Monthly Rally Posts

There are certain materials and supplies that are necessary in order for a CHW to perform his/her job effectively. Not only do these materials and supplies ensure a higher quality of service provision, but also serve to encourage caregiver attendance at the rally posts. Two indicators were used related to this issue (Table 36). It seemed that CHWs regarded certain materials/supplies as necessary, even though, from a service provision standpoint, they are not – such as backpacks, raincoats, registers, etc. CHWs in SA1 reported that they did not have all of the materials/supplies that they needed, thereby not meeting the 60% benchmark that was set; whereas CHWs in SA2 stated that they did – thus meeting this benchmark. What is interesting about these varying performance levels is that CHWs in SA1 are regularly supervised by CRS project staff and thus have regular access to materials/supplies; yet those in SA2 have not had such access because CRS staff have not had a presence in the Grand Anse. The results for these

indicators must therefore be based upon the CHWs definitions of what is indeed "necessary"; perhaps CHWs in SA1 are more aware of what is available and more demanding regarding the supplies and materials they feel that they need in order to hold the rally post.

Table 36: CHWs - Availability of Materials and Supplies

Indicator	MTE Target	Actual performance per SA	
		1	2
Percent of Colvols who, in the last 30 days, have not had a shortage of any of the supplies or materials they needed to do their job correctly	60%	Fail	Pass
Percent of Colvols who, in the last six months, have not had any difficulties providing the expected services to their communities due to inadequate supplies or materials	60%	Fail	Pass

iv) CHW Participation in Monthly Meeting Activities

CHWs monthly responsibilities include the following activities:

- Completion and Submission of the Rally Post Report
- Participation in the monthly continuing education session
- Discussion of the micro-credit program.

CHWs in both supervision areas cleared the 75% benchmark in terms of their completion and submission of Rally Post Reports, and 80% benchmark for participating in the monthly continuing education session (Table 37). CHWs in SA1 did not, however, clear the benchmark for having discussed the micro-credit program in the last monthly meeting, whereas their counterparts in SA2 did meet this 75% benchmark. This particular performance discrepancy may be related to the fact that credit activities were just started in SA2, so perhaps the enthusiasm and motivation levels for CHWs in this area are very high at the moment.

Table 37: CHWs' Participation in Monthly Activities

Indicator	MTE Target	Actual performance per SA	
		SA1	SA2
Percent of Colvols who brought their report to the last Colvol meeting they attended	75%	Pass	Pass
Percent of Colvols who attended the Continuing Education session at the last Colvol meeting they attended	80%	Pass	Pass
Percent of Colvols who discussed the micro-credit program at the last Colvol meeting they attended	75%	Fail	Pass
Percent of Colvols who correctly state it is not okay to give a 5 month old child ORT	80%	Pass	Pass
Percent of Colvols who correctly state that when a child has diarrhea the mother should give the child more food than usual	80%	Pass	Pass

4.5.l. Conclusions and Recommendations – Knowledge, Skills, and Participation of Community Health Workers

CRS' MTE results indicate that Community Health Workers have a positive perception of their knowledge and skill level related to their work at the rally post. The CHWs feel that they have the necessary knowledge to conduct a rally post, which basically has 2 components: an education session for participants on certain key messages and the provision of specific services. Based upon the positive results of many of the MCHN indicators, it appears that the CHWs are doing an effective job at

communicating the key messages to mothers/caregivers during education sessions at the rally posts. Therefore, one could propose a credible link between the high knowledge/skill level demonstrated by the CHWs at Mid-Term and the improved practices demonstrated at the household level by mothers and caregivers since the Baseline survey was undertaken.

It is important to note here, however, that the MTE did expose critical gaps in CHWs knowledge – gaps that will need to be addressed via formal refresher training courses over the remainder of the DAP. While it is true that CHWs do participate in monthly continuing education sessions at the health facilities, it is clear from the data that more formalized technical trainings will also need to be undertaken in order to bring CHW knowledge levels up to programmatic expectations and necessity. CRS plans to undertake such refresher courses in 2005, but, in the meantime, health centers should reinforce the critical BCC messages, along with adult participatory training techniques, at their monthly continuing education sessions. Addressing CHW knowledge issues now, at all levels, will only serve to improve the adoption rate of these behaviors at the household level; thus driving the achievement of project impact in all supervision areas.

The participatory learning methods must be implemented not only at the CHW level but also during education sessions at the rally post where key message and expected behavior must be reinforced. BCC strategy should also use other channels such as mother's clubs, father's clubs and youth clubs to ensure that key messages are being widely diffused and adopted among the community members. Some incentive strategies, such as contests among clubs, should also be taken into considered. In order to keep track of the performance level of the BCC strategies, CRS should monitor CHWs' levels of knowledge by using LQAS in its various SAs on a regular basis throughout the remainder of the program.

In addition, the project staff plans to apply these same indicators to different groups of CHWs next year, after all of them have participated in the refresher training courses, in order to measure if the expected improvements were achieved. The results of this end-of-training evaluation will be compared to the MTE results and appropriate action will be taken if necessary.

As the availability of materials to conduct rally posts determines the quality of service provision, and therefore the attendance rates, CRS will need to ensure that CHWs and health facility staff have the materials they need in order to carry out their responsibilities properly. Assessing the supply chain can also be done on a regular basis henceforth, in the different SAs, using LQAS.

4.5.m. Analysis of Results - Hand Washing Knowledge and Techniques – Cross Sectoral Results

> *"To some extent, childhood illness and disease can be reduced with the undertaking of certain preventative health practices. These include appropriate infant and child feeding practices, and adequate health service delivery, such as childhood immunization against vaccine preventable diseases. Behaviors related to hygiene, safe water, and sanitation are also important for the prevention of illness and disease."*[39]

CRS' Baseline results (Table 38) showed that hand washing knowledge and hand washing techniques were significantly associated with diarrhea prevalence at the time of the survey (difference statistically significant at p=0.001). Children of caregivers who knew of three or more occasions when they should wash their hands had a significantly lower prevalence of diarrhea (20.0%) than those children of caregivers who did not know of at least three occasions (30.9%).

[39] This section is borrowed from Bergeron and Deitchler, Joint Baseline report, 2002

In addition, the children of caregivers who demonstrated correct hand washing technique showed, for example, a lower prevalence of diarrhea (26.4%) than the children of caregivers who demonstrated incorrect hand washing technique (53.4%).

Table 38: CRS Baseline Results (2002) –
Relationship between Water, Sanitation, Hygiene & Diarrhea

Household Characteristic/ Caregiver Knowledge	**Prevalence Diarrhea (%)**
Knowledge about when to wash hands	
1. Respondent knows 3 or more times when hands should be washed	20.0
2. Respondent knows less than 3 times when hands should be washed	30.9
P value	***P=0.001***
Hand washing technique	
1. Respondent demonstrates correct hand washing technique	26.4
2. Respondent demonstrates incorrect hand washing technique	53.4
P value	***P=0.001***

In light of the importance of this issue on the health of the children and program impact in general, the CRS MTE included several indicators aimed at measuring hand washing knowledge and techniques among mothers and participants in different CRS programs. These groups were:

- **Health and Nutrition**: CHWs and three groups of mothers (children of three age groups)
- **Micro-credit**: participants of the micro-credit program
- **Food Assisted Education:** PTA members, school directors, teachers, female students, and male students
- **Safety Net**: SSNI managers, SSNI staff, females 8-13 and females 13&up (see methodology section for more details)

Even though results were analyzed by sector, a final summary table for all sectors was prepared to allow for easier comparison and facilitated the formulation of more generalized conclusions and recommendations across sectors.

i) Hand Washing Knowledge

When asked, "*When should you wash your hands*?", respondents were given the opportunity to provide more than one answer. All of the answers that were provided by the respondent were marked as "YES" by the data collector, and those answers that were not provided were marked as "NO."

Benchmarks for each answer were determined by each sector. In addition to individual answers, a separate analysis was done of a composite of the answers. This composite was made up of the key messages that were promoted by each sector program; and the messages promoted differ for each target group. Therefore, the success of the hygiene education project was measured via "pass/fail" results for specific groups of "key messages".

Table 39 shows the key messages promoted by each program sector, as well as the benchmarks set for each message:

Table 39: Hand Washing Knowledge and Techniques Results across Sectors

When should you wash your hands?	Health and Nutrition		Credit	Food Assisted Education		Safety Net	
	CHWs	Mothers (0-6, 6-12 and 12-24 mo.)	Com'ty Members	PTA Members	School Directors, Teachers, Female & Male Students	Directors & Staff	Females and Males <12 and >12
a. after using the toilet	80%	70%	70%	80%	80%	70%	70%
b. after changing babies' diapers	20%	20%	20%	20%	20%	20%	20%
c. before preparing food	80%	70%	70%	20%	20%	70%	20%
d. before eating	80%	70%	70%	80%	80%	70%	70%
e. before feeding children	80%	70%	70%	20%	20%	70%	20%
f. working in the garden/coming home from school or market	20%	20%	20%	20%	20%	70%	20%
g. after playing	NA	NA	NA	NA	20%	NA	70%
All key messages (promoted by each program) combined	a, c, d, e	a, c, d, e	a, c, d, e	a, d	a, d	a, c, d, e, f	a, d, g
Benchmark for all key messages combined	70%	50%	50%	70%	70%	60%	60%

The cross-sectoral results are presented in Table 40 for comparison purposes.

When looking at the individual messages by program, participants of the Safety Net program were the most knowledgeable on hand washing techniques, followed by the Education program and lastly, the mothers participating in the MCHN program. Community Health workers, who are responsible for promoting the correct messages, met the benchmark for three indicators and failed on three others.

The message that met the benchmark in almost all groups was "after using the toilet", followed by "before eating". Surprisingly, all groups failed on the indicator "before feeding children".

Results showed that the youngest female participants from the Safety Net program were the most knowledgeable on hand washing techniques with five "pass" out of seven indicators. Disturbingly, mothers of children 0-6 months old failed to meet the established benchmarks for five of the six indicators.

For the messages and the corresponding behaviors to be successful, program participants should know and adopt as many correct practices as possible. Therefore, the combination of messages was also tested as another indication of program success. Almost all categories of participants of the Education Program passed the benchmark for the "combined key messages". For the Safety Net program, only the females older than 13 years of age passed the benchmarks. Among all of the MCHN participants, including the CHWs, none of the groups surveyed passed the benchmarks for all of the key messages combined.

These results indicate that messages on hand washing should be reinforced in all programs, but especially so in the MCHN program. Moreover, a standardization of messages across programs could be instrumental in improving hand washing knowledge and techniques, as participants would receive more complete and uniform messages even though the messages would be transmitted via different channels within the same community.

Table 40: Handwashing Knowledge and techniques - Cross Sectoral Results

When should you wash your hands?	Colvol	Mothers 0-6	Mothers 6-12	Mothers 12-24	Women - Credit	PTA	School Director	Teacher	Female Student	Male Student	SSNI Mgr - both SA	SSNI Staff	Female 8-13	Female 13&up
a. after using toilet	Pass	Pass – UD[40]	Pass - UD	Pass - UD	Fail - UD	Pass - UD	Pass	Pass - UD	Pass - UD	Pass - UD	Pass	Pass	Pass	Pass
b. changing babies' diapers	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Pass	Pass	Fail	Fail
c. before preparing food	Fail	Fail	Fail	Fail	Fail	Fail	Fail - UD	Fail - UD	Fail-UD	Fail	Fail	Fail	Pass	Fail
d. before eating	Pass	Fail	Fail	Fail	Fail	Pass	Pass-UD	Pass	Pass - UD	Fail - UD	Pass	Pass	Pass	Pass
e. before feeding children	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail
f. working in the garden/coming home from school or market	Pass	Fail	Pass - UD	Pass - UD	Pass	Pass	Pass	Pass	Pass - UD	Pass	Fail	Fail	Pass	Pass
g. after playing	NA	NA	NA	NA	NA	NA	NA	Fail	Pass - UD	Fail-UD	NA	NA	Pass	Pass
All key messages? (# differs for each group)[41]	Fail	Fail	Fail	Fail	Fail	Pass - UD	Pass	Pass - UD	Pass - UD	Fail-UD	Fail	Fail	Fail	Pass
Correct handwashing technique (baseline method)[42]	Pass	Pass - UD	Fail-UD	Fail-UD	Fail	Fail-UD	Pass-UD	Pass-UD	Fail	Fail	Pass	Pass	Pass	Pass

[40] UD: Unable to determine- the confidence interval overlaps with the MTE target
[41] see narrative for the combination of messages for each group
[42] see table in narrative for description of both methods

Correct handwashing technique (international method)	Pass	Fail	Fail	Fail	Fail	Fail	Fail-UD	Fail	Fail	Fail	Pass	Pass	Fail	Pass

ii) Hand Washing Techniques

As previously discussed, most people interviewed during the Mid-Term were already aware of when hand washing is critical (e.g. before feeding, after toilet use). As in the Baseline study, respondents were also asked to demonstrate the techniques of hand washing. The correct had washing technique has been defined as involving four components:

Correct hand washing technique		
	Baseline method	International method
The use of water	✓	✓
The use of soap	✓	✓
The washing of both hands	✓	✓
Scrubbing a minimum of three times	✓	✓
Drying (towel or shake hands)		✓

With the highly significant association between the correct hand washing technique and diarrhea prevalence, this positive behavior becomes an important means of diarrhea prevention.

MTE results on hand washing techniques are presented in Table 40. All four groups interviewed in the Safety Net centers passed the benchmarks for the Baseline method and three passed for the international method.

Results of the Education sector were less successful since the students did not pass the benchmarks for either the Baseline or international hand washing methods. Even though the directors and the teachers passed the benchmark for the Baseline method, we were unable to definitively state if the MTE target was met or not for this indicator because the range of the confidence interval overlapped the MTE target level.

With regards to the three groups of mothers (of children 0-24 months old), all failed to pass the benchmark set for the international method of hand washing technique. We cannot definitively state if the MTE target was met for the Baseline method because the range of the confidence intervals overlapped with the MTE target.

4.5.n. Conclusions and Recommendations - Hand Washing Knowledge and Techniques – Cross Sectoral

Even though most groups passed the benchmark on some of the most critical messages on hand washing knowledge (e.g. after using the toilet and before eating), the overall results on hand washing knowledge were not at the level we had expected by mid-term. When looking at the three major programs, the Safety Net one was the most successful at transmitting hygiene messages.

With respect to the Education program, the results showed that the students have acquired the knowledge but that their hand washing technique behavior has not yet changed in accordance.

Hygiene issues are critical to the child's health and the MCH program should reinforce its hygiene messages -especially with the CHWs, who are the primary health educators for the thousands of mothers who participate in the rally posts and mothers' club.

In view of the significant association reported in the Baseline study between diarrhea prevalence on the one hand, and hand washing knowledge and the correct hand washing techniques on the other hand, it is recommended that all CRS programs reinforce these important hygiene messages. Behavior change messages emphasizing the importance of hand washing for disease prevention is a recommended area for attention.

Moreover, a standardization of messages across programs would be important so we provide participants with more coherent, complete and focused messages about proper behaviors and practices across

program activities and educational initiatives. Improvements in hygiene behavior may present an opportunity for better child nutrition and health outcomes in the whole of CRS' program area.

4.6. HIV/AIDS

CRS/Haiti has incorporated HIV/AIDS into the DAP by providing food to PLWHA[43] and to Social Safety Net Institutions (SSNI) that care for HIV/AIDS-affected children. CRS has provided HIV/AIDS education and training to SSNI managers, staff, and residents in an effort to:

- Educate SSNI residents, aged 8 years and older, about the health and social issues associated with HIV/AIDS;
- Educate SSNI staff on HIV/AIDS and on how to care for children afflicted with the disease, and
- Raise awareness and solidarity levels in the communities where the SSNIs are located.

In addition to the SSNI sector, indicators on HIV/AIDS were also measured for all respondents targeted by the Education program: PTA members, school directors, teachers, female students and male students. This information was collected to provide "baseline" data for the training program on HIV/AIDS which will be implemented by the Education program in the second half of the DAP.

The MTE collected data on four HIV/AIDS-related topics:

1. Means of transmission
2. Knowledge of HIV/AIDS
3. Perception of Personal Risk, and
4. Stigma and Discrimination.

Table 41 shows the sampling groups on which MTE results on HIV/AIDS indicators were collected.

Table 41: HIV/AIDS Sampling Groups

<table>
<tr><th colspan="2">Safety Net Institutions</th><th>Schools</th></tr>
<tr><th>Received HIV/AIDS training</th><th>No HIV/AIDS training as yet</th><th rowspan="2">No HIV/AIDS training as yet</th></tr>
<tr><th>SA1</th><th>SA2</th></tr>
<tr><td>Management Staff</td><td>Management Staff</td><td>PTA members</td></tr>
<tr><td>Support Staff</td><td rowspan="2">Support Staff</td><td>School Directors</td></tr>
<tr><td>Female children (8-13 years)</td><td>Teachers</td></tr>
<tr><td rowspan="2">Female children (>13 years)</td><td rowspan="2"></td><td>Female students</td></tr>
<tr><td>Male students</td></tr>
</table>

4.6.a. Analysis of Results – Safety Net Institutions

With the objective of using the same sample for both the SSNI program and the HIV/AIDS program, the sampling methodology for this sector originally included a group of institutions where HIV/AIDS training had been carried out during the last two years (SA1) and another group where no HIV/AIDS training has been done to date (SA2).

[43] PLWA: People Living with AIDS

Six groups were targeted for the survey: 1) SSNI Management staff; 2) SSNI Staff; 3) Female children aged 8-13 years old; 4) Male children aged 8-13 years old; 5) Female children aged 13 years and up and 6) Male children aged 13 years and up. Unfortunately, the targeted number of sampling groups could not be reached in both SAs, however, because there were not enough male children in residence that could respond to the questionnaires. This meant that the MTE was not able to present findings for this sampling group (see section on field work results and section on MTE results for SSNI).

i) Means of Transmission – SSNI Management and Staff

The CRS HIV/AIDS training focuses on educating its participants in the means of transmission and prevention of the disease; more specifically on the three most common modes of prevention: 1) abstinence; 2) fidelity; and 3) use of condoms. Other means ways of transmission such as contaminated blood and vertical transmission (mother to child transmission) were also included in the training.

Table 42 presents the knowledge levels of the adults employed at the selected SSNIs - Management Staff persons (Directors) and support staff - on the different ways to transmit the HIV virus.

Table 42: Knowledge on Means of HIV/AIDS Transmission – SSNI Management and Staff

Indicator	MTE Target	Actual performance per SA[44]			
		Director		Staff	
		SA1 *	SA2*	SA1	SA2
Percent of respondents that state one can avoid acquiring HIV/AIDS	75%	Pass	Pass	Pass	Fail
Percent of respondents that state one can avoid HIV/AIDS by abstaining from sex	40%	Pass	Pass	Pass	Pass
Percent of respondents that state one can avoid HIV/AIDS by using condoms	40%	Pass	Pass	Pass	Pass
Percent of respondents that state one can avoid HIV/AIDS by limiting sex to one partner	40%	Pass	Pass	Pass	Pass
Percent of respondents that state one can avoid HIV/AIDS by avoiding unprotected sex with prostitutes	40%	Fail	Fail	Fail	Fail
Percent of respondents that state one can avoid HIV/AIDS by avoiding unprotected sex with persons who have many sex partners	40%	Fail	Fail	Fail	Fail
Percent of respondents that state one can avoid HIV/AIDS by remaining faithful to one partner	40%	Fail	Pass	Pass	Pass
Percent of respondents that state one can avoid HIV/AIDS by avoiding unprotected sex with persons who inject drugs intravenously	40%	Fail	Fail	Fail	Fail
Percent of respondents that state one can avoid HIV/AIDS by avoiding infected blood	40%	Fail	Fail	Fail	Fail
Percent of respondents that state one can avoid HIV/AIDS by avoiding the use of syringes, razors, straight edges	40%	Pass	Fail	Pass	Pass
Percent of respondents that state one can avoid HIV/AIDS by avoiding contact with blood	40%	Fail	Pass	Pass	Pass
Percent of respondents that state that a pregnant woman can give the HIV virus to her child during pregnancy	60%	Pass	Pass	Pass	Pass
Percent of respondents that state that a mother can give he HIV virus to her child during child birth	60%	Pass	Pass	Pass	Pass
Percent of respondents that state that a mother can give the HIV virus to her child via breast feeding	60%	Fail	Pass	Pass	Pass

[44]"Pass" = met the benchmark; "Fail" =: Failed to reach the decision rule for the benchmark;

* SA1 received HIV/AIDS training. SA2 did not receive HIV/AIDS training.

It is interesting to note that there were no significant differences between the SSNI staff that have received training from CRS and those that have not; for example, both groups passed and failed many of the same benchmarks. Both groups were able to correctly identifying three ways by which to avoid the HIV/AIDS virus but failed to reach the benchmark on some of the less mainstream avoidance messages (such as refusing to have unprotected sex with prostitutes, persons who inject drugs intravenously, and persons who have may sexual partners.)

It may therefore be possible that the CRS trainings have not been adding any value to its participants, in that it appears that the mass media may already be doing an adequate job in spreading the most conventional messages regarding HIV/AIDS transmission, namely ABC (Abstinence, Be faithful, and Condom usage) -type messages.

Nevertheless, the results from the survey do provide a certain level programmatic guidance to its future training design activities. For example, transmission messages should be reinforced at all levels in the training and revision of the training materials should be undertaken in an effort to better complement and expand upon the public health messages that are currently being spread by the media.

ii) Means of Transmission – SSNI Children

Children in the SSNIs also participated in the HIV/AIDS training sessions. Children were divided into age groups: children from 8 to 13 years old and children older than 13 years. Unfortunately, the institutions randomly selected for the mid-term evaluation did not have enough male children to take part in the study. Therefore, results are only available for female children.

Table 43 presents the levels of knowledge of both groups of children on HIV/AIDS transmission. This information was only collected in SA1 where the training on HIV-AIDS had taken place. The MTE targets were different for the age groups because it was assumed that the older children would retain more information than the younger group.

Table 43: Knowledge on Means of HIV/AIDS Transmission – SSNI Children – Centers with Previous HIV/AIDS Training Interventions

Indicator	Actual performance			
	MTE target	Female 8-13 years	Females 13 & up	MTE target
Percent of respondents that state one can avoid acquiring HIV/AIDS	30%	Pass	Pass	60%
Percent of respondents that state one can avoid HIV/AIDS by abstaining from sex	30%	Pass	Pass	50%
Percent of respondents that state one can avoid HIV/AIDS by using condoms	30%	Fail	Fail	50%
Percent of respondents that state one can avoid HIV/AIDS by limiting sex to one partner	30%	Fail	Fail	50%
Percent of respondents that state one can avoid HIV/AIDS by avoiding unprotected sex with prostitutes	30%	Fail	Fail	50%
Percent of respondents that state one can avoid HIV/AIDS by avoiding unprotected sex with persons who have many sex partners	30%	Fail	Fail	50%
Percent of respondents that state one can avoid HIV/AIDS by remaining faithful to one partner	30%	Fail	Fail	50%
Percent of respondents that state one can avoid HIV/AIDS by avoiding unprotected sex with persons who inject drugs intravenously	30%	Fail	Fail	50%
Percent of respondents that state one can avoid HIV/AIDS by avoiding infected blood	30%	Pass	Fail	50%

Indicator	Actual performance			
	MTE target	Female 8-13 years	Females 13 & up	MTE target
Percent of respondents that state one can avoid HIV/AIDS by avoiding the use of syringes, razors, straight edges	30%	Pass	Pass	50%
Percent of respondents that state one can avoid HIV/AIDS by avoiding contact with blood	30%	Pass	Pass	50%
Percent of respondents that state that a pregnant woman can give the HIV virus to her child during pregnancy	50%	Pass	Pass	50%
Percent of respondents that state that a mother can give the HIV virus to her child during child birth	50%	Pass	Pass	50%
Percent of respondents that state that a mother can give the HIV virus to her child via breast feeding	50%	Pass	Pass	50%

As Table 43 presents, there was not much difference between the two age groups in their level of knowledge regarding HIV transmission. The results also revealed that the younger age group passed the benchmark for the "infected blood" as a way of transmission while the older group did not.

Interestingly enough, both groups of children were only able to report "abstinence" as a means of preventing HIV/AIDS transmission – even after they had received the CRS training; both groups failed to pass the MTE benchmarks for all of the other ways of avoiding HIV/AIDS. Moreover, they did not indicate any knowledge related to the transmission of the virus during sex, while they passed the benchmarks for the indicators related to vertical transmission and contact with straight edges tools.

The type of knowledge that the children in the SSNIs have as compared to staff persons from the same institutions is informative. Results revealed that children were more informed on non-sexual ways of transmission or prevention while the adults knew more about ways of transmitting the virus sexually. This finding may be related to the content that is being presented to both groups in the training events.

iii) General Knowledge on HIV/AIDS – SSNI Management and Staff

The general knowledge on HIV/AIDS was measured on two indicators: 1) Percent of respondents that state that the virus can take up to six months to be detected; and 2) Percent of respondents that state that there is no cure for people with HIV.

In SA1, both groups of adults passed the 60% benchmark for these two indicators (Table 44). The only benchmark that was not met in SA2, which has not received the training, was the "Percent of respondents that state that the HIV virus can take up to six months to show up as positive on a blood test" – which was not passed by the SSNI support staff.

Knowing one's negative sero-status is the best motivation to protect one self against possible future contamination, it is interesting and encouraging to note that both sampling groups in both SAs passed the 20% benchmark for being tested for HIV..

Table 44: General knowledge on HIV/AIDS- SSNI Management and Staff

Indicator	MTE Target	Actual performance			
		Director		Staff	
		SA1 *	SA2	SA1	SA2
Percent of respondents that have been tested for HIV	20%	Pass	Pass	Pass	Pass
Percent of respondents that state that the HIV virus can take up to six months to show up as positive on a blood test.	60%	Pass	Pass	Pass	Fail
Percent of respondents that state that there are no cure for people who have HIV	60%	Pass	Pass	Pass	Pass

* SA1: received HIV/AIDS training. SA2 did not receive HIV/AIDS training.

iv) General Knowledge on HIV/AIDS – SSNI Children

The only group of SSNI children for which HIV/AIDS knowledge results were obtained, was for females aged 13 years and above who have received training. This group of children passed the 60% benchmark for both indicators related to general HIV/AIDS knowledge (Table 45).

Table 45: General Knowledge on HIV/AIDS – SSNI Children – Centers with Previous HIV/AIDS Training Interventions (SA1)

Indicator	Actual performance	
	MTE target	Female >13
Percent of respondents that state the HIV virus can take up to six months to show up as positive in a blood test	60%	Pass
Percent of respondents that state there are no cure for people who have HIV	60%	Pass

v) Perceptions of Personal Risk – SSNI Management and Staff

Notions of personal risk were assessed using several indicators:

- Indicators that measured false information – such as the possibility of infection through hugging, sharing toilets/bathrooms, and by shaking someone's hand;
- Indicators that measured respondent's attitudes regarding sexual decision-making – such as if it was acceptable for a man or woman to refuse to have sex with his/her wife/husband if he/she has a sexually transmitted infection; and,
- An indicator that measured the acceptance levels of the respondents regarding exchanging sex for material things – such as clothing.

Table 46 shows that the technical and administrative staffs of both categories of safety net centers (those who had access to training and those who did not) have a fairly good perception of personal risk. Both groups passed the 60% benchmarks for the indicators measuring the perception that one cannot be contaminated by superficial physical contact with an infected person (shaking hands, hugging, sharing toilets/bathrooms); and both groups passed the 70% benchmark on the indicators related to gender discrimination in sexual practice. However, the SSNI Directors in SA2 (which have not had HIV/AIDS training) did not pass the 70% benchmark for the indicator that measured their belief that women have the right to refuse sex with their boyfriends or husbands.

Table 46: Perception of Personal risk – SSNI Management and Staff

Indicator	MTE Target	Actual performance			
		Director		Staff	
		SA1 *	SA2	SA1	SA2
Percent of respondents that state that you do not get HIV by shaking hands with someone who has HIV/AIDS	60%	Pass	Pass	Pass	Pass

Indicator	MTE Target	Actual performance			
		Director		Staff	
		SA1 *	SA2	SA1	SA2
Percent of respondents that state that you do not get the HIV virus by sharing a bathroom/toilet with someone who has HIV/AIDS	60%	Pass	Pass	Pass	Pass
Percent of respondents that state that you do not get the HIV virus by hugging someone who has HIV/AIDS	60%	Pass	Pass	Pass	Pass
Percent of respondents that state that a woman has the right to say "no" to having sex with her husband/boyfriend	70%	Pass	Pass	Pass	Pass
Percent of respondents that state that it is not okay if the husband/boyfriend has sex with his wife/girlfriend even if she said "no" to his sexual advances	70%	Pass	Pass	Pass	Pass
Percent of respondents that state that a woman can refuse to have sex with her husband if he has a sexually transmitted infection	70%	Pass	Pass	Pass	Pass
Percent of respondents that state that a man can refuse to have sex with his wife if she has a sexually transmitted infection	70%	Pass	Pass	Pass	Pass
Percent of respondents that think it is not okay for a man to have sexual relations outside of his marriage	70%	Pass	Pass	Pass	Pass
Percent of respondents that think it is not okay for a woman to have sexual relations outside of her marriage	70%	Pass	Pass	Pass	Pass
Percent of respondents that think it is not acceptable for a n/woman to have sexual relations in exchange for the payment of household bills or school fees, for example	70%	Pass	Pass	Pass	Pass

* SA1: with HIV/AIDS training. SA2: without HIV/AIDS training

vi) Perceptions of Personal Risks – SSNI Children

Some of the questions that were asked of the adult SSNI staff were not asked of the children because many of these questions were related more to life experience than actual knowledge per se. As a result, the children were asked fewer questions – with the performance benchmarks set slightly differently, depending upon the age of the child.

Table 47: Perception of Personal Risk – SSNI Children
Centers with Previous HIV/AIDS Training Interventions (SA1)

Indicator	Actual performance			
	MTE target	Female 8-13	Female + 13	MTE target
Percent of respondents that state that you do not get HIV by shaking hands with someone who has HIV/AIDS	50%	Pass	60%	Pass
Percent of respondents that state that you do not get the HIV virus by sharing a bathroom/toilet with someone who has HIV/AIDS	50%	Pass	60%	Pass
Percent of respondents that state that you do not get the HIV virus by hugging someone who has HIV/AIDS	50%	Pass	60%	Pass
Percent of respondents that think it is not okay for a man to have sexual relations outside of his marriage	50%	Pass	70%	Pass
Percent of respondents that think it is not okay for a woman to have sexual relations outside of her marriage	50%	Pass	70%	Pass
Percent of respondents that think it is not acceptable for a man/woman to have sexual relations in exchange for the payment of household bills or	Not Asked	Not Asked	70%	Pass

Indicator	Actual performance			
	MTE target	Female 8-13	Female + 13	MTE target
school fees, for example				
Percent of respondents that state one can avoid HIV/AIDS by remaining faithful to one partner	30%	Fail	50%	Fail

Both groups of children in the centers passed their respective benchmarks on their perceptions of their personal risks with regard to HIV/AIDS transmission via shaking hands, sharing bathrooms or hugging (Table 47). They also passed their benchmarks for their opinions that faithfulness is important for both men and women and that it is unacceptable to have sex for material gain.

These positive results suggest that the training sessions that are being offered are well understood by the children.

vii) Stigma and Discrimination – SSNI Management and Staff

In an effort to investigate issues of stigma and discrimination, the indicators chosen related to the negative beliefs on the moral or religious causes of infection for PLWHA and how these beliefs impact relationships with PLWHAs.

Table 48 shows the results on stigma and discrimination among the groups of management and support staff of the SSNIs surveyed.

Table 48: Stigma and Discrimination – SSNI Management and Staff

Indicator	MTE Target	Actual performance			
		Director		Staff	
		SA1*	SA2*	SA1	SA2
Percent of respondents that state knowing someone with the HIV virus	40%	Pass	Pass	Pass	Pass
Percent of respondents that state they are friends with someone infected with HIV, or suffering from AIDS	40%	Pass	Pass	Fail	Fail
Percent of respondents that state that if a friend of theirs was diagnosed as HIV positive, they would continue your friendship with that person	70%	Pass	Pass	Pass	Pass
Percent of respondents that state they would be willing to take care of a family member that is infected with the HIV virus in their own home	70%	Pass	Pass	Pass	Pass
Percent of SSNI respondents that state that they would accept a child into the center that they know to be HIV positive	70%	Pass	Pass	Pass	Pass
Percent of respondents that state they do not believe that people who have the HIV virus deserved getting the disease because of their past behavior	70%	Pass	Pass	Pass	Pass
Percent of respondents that state they do not believe that people who have the HIV virus deserved getting the disease because they are bad religious people	70%	Pass	Pass	Pass	Pass

At least 40% of the adult respondents knew someone infected with the HIV virus, and at least 40% of the staff considers themselves as friends of a PLWHA. With this experience of friendship, it is positive to see that at least 70% of the respondents, in both SAs and sampling groups, reported good will and acceptance toward PLWHAs and did not seem to have significant, if any, moral or religious judgment against them.

viii) Stigma and Discrimination – SSNI Children

In terms of stigma and discrimination levels for children, the MTE targets were set at 50% for 8-13 year olds and 60% for children older than 13 years old (Table 49).

Table 49: Stigma and Discrimination – SSNI Children -
Centers with Previous HIV/AIDS Training Interventions (SA1)

Indicator	Actual performance			
	MTE target	Females 8-13	Females + 13	MTE target
Percent of respondents that state knowing someone with the HIV virus	20%	Pass	20%	Fail
Percent of respondents that state they are friends with someone infected with HIV, or suffering from AIDS	50%	Pass	20%	Fail
Percent of respondents that state that if a friend of theirs was diagnosed as HIV positive, they would continue your friendship with that person	50%	Pass	60%	Pass
Percent of respondents that state they would be willing to take care of a family member that is infected with the HIV virus in their own home	NA	NA	60%	Pass
Percent of respondents that state they do not believe that people who have the HIV virus deserved getting the disease because of their past behavior	50%	Pass	60%	Pass
Percent of respondents that state they do not believe that people who have the HIV virus deserved getting the disease because they are bad religious people	50%	Pass	60%	Pass

Both groups of children passed the benchmark set for their expected levels of stigma and discrimination against PLWHA. The younger age group passed the benchmark of 50% and the older age group passed the benchmark of 60% on two specific indicators relating to these issues: 1) their willingness to remain friends with someone who is found HIV positive; and 2) they do not have any moral or religious prejudice against PLWHAs. Moreover, for the older age group, the 60% target was met for the indicator "Percent that state they would be willing to take care of a family member that is infected with the HIV virus in their own home." These results were very encouraging and show a positive impact of the HIV/AIDS training in the SSNIs.

4.6.b. Conclusions and recommendations – SSNIs

The overall results for the HIV/AIDS surveys show that there is not a lack of knowledge on the part of program participants. All of the respondent groups - adults and children, males and females, students and SSNI residents - all showed acceptable levels of general knowledge on the topic. However, the results also showed that providing information is not enough. Programs have to identify strategies for addressing the negative attitudes and practices that continue to stigmatize and be used to discriminate against PLWHAs. Behavior Change and Communications (BCC) Strategies need to be reinforced in the schools in order to change prevailing attitudes and practices – as performance levels on related issues were higher in SSNIs where the HIV/AIDS program has been incorporating BCC activities.

The main programmatic recommendation that is supported by these results is that the HIV/AIDS program should upgrade the level of information provided through the program and that the training should go beyond the conventional information that is already provided by mainstream media outlets.

4.6.c. Schools

Data on HIV/AIDS knowledge and attitudes was collected in schools where CRS has been supporting educational programs but not HIV/AIDS training, as yet. The questions that were asked of the adults and children in the SSNIs were also asked of the adults and children in the schools. The following section presents the HIV/AIDS results in the schools.

i) Means of Transmission – School Staff and PTA Committee Members

Table 50 presents the respondent's knowledge on HIV/AIDS transmission of three groups of adults in the CRS supported school system: 1) Members of the Parent-Teacher Associations (PTA) Committee; 2) School Directors; and 3) Teachers. The same MTE targets that were set for SSNIs were also set for the Education groups – even though the HIV/AIDS education and training has yet to take place within the education sector. The school data were collected in four supervision areas[45] allowing the decision rule for pass/fail to be taken for each zone.

Table 50: Knowledge of HIV/AIDS Transmission – School Staff and PTA Committee Members

[45] SA1 : La Colline d'Aqui, Aquin, Vieux Bourg d'Aquin, Ile a Vache, SA2: Baraderes, Beaumont, Jeremie, Les Abricots, SA3: Tiburon, Port a Piment, SA4: Fond des Blancs et Cotes de Fer

Indicator	MTE Target	Actual performance											
		PTA member				School director				Teacher			
		SA1	SA2	SA3	SA4	SA1	SA2	SA3	SA4	SA1	SA2	SA3	SA4
Percent of respondents that state one can avoid acquiring HIV/AIDS	75%	P	P	P	P	P	P	P	P	P	P	P	P
Percent of respondents that state one can avoid HIV/AIDS by abstaining from sex	40%	P	P	P	P	P	P	P	P	P	P	P	P
Percent of respondents that state one can avoid HIV/AIDS by using condoms	40%	P	P	P	P	P	P	P	P	P	P	P	P
Percent of respondents that state one can avoid HIV/AIDS by limiting sex to one partner	40%	F	P	F	P	P	P	P	P	P	P	F	P
Percent of respondents that state one can avoid HIV/AIDS by avoiding unprotected sex with prostitutes	40%	F	F	F	F	F	F	F	F	F	F	F	F
Percent of respondents that state one can avoid HIV/AIDS by avoiding unprotected sex with persons who have many sex partners	40%	F	F	F	F	F	F	F	F	F	F	F	P
Percent of respondents that state one can avoid HIV/AIDS by remaining faithful to one partner	40%	P	P	P	P	P	P	P	P	P	P	P	P
Percent of respondents that state one can avoid HIV/AIDS by avoiding unprotected sex with persons who inject drugs intravenously	40%	F	F	F	F	F	F	F	F	F	F	F	F
Percent of respondents that state one can avoid HIV/AIDS by avoiding infected blood	40%	F	F	F	F	F	F	F	P	P	P	F	F
Percent of respondents that state one can avoid HIV/AIDS by avoiding the use of syringes, razors, straight edges	40%	P	P	P	P	P	P	P	P	P	P	P	P
Percent of respondents that state one can avoid HIV/AIDS by avoiding contact with blood	40%	F	F	P	P	P	F	F	P	P	P	F	P
Percent of respondents that state that a pregnant woman can give the HIV virus to her child during pregnancy	60%	P	P	P	P	P	P	P	P	P	P	P	P
Percent of respondents that state that a mother can give he HIV virus to her child during child birth	60%	P	P	P	P	P	P	P	P	P	P	P	P
Percent of respondents that state that a mother can give the HIV virus to her child via breast feeding	60%	P	P	P	P	P	P	P	P	P	P	P	P

The results indicated that, in general, all three groups passed the 40% benchmark on the commonly known ways of avoiding HIV/AIDS transmission, namely abstinence, faithfulness, and condoms (Table 50). An area of demonstrated weakness, however, dealt with the issue of unprotected sex with persons belonging to higher risk groups – such a prostitutes, intravenous drug users, and persons with many sex partners. Several of the sampling groups failed to meet the 40% benchmarks set for these indicators.

All three sampling groups in the four supervision areas passed the benchmark of 60% for the indicators related to Mother-to-Child transmission during pregnancy and breastfeeding.

When analyzing the results by category of respondent, it is noted that the teachers are better informed than the directors on the ways of transmission of the HIV virus whereas the PTA members are the least knowledgeable on the ways of transmission.

Reviewing the data by SA, it is observed that SA4 performed the best with regards to knowledge on the ways of HIV/AIDS transmission; whereas SA3 was the poorest performer.

ii) Means of Transmission – School Children

The school students were segregated by gender. The team wanted to assess potential inequities in their levels of knowledge on HIV/AIDS-related issues. With respect to their knowledge on ways of transmission, the students were only asked about Mother to Child transmission, since sexual education is not part of their curriculum. Both groups of children in all of the SAs passed the 60% benchmark set for their knowledge on HIV/AIDS and its potential transmission during pregnancy, childbirth or via breastfeeding (Table 51).

Table 51-: Knowledge of Means of HIV/AIDS Transmission – School Children

Indicator	MTE Target	Actual performance							
		Female student				Male student			
		SA1	SA 2	SA3	SA 4	SA1	SA2	SA3	SA4
Percent of respondents that state that a pregnant woman can give the HIV virus to her child during pregnancy	60%	Pass	Pas s	Pass	Pa ss	Pass	Pass	Pass	Pass
Percent of respondents that state that a mother can give he HIV virus to her child during child birth	60%	Pass	Pas s	Pass	Pa ss	Pass	Pass	Pass	Pass
Percent of respondents that state that a mother can give the HIV virus to her child via breast feeding	60%	Pass	Pas s	Pass	Pa ss	Pass	Pass	Pass	Pass

iii) General knowledge of HIV/AIDS – School Staff and PTA Committee Members

General levels of knowledge on HIV/AIDS was measured via two indicators: 1) Percent that state that the virus can take up to six months to be detected; and 2) Percent that state that there is no cure for people with HIV/AIDS. Moreover, to find out if HIV/AIDS is a priority topic in the schools, it was asked to the PTA member if this topic has ever been discussed in any of their PTA meetings in the past.

Table 52 shows that all three groups passed the 60% benchmarks set for the two indicators measuring the respondent's general knowledge of HIV/AIDS. With regards to the PTA meeting, three SAs passed the benchmark of 55% for the "Percent that state that HIV/AIDS has been discussed at their PTA meetings" – which is encouraging.

Table 52: General Knowledge of HIV/AIDS- School Staff and PTA Committee Members

Indicator	MTE target	Actual performance											
		PTA member				School Director				Teacher			
		SA 1	SA 2	SA 3	SA 4	SA 1	SA 2	SA 3	SA 4	SA 1	SA 2	SA 3	SA 4
Percent of respondents that state that the HIV virus can take up to six months to show up as positive on a blood test.	60%	P	P	P	P	P	P	P	P	P	P	P	P
Percent of respondents that state that there are no cure for people who have HIV	60%	P	P	P	P	P	P	P	P	P	P	P	P
Percent of respondents that state that HIV/AIDS has been discussed at their PTA meetings	55%	P	F	P	P	NA	NA	NA	NA	NA	NA	NA	Na

iv) General Knowledge of HIV/AIDS – School Children

The general knowledge of children was assessed using the same indicators and benchmarks as for the adults. Table 53 shows the level of general knowledge of the students by gender and supervision area. It indicates that students in SA1, SA2 and SA3 passed the benchmark of 60% set for the indicator

measuring if the HIV virus can remain undetected in the bloodstream for up to 6 months. SA4 did not pass the benchmark for that indicator. On the other hand, students in all of the SAs knew that there is no cure for HIV/AIDS. This result differed from those revealed in the SSNIs - where all of the girls older than 13 years of age passed the benchmark set at 60%.

Table 53: General Knowledge of HIV/AIDS- School Children

Indicator	MTE target	Actual performance							
		Female student				Male student			
		SA 1	SA 2	SA 3	SA 4	SA1	SA2	SA3	SA4
Percent of respondents that state that the HIV virus can take up to six months to show up as positive on a blood test.	60%	P	P	P	F	P	P	P	F
Percent of respondents that state that there are no cure for people who have HIV	60%	P	P	P	P	P	P	P	P

v) Perceptions of Personal Risks – School Staff and PTA Committee Members

Notions of personal risk were assessed by several indicators relating to misinformation regarding HIV/AIDS – such as that it is possible to get infected by hugging, sharing toilets, and/or shaking someone's hand. Benchmarks were also set for indicators that measured discrimination against PLWHA and on issues related to sexual decision making among men and women.

All adult groups passed the 60% benchmark that was set for the indicator that one cannot get the HIV virus by shaking hands, sharing bathrooms or hugging someone that is infected with the disease (Table 54).

Table 54: Perceptions of Personal Risk – School Staff and PTA Committee Members

Indicator	MTE Target	Schools											
		PTA member				School Director				Teacher			
		SA 1	SA2	SA3	SA4	SA1	SA2	SA3	SA4	SA1	SA2	SA3	SA4
Percent of respondents that state that you do not get HIV by shaking hands with someone who has HIV/AIDS	60%	P	P	P	P	P	P	P	P	P	P	P	P
Percent of respondents that state that you do not get the HIV virus by sharing a bathroom/toilet with someone who has HIV/AIDS	60%	P	P	P	P	P	P	P	P	P	P	P	P
Percent of respondents that state that you do not get the HIV virus by hugging someone who has HIV/AIDS	60%	P	P	P	P	P	P	P	P	P	P	P	P
Percent of respondents that think it is not okay for a man to have sexual relations outside of his marriage	70%	P	P	P	P	P	P	P	P	P	P	P	P
Percent of respondents that think it is not okay for a woman to have sexual relations outside of her marriage	70%	P	P	P	P	P	P	P	P	P	P	P	P
Percent of respondents that think it is not acceptable for a man/woman to have sexual relations in exchange for the payment of household bills or school fees	70%	P	P	P	P	P	P	P	P	P	P	P	P

Similar results were found for the other indicators as well: “Percent of respondents who think that is not correct for a husband or a wife to have sexual relations outside of their marriage”; and “Percent of respondents who think it is not acceptable to have sexual relations in exchange of any kind of favor like payments of bills, school fees, or others”. These results show that the adults interviewed are well aware of their personal risks of being exposed to the HIV virus.

vi) Perceptions of Personal Risks – School Children

Students in schools were asked the same questions as the adults were, except for the indicator concerning the exchange of sex for material benefits.

The results show that the students passed the benchmark of 60% for the indicators that measured common misbeliefs about risk of HIV infection (Table 55). They also passed the benchmark of 70% regarding extramarital relations as a risk to be infected by the HIV virus. Results are similar for male and female children through the four SAs.

Table 55: Perceptions of Personal Risks – School Children

Indicator	MTE target	Actual performance							
		Female student				Male student			
		SA1	SA2	SA3	SA 4	SA1	SA2	SA3	SA4
Percent of respondents that state that you do not get HIV by shaking hands with someone who has HIV/AIDS	60%	P	P	P	P	P	P	P	P
Percent of respondents that state that you do not get the HIV virus by sharing a bathroom/toilet with someone who has HIV/AIDS	60%	P	P	P	P	P	P	P	P
Percent of respondents that state that you do not get the HIV virus by hugging someone who has HIV/AIDS	60%	P	P	P	P	P	P	P	P
Percent of respondents that think it is not okay for a man to have sexual relations outside of his marriage	70%	P	P	P	P	P	P	P	P
Percent of respondents that think it is not okay for a woman to have sexual relations outside of her marriage	70%	P	P	P	P	P	P	P	P

vii) Stigma and Discrimination - School Staff and PTA Committee Members

To assess problems of stigma and discrimination in the schools, respondents were asked questions about their personal relations with and attitudes toward PLWHAs. Results are presented in Table 56.

Five of the 12 groups sampled did not pass the benchmarks set for the “percent of respondents that know someone with HIV virus”; nor did they pass the same benchmarks that were set for the ”percent of respondents that state they are friends with someone infected with HIV or suffering from AIDS.” However, all of the groups did pass the 70% benchmarks for the indicators measuring stigmatization and discrimination issues - such as taking care of infected family members in their own homes.

Table 56: Stigma and discrimination – School Staff and PTA Committee Members

		Actual performance		
		PTA member	School Director	Teacher

		SA 1	SA 2	SA 3	SA 4	SA1	SA2	SA3	SA4	SA1	SA2	SA3	SA4
Percent of respondents that state knowing someone with the HIV virus	40%	F	P	F	P	P	P	F	P	F	P	F	P
Percent of respondents that state they are friends with someone infected with HIV, or suffering from AIDS	40%	F	F	F	F	F	F	F	P	F	F	F	F
Percent of respondents that state that if a friend of theirs was diagnosed as HIV positive, they would continue your friendship with that person	70%	P	P	P	P	P	P	P	P	P	P	P	P
Percent of respondents that state they would be willing to take care of a family member that is infected with the HIV virus in their own home	70%	P	P	P	P	P	P	P	P	P	P	P	P
Percent of respondents that state they do not believe that people who have the HIV virus deserved getting the disease because of their past behavior	70%	P	P	P	P	P	P	P	P	P	P	P	P
Percent of respondents that state they do not believe that people who have the HIV virus deserved getting the disease because they are bad religious people	70%	P	P	P	P	P	P	P	P	P	P	P	P

viii) Stigma and Discrimination – School Children

The same questions were also asked of male and female students in the four supervision areas. Table 57 shows the results for students.

Table 57: Stigma and Discrimination – School Children

Indicator	MTE target	Actual performance							
		Female student				Male student			
		SA 1	SA2	SA3	SA 4	SA1	SA2	SA3	SA4
Percent of respondents that state knowing someone with the HIV virus	20%	F	P	P	P	P	P	P	P
Percent of respondents that state they are friends with someone infected with HIV, or suffering from AIDS	20%	F	F	F	F	P	P	F	F
Percent of respondents that state that if a friend of theirs was diagnosed as HIV positive, they would continue your friendship with that person	60%	F	F	F	F	F	F	F	F
Percent of respondents that state they would be willing to take care of a family member that is infected with the HIV virus in their own home	60%	P	P	P	F	P	F	P	F
Percent of respondents that state they do not believe that people who have the HIV virus deserved getting the disease because of their past behavior	60%	P	P	P	P	P	P	P	P
Percent of respondents that state they do not believe that people who have the HIV virus deserved getting the disease because they are bad religious people	60%	P	P	P	P	P	P	P	P

Surprisingly, among all categories of respondents evaluated during the MTE, the students are the only ones who met the target of 20% for knowing someone with HIV/AIDS. They also passed the 60% benchmark for stating that people who have the HIV virus did not deserve getting the disease. In spite of this relative openness, these children still discriminate against PLWHAs in that they: 1) would not stay friends with someone whom they learned to be infected and 2) would not be willing to take care of a family member infected with HIV in their own home.

This finding is the most significant of all these MTE results for HIV-AIDS in that it calls for the necessity of an HIV/AIDS education program that reaches its participants on an intellectual level, but also on attitudinal levels as well.

4.6.d Conclusions and Recommendations – School Staff, PTA Committee Members, and School Children

The overall results for the HIV/AIDS surveys show that there is not a lack of knowledge on the part of program participants. All of the respondent groups - adults and children, males and females, students and SSNI residents - all showed acceptable levels of general knowledge on the topic. However, the results also showed that providing information is not enough. Programs have to identify strategies for addressing the negative attitudes and practices that continue to stigmatize and be used to discriminate against PLWHAs. Behavior Change and Communications (BCC) Strategies need to be reinforced in the schools in order to change prevailing attitudes and practices – as performance levels on related issues were higher in SSNIs where the HIV/AIDS program has been incorporating BCC activities.

The main programmatic recommendation that is supported by these results is that the HIV/AIDS program should upgrade the level of information provided through the program and that the training should go beyond the conventional information that is already provided by mainstream media outlets.

Another recommendation that emerges from these results is that children in the education program should have access to HIV/AIDS programs that are aiming at behavioral change. Discrimination and stigmatization issues must be addressed in the youngest of the program's participants in order to contribute to improved conditions for PLWHA on the societal level.

4.7. Social Safety Net Institutions - SSNIs

CRS-supported Social Safety Net Institutions (SSNI) care for more than one hundred housed orphans and abandoned children. The SSNI sector was not covered by the 2002 Baseline study; therefore, indicators measured during the MTE will be used as baseline, and guide CRS staff in setting targets for the final evaluation. For the purposes of the MTE, SSNIs were divided into two supervision areas: those that had participated in CRS-sponsored HIV/AIDS education activities in the last two years, and those that had not. Five groups within each SSNI were targeted for the survey. Unfortunately, the targeted numbers could not be reached for all five groups in both SAs (see Table 58 and section on field work results).

Table 58: Safety Net Institutions Sampling

Target groups	Sectors covered by MTE		Intended Number of Samples		Number of Samples Realized	
	Safety Net	HIV/AIDS	SA1	SA2	SA1	SA2
SSNI Management Staff person	✓	✓	29	19	27	17
SSNI Support Staff person		✓	29	19	27	17
Female Child (8-12 years old)	✓	✓	29	19	25	(*)
Male Child (8-12 years old)	✓	✓	29	19	(*)	(*)
Female Child (>13 years old)	✓	✓	29	19	24	(*)
Male Child (>13 years old)	✓	✓	29	19	(*)	(*)

(*) The number of respondents for these age groups was too small to allow for the statistical analysis of the results (see the section on the MTE Field Work)

As the table above indicates MTE SSNI results could not be calculated for any of the male children groups; neither from the 8-12 year old group, nor those that were 13 years old and up – in either SA. This unfortunate situation largely arose out of the fact that many of the SSNIs that were selected during the sampling process served female children only, and so there were not enough male children in the overall sample to make definite performance determinations.

The same can be said for the situation in SA2. The SSNIs in SA2 had never received HIV/AIDS education from CRS over the past two years, essentially because most of the populations served by these SSNIs are "special needs" groups, such as mentally and/or physically handicapped children, orphaned infants, etc. – groups that are not able to participate in such initiatives in any meaningful way. Results in SA2 were thus only obtained for the staff people.

4.7.a. Analysis of Results

i) SSNI Management and Staff

A part of CRS' SSNI program consists in providing training to center management and support staff on universal children's rights. The MTE results showed that at least 85% of SSNI Management in both supervision areas could name at least two of these rights, thus passing the performance benchmark set for this indicator (Table 59). This sampling group also passed the 20% benchmark for the percent SSNI Managers that attended a Ruche (or, SSNI federation) in the last six months.

Table 59: SSNI Management and Staff

Indicator	MTE Target	SA1	SA2
		MTE Benchmark Met? (Pass/Fail)	MTE Benchmark Met? (Pass/Fail)
Percent SSNI Management who can name 2 or more universal rights of children	85%	Pass	Pass
Percent SSNI Management who have attended a Ruche meeting in the last six months	20%	Pass	Pass

Meeting the MTE benchmarks for cleanliness proved more difficult for some of the SSNIs. While centers in both SAs met most benchmarks, they did not maintain levels of cleanliness defined as adequate by CRS (Table 60). For example, centers in SA1 failed to meet three benchmarks that were set at 50%: being acceptably clean and relatively free of trash, having soap available at the closest water point to the kitchen, and having toilets/latrines found to be clean upon inspection. SSNIs in SA2 failed to meet the 50% benchmark for having a food preparation area found to be smooth/free of sticky substances. Overall, it appeared that the SSNIs in SA2 were found to be cleaner and better maintained than those in SA1. The following table presents results on the hygiene conditions observed at the selected centers along with two indicators dealing with canteen management.

Table 60: SSNI Hygiene Conditions and Canteen Management

Indicator	MTE Target	SA1	SA2
		MTE Benchmark Met? (Pass/Fail)	MTE Benchmark Met? (Pass/Fail)
Hygiene conditions			
% centers found to be clean and relatively free of trash	50%	Fail	Pass
% kitchens found to be acceptably clean and free of trash	50%	Pass	Pass

% kitchens without uncovered food out on the counters	75%	Pass	Pass
% kitchens food preparation areas found to be smooth/free of sticky substances	50%	Pass	Fail
% kitchen food preparation stations found to be free of evidence of pests or rodents	70%	Pass	Pass
% kitchens with soap available at the closest water point to the kitchen	50%	Fail	Pass
% centers in which latrine/toilet areas found to be clean	50%	Fail	Pass
% centers with doors on all of the latrines/toilets	60%	Pass	Pass
% centers in which all latrine/toilets doors close completely	50%	Pass	Pass
% centers in which latrine/toilets provide adequate superstructure	30%	Pass	Pass
Canteen management			
% centers without food shortages in the center canteen in the last month	70%	Fail	Fail
% centers with at least one entry for a financial withdrawal or deposit that is dated within the last 30 days in the bookkeeping ledger	50%	Pass	Pass

Another important area investigated in the MTE related to the management of the SSNI canteens. Center management and staff were asked if the center had experienced any food shortages in the last month. Results showed that at least 30% of canteens had experienced food shortages in that period. Thus the program did not pass the 70% benchmark for the indicator "Percent of centers without ford shortages in the center canteen in the last month." As nutritional supplementation is an important factor in CRS' support of SSNIs, the reasons behind this level of shortages will need to be more closely examined.

Since the beginning of the DAP, most center staff have received training on center management strategies, including bookkeeping. In an effort to measure the application of the new skills that have been learned as a result of these trainings, the MTE examined the financial ledgers for all of the SSNIs that were visited. Results indicated that at least 50% of the centers have been maintaining their ledgers in the last 30 days, as evidenced by at least one entry for a financial withdrawal or deposit.

ii) SSNI Female Children 8-13 Years of Age

Female children 8-13 years of age at selected SSNIs were interviewed to determine if DAP indicators for primary school attendance, possession of a birth certificate, consumption of CRS supplied food (SFB, cornmeal and lentils), and consumption of other food types met mid-term project benchmarks. In the case of these four indicators, CRS/Haiti met or exceeded the expected benchmark results (Table 61).

Table 61: SSNI Female Children 8-13 years old

Indicator	MTE Benchmark	Numerator SA1	MTE Benchmark Met? (Pass/Fail)
Percent of female children 8-13 who report going to primary school	80%	25	Pass
Percent female children 8-13 yrs reporting having a birth certificate	80%	22	Pass
Percent female children 8-13 yrs having eaten SFB, cornmeal or lentils in the last 24 hours	90%	23	Pass
Percent female children 8-13 yrs having eaten something other than SFB, cornmeal or lentils in the last 24 hours	30%	24	Pass

iii) SSNI Female Children 13 Years of Age and Up

Interview responses obtained from older female children, those aged 13 years and above, were compared against expected DAP mid-term benchmarks (Table 62). These girls were asked if they attended school or received other training, possessed a birth certificate, ate CRS supplied food (SFB, cornmeal and lentils), and ate other food types in the last 24 hours. CRS/Haiti met or exceeded all the expected benchmarks on these indicators.

Table 62: SSNI Female Children 13 Years of Age and Up

Indicator	MTE Benchmark	Numerator SA1	MTE Benchmark Met? (Pass/Fail)
Percent Female children 13 yrs & up currently going to school or receiving any training	80%	24	Pass
Percent Female children 13 yrs & up reporting having a birth certificate	80%	23	Pass
Percent Female children 13 yrs & up having eaten SFB, cornmeal or lentils in the last 24 hours	90%	23	Pass
Percent Female children 13 yrs & up having eaten something other than SFB, cornmeal or lentils in the last 24 hours	30%	22	Pass

4.7.b. Conclusions and Recommendations - SSNIs

In regards to the indicators relating to SSNI cleanliness, it is clear that the benchmarks should have been set higher. More specifically, the benchmark for the indicator concerning evidence of pests was only set at 30%, meaning that only 4 out of 27 selected centers had to be free of such evidence in order to pass the benchmark. Analyzing a bit further, what this meant was that only 9 centers were "free" from pests while 18 were not. In retrospect, the benchmark should have been higher in order to reflect the cleanliness standards that should already be in place in the CRS-supported centers. While CRS/Haiti met its mid-term target of 30% for this indicator it seem is clear that more needs to be done to improve the cleanliness of SSNIs.

To encourage higher sanitation levels, CRS/Haiti will work with SSNI center staff to create a checklist of regular cleaning tasks. Responsibilities for completing the tasks will be assigned to specific center staff persons, while center managers will be responsible for verifying that these daily tasks are completed every day. Additionally, CRS/Haiti will also strengthen its Health, Hygiene and Nutrition (HHN) training materials in an effort to underscore the critical links between cleanliness at the SSNI and good health.

The fact that CRS-supported SSNIs are experiencing food shortages may be attributed to the volatile political situation in Haiti over the last months, which have made the timely delivery of food items difficult if not impossible at times. Nonetheless, further investigation will need to be undertaken to pinpoint why the centers are not receiving their entitled food supplementation supplies.

4.8. Civic Education

Catholic social teaching recognizes that the dignity of the human person involves the right to political freedom and participation. In an effort to increase people's realization of these inherent rights, the DAP has begun integrating civic education and training into its activities, via the Civil Society, Human Rights and Peace building Program (CSHRPB). It is believed that people's improved understanding of their political rights and system of governance, will encourage a more active and constructive role in local and national politics, which will in turn focus greater attention and resources on the fight against poverty and hunger in Haiti. Improved governance, especially the ability of communities to influence factors and decisions that affect their food security, is an important contributor to achieving CRS program impact[46].

CRS took advantage of the opportunity provided by the DAP Mid-Term Evaluation to develop thirteen indicators based upon the four main components of this educational initiative, namely: civic education,

[46] Concept Paper for its Strategic Plan for 2004-2008, Fifth Draft », Bureau for Democracy, Conflict and Humanitarian Assistance, March 17, 2003, p18.

community advocacy, governance, and conflict resolution. Since those indicators are new, they were not collected at baseline thus the MTE results are used as baseline values for this sector. Program activities planned for FY05 and FY06 will be assessed once again at the end of the DAP, as the program will have trained CRS staff and partners in these basic concepts; who will have, in turn, trained community members and leaders as part of this "tickle down" effort to engage citizens at all levels of society.

A total of 11 groups were targeted by the MTE for this program. Table 1 below presents results of the MTE on questions assessing the levels of civic knowledge of PTA members, School Teachers, and School Directors in four supervision areas, and Community Health Workers (CHW) in two supervision areas; Table 2 presents the results on the same questions for mothers and credit program participants in four supervision areas, and for members of Farmer Associations in two supervision areas. Expected performance benchmarks were different for all of the surveyed groups and depended upon the perceived or verified levels of community and civic involvement, education levels, and past CRS interventions with specific target groups.

4.7.a. Analysis of Results

i) School Staff, PTA Committee Members, and CHWs

Looking at the MTE results presented in the tables below, several observations can be noted about these groups. All of the target populations knew that:

- They have the right to form an association or social group
- They have the right to form a political party
- That "Kazèk" and "Azèk" obtain their positions by winning elections

None of the groups (with the exception of the School Directors) knew that:

- The state is founded upon three principles: property, government and citizenry
- Both the state and the general population are responsible for taking care of the environment
- That another name for the Constitution is "Maman lwa peyi-a"

The most successful results came from **School Directors**, who answered all thirteen questions correctly. This comes as no real surprise, given that School Directors tend to be the most educated of all of the surveyed groups, and that many have participated in CRS-initiated civic education training in the past (Table 63).

Interestingly, **School Teachers and PTA Committee Members** passed and failed on the very same questions; both groups passed the benchmarks for questions 1-8, 12 and 13 and failed on questions 2-6 and 9-11. Looking more closely at these results, the questions on which these groups passed relate to issues which impact them at the community level; whereas those on which they failed dealt more with larger democratic concepts and facts, like the names of the three branches of the national government. As School Teachers are responsible for communicating basic civic education to children, special attention will need to be placed on emphasizing the importance and relevance of such key knowledge to Teachers.

Similar trends were revealed in the performances of CHWs as well; CHWs passed and failed on the same indicators across both supervision areas.

Table 63: Civic Education Knowledge: School Staff, PTA Committee Members, and CHWs

Indicator	MTE B'mark	LOA	MTE Performance[47]				
			PTA Members	School Directors	School Teachers	CHWs SA1	CHWs SA2
% who know that the state is founded on 3 principles – property, government, citizenry	30%	80%	25.7%	32.4%	11.9%		
			UD	UD	Fail	Fail	Fail
% who know that "Deputes" are elected for two-year terms	30%	80%	47.6%	72.3%	56.6%		
			Pass	Pass	Pass	Pass	Pass
% who know the name of the tribunal in their commune	80%	90%	84.4%	88.0%	81.8%		
			UD	Pass	UD	Pass	Pass
% who know that political parties gain political office by winning elections	80%	90%	83.9%	97.4%	95.9%		
			UD	Pass	Pass	Pass	Pass
% who know they have the right to form an association or social group	80%	90%	98.7%	98.7%	100.0%		
			Pass	Pass	Pass	Pass	Pass
% who know they have the right to form a political party	80%	90%	82.2%	96.0%	95.9%		
			UD	Pass	Pass	Pass	Pass
% who know that Senators can propose laws	80%	90%	78.3%	83.9%	73.3%		
			UD	UD	UD	Fail	Pass
% who believe that the state and the population are both responsible for taking care of the environment	80%	90%	60.0%	87.0%	62.7%		
			Fail	UD	Fail	Fail	Fail
% who know that a "majistra komenal" (Mayor) obtains his/her position by winning elections	80%	90%	85.3%	96.2%	92.2%		
			UD	Pass	Pass	Pass	Pass
% who know that KASECS obtain their position by winning elections	80%	90%	88.1%	96.2%	90.9%		
			Pass	Pass	Pass	Pass	Pass
% who know that ASECS obtain their position by winning elections	80%	90%	88.0%	94.8%	90.9%		
			Pass	Pass	Pass	Pass	Pass
% who know that another name "maman lwa peyi a" (the constitution) is "La Loi Mere"	80%	90%	55.87%	92.3%	56.0%		
			Fail	Pass	Fail	Fail	Fail
% who know that there are three branches of government – Executive, Legislative and Judiciary	80%	90%	57.03%	90.8%	77.4%		
			Fail	Pass	UD	Pass	Pass

ii) Analysis of Results - Mothers, Credit Program Participants, and Farmer Association Members

Of all of the targeted groups, mothers of children less than 2 years old failed most to meet performance benchmarks on civic knowledge: all three groups of mothers (mothers of children 0-6, 6-12 and 12-24 months) failed to meet the benchmarks for five to six of the 13 indicators. Though they did pass on one indicator, we are unable to state with certainty if weighted coverage estimates on the others actually cleared the benchmarks since the confidence intervals overlapped with the benchmark. Perhaps the tremendous burden put on women at the household level limits their exposure to politics and civic education, explaining their poor knowledge of those issues. Further investigation of those results should be undertaken to better understand why their knowledge is so limited, and how the CSHRPB program can encourage and facilitate their future inclusion in those educational activities. The knowledge of participants in the micro-credit program is slightly better, perhaps because they have already begun to receive training in topics such as participatory decision making and association formation (including the establishment of member rights and responsibilities). As to farmer association members, they generally faired better, which may suggest that associative structures are perhaps more conducive to the transfer of key CSHRPB concepts and the replication and reinforcement of civic principles.

[47] *The MTE Performance values expressed as % are weighted coverage estimates calculated by aggregating the data from SAs. "Pass" = met the benchmark; "Fail" =: Failed to reach the decision rule for the benchmark; "UD" (Unable to Determine) = given that the benchmark falls within the results' confidence intervals, we cannot state with certainty that the weighted average cleared the benchmark. In such cases, we do not make a judgment for the overall sample. We looked instead only at individual SA performance. For ease of presentation, results by individual SA are not presented in that table. The MTE Performance values expressed as either "Pass" or "Fail" (no %) are for sectors that did not have 4 Supervision Areas from which to aggregate the data.

Table 64: Civic Education Knowledge: Mothers, Credit Program Participants and Farmers

Indicator	MTE B'mark	LOA	MTE Performance					
			Mothers			Credit Parts.	Ag. Ass. M'bers SA1	Ag. Ass. M'bers SA2
			0-5.99 mos	6-11.99 mos	12-23.99 mos			
% who know that the state is founded on 3 principles – property, government, citizenry	20%	50%	1.3%	2.1%	0.8%	1.2%		
			Fail	Fail	Fail	Fail		
% who know that "Deputes" are elected for two-year terms	20%	50%	13.7%	11.2%	12.9%	30.4%		
			UD	Fail	UD	Pass	Pass	Pass
% who know the name of the tribunal in their commune	50%	80%	20.5%	28.1%	16.6%	42.2%		
			Fail	Fail	Fail	UD	Pass	
% who know that political parties gain political office by winning elections	50%	80%	47.0%	53.6%	40.7%	49.1%		
			UD	UD	UD	UD	Pass	Pass
% who know they have the right to form an association or social group	50%	80%	79.2%	61.8%	73.1%	82.6%		
			Pass	Pass	Pass	Pass	Pass	Pass
% who know they have the right to form a political party	50%	80%	56.0%	52.9%	47.2%	34.0%		
			UD	UD	UD	Fail	Pass	Pass
% who know that Senators can propose laws	50%	80%	57.4%	51.1%	46.9%	55.5%		
			UD	UD	UD	UD	Pass	Pass
% who believe that the state and the population are both responsible for taking care of the environment	50%	80%	6.9%	3.7%	7.9%	20.4%		
			Fail	Fail	Fail	Fail	Fail	Fail
% who know that a "majistra komenal" (Mayor) obtains his/her position by winning elections	50%	80%	46.3%	49.2%	48.2%	60.7%		
			UD	UD	UD	UD	Pass	Pass
% who know that KASECS obtain their position by winning elections	50%	80%	50.9%	53.1%	53.4%	66.6%		
			UD	UD	UD	Pass	Pass	Pass
% who know that ASECS obtain their position by winning elections	50%	80%	53.4%	53.1%	52.1%	65.5%		
			UD	UD	UD	Pass	Pass	Pass
% who know that another name "maman lwa peyi a" (the constitution) is "La Loi Mere"	20%	50%	5.0%	6.5%	3.4%	5.0%		
			Fail	Fail	Fail	Fail	Pass	Pass
% who know that there are three branches of government – Executive, Legislative and Judiciary	20%	50%	17.5%	15.2%	5.5%	7.3%		
			UD	UD	Fail	Fail	Pass	Pass

4.7.b. Conclusions and Recommendations – Civic Education

CRS is committed to empowering its beneficiaries to take an active role in deciding and negotiating issues that affect their daily lives. Improving the levels of civic knowledge is one step in that direction. In pursuing this commitment, the CSHRPB program must design training programs that speak to the needs and constraints of all the target groups; particularly mothers, CHWs, PTA Members and School Teachers – all of whom fared poorly on the indicators for this sector. For instance, the civic education sessions for women's groups should be designed to be precise and short so to not require too much of their time, considering that, in most cases, they have to juggle several responsibilities at once.

Although all of the target groups knew that "Kazèk and Azèk" obtain their positions by winning elections, it is important that the CRS Staff and partners who facilitate the civic trainings define clearly these officials' roles and responsibilities, to provide the target groups with the information they need to make educated decisions when voting—especially since this is an election year in Haiti.

CHAPTER 5 – MTE RESULTS BY SECTOR – PHASE II

5.1 Micro-Credit

5.1.a. Community Credit Program

~~**WOMEN CREDIT PROGRAM**~~

Results from Phase I MTE related to women's credit raised two main questions:

i) Why do some women report having problems reimbursing their loans, and why some are not reimbursing at all?
ii) Why do some women report not investing more in the feeding of their children since they joined the credit program?

i) Why is it difficult for some women to reimburse the loan?

To understand the difficulties associated with the reimbursement, many factors must be taken into consideration:

- The economic situation of the people prior to joining the credit program
- The conditions associated with making profit, such as
  - Type of investment
  - Past experience in doing business
- The conditions set for the reimbursement of the interest and the principle
  - Payment of the interest
  - Reimbursement of the principle
  - Conditions for renewing the loan in the following cycle
- The training and support received
- The participants selection process

When exploring the reasons why some women have difficulties reimbursing their loan, all of the above elements were reported during the interviews.

The participants' economic situation prior joining the credit program:

According to the persons interviewed, in order for the loan to generate benefits, the person should have other sources of income such as livestock or agricultural activities or a certain amount of money already invested in a small business. Very often those investments are used to pay the monthly interest and even to reimburse the principle borrowed from the credit program. When a person only depends on the small business to fulfill her/his family needs, the risk for bankruptcy is higher; since profits are rarely sufficient to pay back the interest, the loan principle is often used to make interest payments. .

It was also noted that part of the interest is often used to pay for family emergencies such as school fees, rent, health care, etc. Those who have an alternative source of income can recover that money much more easily. However, those without supplemental forms of income are very likely to ever be able to pay back the debt owed on the loan.

Observations:
According to one key informant in Port a Piment, one major problem for reimbursement in that area is the extreme poverty of the people and not a general lack of trust as it was anticipated. People in this area have many children, the agricultural systems are archaic, and many people only generate sufficient income to fulfill basic family needs. Typically, men in the town of Port Piment do not farm and are often unemployed. One of the people interviewed even reported a stigma associated with performing farm work: "working on the farm is considered a disgrace for a man who lives in a town ". The same person had been a victim of such stigma himself and was rejected by his friends. Even his wife was very critical of his choice to farm in order to meet the needs of his family

In Port a Piment, many women who were interviewed reported to have had to use a major part of their loan to satisfy family obligations. Many women have between 2 and 9 children. Among the eight women interviewed, only three of them live with a spouse, one is a widow, and the other four receive nearly no assistance from the father of their children.

Conditions related to profit generation

Types of investment
According to the women with more business experience, credit participants should reinvest their profit and even diversify their investments into activities outside of the small business such as farming and livestock. In this way participants would be able to sell an animal or produce whenever they are in need of emergency funds instead of dipping into the loan principle. Those who only invest in small businesses do not have such an alternative.

Past business experience
Experience in managing business is an important contributing factor for profit generation. The person who is running the business must pay attention to all potential opportunities. To make a profit, one must know in which type of business to invest in order to sell products quickly (the expression in Creole used to describe this is: "fok ou konn brase lajan an"the principle must turn around quickly in order to make a profit.) Those who make more profit are the "madame sara" or business women who move from one large market to another. In order to be able to do this, the person needs a larger amount of principle to cover costs such as travel expenses. The loan alone is not sufficient to have a profitable business. Those who sell at home or in the local market do not make much profit. Competition is also more important since many people are in the same type of business.

According to a key informant, people who receive a loan must be "authentic business woman " in order to be able to make some profit. This issue was reported as a problem in Port a Piment. The preliminary work of identifying the « true business women » was not completely done.

Remarks :
All groups unanimously reported that, currently, profits are much smaller than what they were a few years ago. They gave the following explanations:

- They tend to invest more for a smaller quantity of products
- Sales are very slow. Women explained that their purchasing power has decreased. Moreover, key informants reported that there are more people in the same area doing the same type of business. They suggest that they should have more opportunity to be able to add more variety to their type of business and types of products that are sold. This would also facilitate the fulfillment of customers' various needs and preferences.
- The cost of transport and other business-related costs are very high. According to the women, in order to reduce overall transportation costs, they should buy a greater quantity of products at a time.
- Women must cope with unpredictable situations such as:
    - Payments made with forged banknotes. Many women reported to have been the victims of such instances of counterfeit.
    - Goods stolen at the market or the warehouse.
    - Robberies.
    - Loss of perishable goods that cannot be sold rapidly enough during periods of bad weather or political crisis.
    - Selling on credit is also a risk. The cash value of the products sold on credit is not often recovered. Women report that it is sometimes difficult to turn down credit to their customers.

Faced with such problems, many women in Port a Piment, said they had to abandon the credit program not to have to face the stress of constantly searching for money to make interest and principle payments

In the commune of Aquin, it appears easier for women to run their small businesses in spite of the difficulties mentioned above. These women tend to have more access to larger markets, and all women who were interviewed are experienced business women or “madame sara”. The majority of women participants in Aquin have left the credit program and are continuing to run their business supported by the program..

In Port a Piment, the situation is quite different. According to a key informant, this area is not an active trade area, as there are no major markets in the commune as in Aquin. Women in the Port-a-Piment area said they are very poor, and many of them no longer have their small businesses supported by the credit program.

Conditions for reimbursement of the principle and interests:

Payment of interest:
In Aquin commune, women who were interviewed report that the payment of monthly interest is not a problem for them; they are able to pay it back with the profits generated from their small businesses.

However, in **Port a Piment** women are confronting serious problems since their profits are not sufficient to make interest payments. Many women report being many months behind on their payments and, as a result, used one of the following strategies to make interest payments:

- Use part of remittances received from relatives living abroad
- Use part of the loan principle
- Use a combination of profits and loan principle
- Sell of an animal such as a goat or a pig
- Sell a piece of furniture such as a chair, table, or kitchen utensils
- Sell part of their harvest of corn or beans. (When such an option is not possible during drought periods women’s economic situation becomes more desperate .
- None of the women interviewed reported borrowing additional money to make interest payments. They preferred dealing with Caritas instead of individuals or loan sharks and they did not want other people to be aware of their financial difficulties.

In both Aquin and Port a Piment, all categories of people interviewed (credit participants, Colvols and key informants) unanimously agree that the credit conditions offered by FODA (the Caritas-CRS credit program) are more advantageous than the other credit programs available. However, they believe that interest is still too high since, in order to be able to it back , women are forced to use a larger part of their small business profits.

Reimbursement of loan principle:
In **Aquin** commune, the reimbursement of loan principle seems to be the most difficult issue for credit participants. At the end of each cycle (generally 6 months), all participants within each group have to return the entire principle in addition to the monthly interest payments. For most women, it is extremely difficult to come up with the full principle every six months and they have to use different strategies to be able to do it. Those who raise animals while managing their small business will sell an animal in order to be able to get the amount needed. Others participate in “consortium” schemes to have access to the required amount at the time the reimbursement is due. Regular saving is not the most commonly used method; only one woman reported doing that. Many report having to sell all their products to be able to pay back the principle. In case the amount is insufficient or participants have not sold everything, they will end up borrowing the difference. The credit officer and the key informants also confirmed this information that participants provided. According to women who had participated in the credit program, they borrow from friends or relatives without interest.

In **Port a Piment**, women are not obligated to return the principle at the end of each cycle; it is only done at the end of the first cycle. The principle must be reimbursed when a participant decides to leave the program.

Conditions for loan renewal:
With regards to conditions to renew loans in a new cycle, women in Aquin reported two problems:

1. As mentioned above, women must return the amount of the principle at the end of each cycle. This money is handed over to the credit officers. Documents are then filled in to renew the credit for the group. If all group members bring back their money, the money is returned to the beneficiaries to start a new cycle. This can be done on the same day or within the following two days. Credit participants and key informants believe that, in light of the numerous sacrifices and losses the participants must face to find the money, it should not be mandatory for them to bring the money back since it ends up being given right back to them anyway.
2. Moreover, in order for each group member to receive their money back on the last day of the cycle, all of them must returned the full amount. If any participant does not return part of the loan, no one in the group receives their new loan. This strategy unduly penalizes those who have made sacrifices to bring back the money.

The support and training received:
According to all categories of people interviewed in the commune of Aquin (key informants, credit participants, colvols), the problems arise when the groups become self-sufficient, this usually happens after two years. At that stage, they do not receive much support from the credit officer. There is nobody to motivate, train and support the group, which creates confusion within the group.

Participant selection process:
Solidarity is the foundation of this credit program. This means that the whole group is responsible if one member does not pay. If this happens, the entire group needs to reimburse for the delinquent member. Therefore, the participant selection process is crucial. Everyone must answer for everyone else's integrity and accept to associate herself with the others. The participant selection process has a significant impact on the regularity of reimbursements. According to the information collected during the meetings, members who do not reimburse after having received the credit are people who are not well recognized by the existing group.

According to the key informants, program participants and colvols **in Aquin**, when the program just started, groups used to reimburse on a regular basis. Participant selection was done at the level of the rally-posts (MCH program) using regular participation and credibility status in the community as important selection criteria. Participants were able to choose their own associations or "makonn". Problems arose when "makònn" members started to quit the credit program and the replacement process was not well defined. According to the information collected during the interviews, the on-going members are not informed about the origin of the new members added to the group to replace those who have left. The group committee submits the names of the new members to the credit officer without consulting with the whole group. Selection criteria for these new members are not well defined. New members are not necessarily rally-post participants and often live in either isolated areas or in areas unknown from the group. According to women participants and key informants those new members are the ones who tend to have problems with reimbursement and are often the reason groups fail and break up. .

In **Port-à-Piment**, credit beneficiaries are not selected from the rally posts' participants. Right from the beginning, selection criteria were not established and not correctly applied. The problem comes from the fact that, at the group level, some members do not even know each other and some even live in different localities. Moreover, according to a key informant, there is too much disparity among members of within each group. Such differences include lifestyle, past experiences, life interests and attitudes and outlooks. All of these elements are essential for solidarity within the group and a crucial condition for the success of a credit program.

Recommendations made by the participants and key informants

In Aquin commune

- According to the key informants, beneficiaries who participate in the credit program should receive a training on marketing issues to assist them in identifying the type of business to establish while taking into account community needs

- Key informants also propose that beneficiaries do not reimburse the principle at the end of each cycle. They think that the interest paid on a monthly basis should be considered as a long-term reimbursement of the loan principle.
- With regards to the participant selection process, it was suggested that, when a member quits the group, her replacement cannot be chosen without consulting with the colvols in the community and the other group members. The colvols should always have a waiting list of potential candidates interested in joining the credit program in case some members decide to quit. It was also suggested that the colvol in charge of the community rally post participate in each end-of-credit cycle meeting, be informed of cases of abandonment, and be able to propose new members to the group. If a new member wishes to join a group, the group must approve its choice. Moreover, any change within a group should be the subject of a new agreement between the group and the organization that loans the money.
- With regards to the management of the funds, the key informants proposed the following:
    - The group bank book should be in the hands of the committee
    - Two committee members should have the right to sign on the bank book
    - Two signatures should be mandatory for any bank withdrawal: the credit officer and a committee member
    - Group members should be informed before any withdrawal is done. The amount and the purpose should be recorded in the meeting book
    - Group members should be regularly informed on the balance of the group bank account.
    - If a group has completely reimbursed the principle, a member who wishes to quit the program should have access to his/her savings
    - Procedures should be simplified to allow members to have access to their savings
    - Group members should have access to a share of the interest
- In the case of non-reimbursement of the principle by all group members, the program should establish a fair procedure for sharing savings
- The credit officer should continue to support credit groups even though they have reached "autonomous" status.
- The role of the committee should be better defined. The committee should not make decisions without consulting with the other group members. The committee is perceived as having too much authority on the group, which is often kept out of the decision-making process. At the same time, the committee is often not able to assume certain responsibilities since it is under direct control of the credit officer.

A Port à Piment

Suggestions proposed by the persons interviewed are the following:

- Revise the participant selection process
    - Collect better information on their credibility
    - Participants must be authentic business women
    - Within each group, members must have similar socio economic backgrounds and life styles
- Beneficiaries should receive continuous support from the credit officer
- Interest rates should be decreased
- Port a Piment, being a difficult area for commercial activities, micro-credit could be used for small food processing projects.

ii) Do young children benefit from the credit program for mothers?

According to some interviews conducted in **Port-à-Piment**, the credit did not help women in improving their economic situation. On the other hand, for some women, the money received allowed them to take care of some emergency situations such as school fees, rent and medical treatment. At the beginning, some women were able to make a small profit, but not sufficient to pay the interests and fulfill all household needs. For the majority, the credit did not directly contribute to the improvement of child feeding and nutrition. However, they report dipping into their business inventory to feed their children, since most of them run food-related businesses.

In **Aquin** commune, the situation is completely different. Even though women report not investing more in the feeding of their children, the latter indirectly benefit from the small business program. ~~Les bénéfices réalisés par les femmes ne sont pas perçus de façon monétaire tout comme les femmes ne sont pas en mesure de dire ce que représente le crédit (Elisabeth est-ce plutot "profit" ??) dans le du business.~~ Women do not readily report an improvement in child nutrition as a benefit of the credit program. However, all report that going to the market on a daily basis gives them the opportunity to buy foodstuffs for the household. This also allows them to diversify the food given to the children and to avoid using all harvested crops for household consumption. As such, they are able to store part of the harvest and sell it when prices are higher.

In both **Aquin and Port a Piment,** the people interviewed acknowledged the impact of the credit program on reinforcing social capital and relations among group members. They learn how to work as a group and to better organize themselves. It was also their first opportunity at saving. Some received training on how to manage a business. All beneficiaries report that the credit allowed them to have access to loan to meet an emergency without having to borrow from high-interest street lenders or loan sharks.

In **Aquin**, all beneficiaries unanimously acknowledged the changes that occurred in their lives since they received the credit. They were able to reinforce their small business. They also used the profit to improve their housing conditions, to launch or expand animal raising activities, or to buy seeds or fertilizers. Key informants report that it is difficult to imagine the level of abject poverty of women participants before joining the credit program.

5.1.b. Community Health Workers Credit Program

With regards to the colvols credit program, the objectives of Phase II were the following:

i) Examine the difficulties encountered by the colvols during loan reimbursement
ii) Examine the impact of the credit program's incentive effect on colvols' work
iii) Discuss alternative sources of motivation and incentives for participation other than credit

i) What are the difficulties colvols will face under the new credit program management?

Right at the beginning of the meeting***, colvols in Aquin commune,*** expressed their concern regarding CRS' decision to change the management of the credit program. According to the colvols, CRS would like the colvol credit program to begin to be managed by the partner Caritas, despite the fact the program has been well managed by colvols themselves ever since 1991. They feel such a change is unnecessary given that the program has produced positive results under colvols' direction. Many participants feel that the change in program management will be to their disadvantage, as conditions for participation will likely change. Therefore, many colvols plan on discontinuing their participation in the credit program once they have paid off their existing loans.

According to the colvols:

- The change represents a loss of autonomy and self-worth for colvols, since they were managing their own credit portfolio perfectly well until the decision was made to have another partner assume management responsibility.
- The old management system allowed colvols to create a growing and revolving line of credit through the interest that was paid on the loans. The perception now is that the interest will not be used to increase the revolving credit.
    - Through Caritas, they are asked to reimburse the loan principle at the end of each cycle rather than continuing a line of credit as practiced under the old management system. This procedure will have severe implications on their business activities. In order to be able to return the capital at the end of each cycle, they are losing profits generated by their small business activities. In many cases, reimbursing at the end of each cycle is the equivalent to losing their initial investment.

- By and large, colvols report that, under these new terms, they would prefer to return their loan principle and end their participation in the credit program altogether.

According to the colvols and key informants ***in Port à Piment,*** the credit management is already being undertaken by Caritas. Colvols report that they also have to reimburse the principle at the end of each cycle. As in Aquin, this is a problem for Port-a-Piment colvols since it is often difficult to find that money.

A key informant in Port-a-Piment reported additional factors that could explain the difficulties colvols have faced regarding loan reimbursement:

- People have different ways of managing their business
- There are several constraints linked with last year's severe drought
- From an economic point of view, problems differ from one person to another
- It is more difficult to make profits with certain types of businesses. For example, if someone sells an agricultural product such as rice, a portion of it is often used for household consumption.
- Many colvols lack alternative sources of income.

Advantages of the credit program for the colvol:

In the commune of Aquin, even though the colvols were not pleased with the management changes, they were, on the other hand, very enthusiastic during the discussion on the impact the credit program has made in their lives. The credit has enabled them to do the following:

- Compile savings. "Before joining the credit program, we did not know what a savings bank book was", stated one participant.
- Learn how to manage small businesses.
- Avoid using loan sharks and street lenders during emergencies..
- Avoid the humiliation of borrowing through informal channels (friends, family, street lenders, etc.)
- Send children to school
- Use the profits for the feeding children, especially during the lean and dry seasons
- Provide care and treatment for severely ill children thanks to the profits generated by small businesses.
- Make home improvements
- Obtain the satisfaction of starting a small business and watching it grow.
- Buy and store grains when prices are low and resell them at a profit.
- Invest in profitable small businesses such as the raising of small animals.
- Have access to purchase more goods in order to expand small businesses.

According to the key informants in Aquin, the credit program helped significantly improve colvols' living conditions and quality of life. Overall, the colvols felt that the credit program not only improved their economic outlook but also improved their self-esteem and made them feel like productive members of society. Most colvols felt that, in the absence of the credit program, their ability to provide for themselves and to run profitable small businesses would substantially diminish.

In Port à Piment, key informants and colvols were reticent when asked what the credit program had done for them or what they would do without the credit. One colvol replied, "sometimes the loan helps you a lot and sometimes, it puts you in a bind [financially]". According to a key informant, in the past, it was not difficult to manage and take advantage of the credit. The drought and the high cost of living have made activities such as animal-raising and agricultural very difficult, thus making loan reimbursement less more challenging. The interview participants spoke more about the difficulties of loan reimbursement than about the advantages and opportunities the credit afforded them. Colvols in the Port-a-Piment areas experienced many of the same problems experienced by the women credit program beneficiaries.

ii) Impact of the credit program as an incentive for Colvol participation in MCHN activities

According to key informants, the credit program encourages the colvols to do their best in participating in the very demanding work expected of them in the MCHN program. This work consists of organizing

rally posts, preparing reports, participating in community meetings, making home visits, etc. The credit represents a small compensation compared to the services they provide to their respective communities. The key informants interviewed perceive the colvols in the following ways:

- The colvol is the link between the hospital and the mothers. He/she encourages and sometimes accompanies mothers to go to the health centers. According to key informants, without the colvols, there would not be as many people going to health centers.
- The colvol facilitates communication between the health center and the community. He/she passes on important health messages to the community.
- According to some people responsible for health centers, their success is directly related to the colvols' presence.
- The colvol's work is very important for the community and very demanding for the colvol. Communities are very rarely critical of their work or performance.
- The colvol is the key to making community health care activities work.
- The colvol is like the "salt in the food"; he/she is the core strength of the health centers. This is because the colvols are the ones doing the most demanding work: traveling to isolated areas to conduct rally posts, administer vaccinations, and conduct motivation and training sessions for mothers.
- Without the colvols, there would be a huge gap in health care provision in the targeted communities.
- The colvol is devoted. He receives no salary.
- The colvol is the most important and often the most admired worker in the health care system
- The colvol performs wonderful work and deserves more encouragement

The mothers also show a great appreciation for the work of the colvol. Covols encourage them, give them advice, and inspire trust from them.

From their perspective, ***the colvols*** report to be the leaders and among the most well known members in their communities. As such, they would continue to work as colvols even if they did not benefit from the credit program. However, they would probably not have the same level of strength to perform their duties since the credit program allows them to eat better than before.. Moreover, had the credit program not come along, they would probably have eventually moved somewhere else to escape their poverty; the credit program prevented this from happening by offering colvols the possibility of developing profitable small businesses.

The most motivating factors for a colvol are the following:

- Providing a real service to their community
- Being well recognized in their community.
- Establishing trust with the people they serve.
- Earning respect and self-esteem through their work.
- Helping save children's lives.

Other factors that encourage them are the following:

- Training provided by CRS
- Small per diems provided during trainings
- Some colvols report being treated with respect by CRS and the health institutions with which they are associated.

iii) What are the other elements that could contribute to motivate the colvols in their work

The colvols wish they could have more possibilities to help the people in their community because, very often, they are the first to be contacted when community members have problems. They would like the following:

- More training to better develop the health education topics. They would like to have the same training as that provided to conduct the mothers' clubs.

- Learn how to give vaccines.
- Learn how to control blood pressure. Some people suffer from high blood pressure in their communities and they could refer them to the health center in case of emergency.
- Have access to a first aid kit.
- Have a stretcher to transport urgent cases to the health center

The colvols wish we could offer them more benefits for participation such as:

- To be used as resources for some positions for which they have the qualifications.
- Have an access card for health care services, including a special rate for health care and medication for themselves and their families.
- Benefit from some benefits in the health institutions, such as access to free consultation when they are sick, a letter of reference when they need to consult another health center, exemption in case they need to buy medications, better and more rapid access to health services in the centers for which they work.
- Have an identification badge.
- Participate in a large meeting of all colvols on a periodic basis (yearly or every two years); this would give them the possibility to exchange ideas and share experiences, etc
- The reopening of the household latrine program and water capping projects that used to help the communities while providing them with some income (colvols were actively participating in the latrine program and received stipends for the construction work they were doing)
- "Have a kind gesture" for them (small amount of money) at some specific periods of the year, such as the beginning of the school year, Mother's day, and the end-of-the year holidays in December.

5.2 Water and sanitation

School Latrines

To explain the weaknesses observed in the maintenance of school latrine infrastructure (Phase I report), interviews were conducted with CRS education program field animators, school directors, teachers and PTA board members in two schools where latrines were not adequately maintained. The two schools visited were in Chardonnières and Port-à-Piment.

Three elements were considered for the maintenance of the latrine building: the closing of the doors, the cover on the latrine seat and the lock from the inside. The results of the interviews show that the incorrect functioning of any of those elements does not result from a misunderstanding between the school office and the PTA members. The relationships between those entities seem fine and PTA members seem well involved in school activities by providing their contribution. The interviews showed that the problems in the maintenance of the latrine structure were rather the results of some communication issues and slight negligence.

The closing of the doors: according to the interviewees, all doors have functional locks. The keys are kept in the director's office or by the guard. However, some doors present some construction defects in the way they are installed and the doors can be opened from the outside without using a key. This is the case for one of the schools where the lack of fence facilitates access to the schoolyard to intruders thus making the proper management of the latrines difficult.

For the **cover on the latrine seat,** interviewees from one the two schools claimed that they were not informed that the latrines should be covered; they received this information about a month ago by a CRS animator. The school director confirmed that the covers are currently being made and they will be installed shortly. For the other school, the personnel in charge confirmed that the covers exist; however, according to the assistant director, one of them came off and it seems difficult to reinstall it. PTA members were not informed of that situation.

For the **locks from the inside**, it is simply non-existent in both of the schools visited. In one case, interviewees thought they existed, but never paid any attention during maintenance checks. CRS animators confirmed they failed to insist on the importance of a lock from the inside of the latrine and they will soon present the correct message.

5.3 Education

Some key issues pertaining to education that were not addressed during Phase I were examined during Phase II. Those points were the following:

- Causes of students' school dropout
- Use and assessment of training materials provided by CRS
- PTA members' contribution to the development of their schools.

Causes of school dropout:

CRS decided to examine the reasons why a high rate of school dropout was observed in some schools of Aquin commune. To address this issue, meetings were conducted with a first group composed of school directors, teachers and PTA members from three different schools in Aquin commune, and a second group composed of parents whom children had dropped out from those same schools.

According to the two groups, the main cause of school dropout is associated with financial difficulties. Very often, parents cannot manage to pay the school fees of 600 to 750 gourdes per year (including entry, school and canteen fees) payable by installments throughout the year. According to the parents met during the survey, the lack of financial means is the primary cause of school dropout. If a parent fails to settle his debt with the bursar office, the school director will wait for a few days and then send the student home. This situation frequently occurs before quarterly and final exams. However, there are cases where the action is not taken by the school director. Sometimes the decision not to return to school is made by the student himself/herself who decides to stay home to avoid the humiliation associated with the parents having failed to pay the school fees. In some cases, the director's office publicly reports the names of those who are have debts with the bursar office.

The parents stated that a student is not definitively returned home because of debts. As soon as the parents pay their dues, the student can return to school. This kind of regular disruption results in several days or months of missed classes and exams. Consequently, the student's ability to learn is severely affected. Very often, the student cannot keep up with the current class level and must repeat the same grade the year after year. As a result, a student may remain in the same class for several years or may simply leave the school altogether because he/she has either become too old or was not able to keep up with their grade level. Therefore these kinds of periodic suspensions and absences often lead students to drop out of school completely. .

With the persistent increase of school fees and of the cost of living in general, parents report that it is becoming more and more difficult for them to pay for school fees. This situation is exacerbated when the harvests are poorer in single parent households (for example, in the case of a widow or single mother). According to parents, the underlying cause of dropout is due to these socio-economic factors.

In the case of a poor family with many school-aged children, parents are forced to choose between what children will attend and those who will not. How is the selection done?

- Some parents report continuing with those children who are in the higher grades and withdraw the younger ones from school to allow the older ones to acquire as much knowledge as possible.
- Even though the above strategy is the most common one adopted by the parents, they will only keep the more advanced children in school until they reach a certain level. As explained by some parents, "Until *they are able to survive by themselves, to sign their name, etc".* At some point, the older ones will be withdrawn from school to allow the younger ones to also acquire a minimum of knowledge.

- The choice depends on the learning abilities of the child and his/her school performance. Under this scenario, the *smarter* ones remain in school.
- Sometimes the choice is made by the school director who decides to let a child attend the school in spite of his/her debts, because he/she is particularly gifted and intelligent.
- The type of school attended by the child could also have an impact on the choice and priority. According to a key informant, parents will prioritize fees for children attending a congregational school, then, a secondary public school, and so on.

According to the parents, the sex of the child does not influence their choice. This was confirmed by a rapid analysis of available data on children of both sexes attending school compared to the number of children of both sexes in the same area. Results show that there is no sex discrimination when it comes to decide which child should go to school.

Even though the non-payment of school fees remains the most important reason for school dropout, questions were discussed with the two groups to look for other causes of school dropout. The results are the following:

- According to some school directors and teachers, some children must stay home to help with agricultural tasks and animal husbandry. This is especially common in the case of a single mother. However, according to interviewed parents, if a child cannot attend school, the primary reason is not because the child is needed for household tasks but because the family simply does not have the financial means to send him/her to school. All parents all would like to see their children go to school.
- The quality of education and the quality of teachers are also mentioned as a cause of school drop out by all three groups: directors, teachers and parents. Sometimes parents change schools just to have their children in the class of a specific teacher they believe is good. The opposite is also true.
- Occasionally parents will have a child change schools because of his/her poor performance.
- The school discipline and punctuality of the teachers are other important elements for the parents. Some parents mention having had to withdraw their child from a school because of the teachers' irregularity.
- Early pregnancy among adolescents: school directors and teachers indicate that cases of school dropouts due to early pregnancy are common among adolescents. This often occurs when the school fees are paid by a male friend. When a girl is pregnant, the school prevents her from coming to school. She may also be subject to the mockery of other schoolmates. One of the parents interviewed during the survey reported having to have her child dropped out the school because she had become pregnant.
- Relationships with other students, the appearance of the school building and the uniform: according to school directors and teachers, some students would like to be with their friends who attend another school; others refuse to remain in a school because they are the subject of jokes from their schoolmates because their clothing is ruined or dirty, or simply because they do not have decent shoes.
- Parents' incapacity to buy school materials or to fulfill some school requirements, such as the uniform and the closed black shoes, is also another cause of school dropout mentioned by the interviewed parents.

School dropout resulting from household financial difficulties (the most common reason) often leads to a definitive drop out. In most of the other cases, the problem can be solved by a change of school if the parents have the means.

According to the groups met during the interviews, children who withdraw definitively from a school are emotionally affected. They feel inferior and become bitter. Parents loose their control more rapidly; they hang in the streets or in the bush. They are more exposed to bad companions, alcohol and drugs.

Impact of school canteen:

Even though they acknowledge its importance, parents do not consider the non-existence or the quality of a school canteen as a cause of school dropout by a student. However, school directors and teachers in the area of Aquin report that even though this does not represent a cause of school dropout, the canteen is an incentive for children to come to school. They explain that when there is a disruption in the stock, fewer children come to school and, for those who come late; they cannot concentrate easily and have to be dismissed earlier than usual. According to interviews done with school directors and teachers in les Anglais and Port-à-Piment, a similar situation prevails on the south coast.

Use and assessment of training materials provided by CRS:

In both areas covered by MTE Phase II, Aquin and the southern coast, school directors and teachers appreciate trainings provided by CRS These trainings consist of pedagogical sessions related to the use of attendance books, pedagogical boards and practical guides for administrative procedures.

All interviewed teachers had the opportunity to participate in a whole series of pedagogical training sessions from September 2004 to March 2005, except for one new teacher who only attended one session. This training allowed them to considerably improve the quality of their course work. They do not perform lectures as they used to do, but rather encourage more student participation. They are able to better prepare their courses and use concrete and practical examples. They can also prepare better evaluation tests for the students. The success rates for the primary school national exams (CEP) have increased as a result.

The school directors show more interest in the preparation of the lessons, and can provide a better support to the teachers. They can also review and correct exams. Thanks to the training received on the "Guide Pratique d'Administration Scolaire (GPAS), they now know how to use the detailed national program developed by the Ministry of Education, are aware of the criteria for teachers' recruitment and students' admission, and can better control students' attendance and monitor absences. Consequently, the success rate for the Primary School National Exams has increased. In one school of Port-à-Piment, the success rate for the primary school exam was less than 50% three years ago, 64% in 2002-2003, and reached 100% in 2003-2004.

The teaching materials/pedagogical posters have allowed for improved presentation skills and a better involvement and participation of students; however, the number available is insufficient. The school directors in Aquin report that they did not have the means to acquire more than three posters. They are kept in the school director's office, and are often used to the benefit of students of higher classes and not for the youngest ones.

School directors raised the issue of high rates of resignation and quitting by teachers after they have received training sessions from CRS. They consider that to be a major loss for their school. In Aquin, each of the three school directors interviewed reported the loss of three trained teachers. Of these 9 teachers, four definitively left the teaching career and the remaining five work in different schools. According to the school directors, salary is the main reason for their departure.

All interviewed parents said that they are aware of the activities realized by CRS in the schools. They mentioned:

- School canteens
- Deworming medicines
- Health, hygiene and nutrition trainings
- Distribution of materials (desks, benches)
- Training for PTA members

Interviewees have expressed a high level of satisfaction and appreciation for the work CRS is doing.

PTA members' contributions to school development:

According to PTA members and school directors present in the focus group debates, PTA members implement numerous activities that contribute to the development of their school. Among those, PTA members

- Participate in the construction of school buildings or the rehabilitation of some rooms, by providing water, construction materials, or by working as a daily worker.
- Participate in cleaning the school.
- Assist in re-establishing discipline inside the school.
- Make sure school canteens are properly managed ensuring the quality of the meal
- Bring their contribution to the daily operations of the school canteen, such as wood/charcoal for cooking the food.
- Contribute financially to the acquisition of some materials or furniture for the schools.
- Conduct quarterly meetings with the parents.
- The school directors turn to the PTA members to encourage the parents to pay the school fees.

PTA members report to be interested in all aspects of student life and school-related activities.

At the moment PTA committees were created, their relations with the school director were somewhat tense due misconceptions one another's roles. PTA members felt they had the ultimate say and decision-making power over all aspects of school administration. The directors, however, did not feel comfortable with working with the PTA members who presented a challenge and threat to their authority over the school. . A school director admitted that initially they viewed the PTA as an embarrassing organization. Through CRS training sessions, they gradually came to an understanding with one another and the directors began to understand the importance of the PTAs. Additionally, PTA members realized that what was really needed was open and honest cooperation between themselves and the school director.

According to CRS animators, there is a major change in the integration of PTA members in school activities. Some directors even recommend refresher sessions so that they can continue to deepen this cooperation. When there is an open understanding and trust established between the community and the school staff, it allows for an increased approval and success rate of school-related projects and ensures that school infrastructure is maintained.

5.4 MCHN

MTE Phase II objectives for the MCH program were the following:

~~1.~~a. Identify the factors that motivate mothers to take their children to the rally-posts and eventually, the factors that could contribute to increasing their motivation
~~2.~~b. Understand the reasons why the percentage of pregnant women who deliver in health institutions is lower than expected in comparison with those delivering at home
~~3.~~c. Collect additional information on the food rations received by pregnant and lactating women.
~~4.~~d. Understand the reasons why women in the area of Aquin attend fewer prenatal visits than in the other areas

a. Factors that motivate mothers to take their children to the rally posts

Results from Phase I showed that children 12-24 months old are not taken to the rally posts as regularly as children less than 12 months old. This finding is more pronounced in the area of Aquin. During Phase II, focus groups were conducted to better understand what motivates mothers to take their children to the rally posts.

All mothers who were interviewed had children more than 12 months old and continued to take them to the rally posts. They report to be interested in all activities carried out at the rally post:

- *Vaccination:*
  Vaccination is reported as the most motivating activity conducted at rally posts. According to mothers, rally posts are often overcrowded with children of all age groups when vaccinations are being administered. Even mothers who do not usually take their children to the rally posts are present on those days. . By the time a child has received all his/her vaccines, many mothers stop taking their children to the rally post.
- *Weighing*
  Mothers are interested in weighing their children in order to monitor their progress. They report to be proud when the child gains weight, and when the child does not gain weight, they receive advise on how to help them to recover. The weighing seems to be more important for children less than 12 months old. Mothers explain that, at that age, children are more fragile and they can die easily from "minor" illnesses. After one year of age, there are people in the community who believe that children are more resistant to disease and that the risk of mortality has been reduced (The expression in Creole used to describe this is, "yo finn chape").
- *Education sessions*
  Mothers report to greatly appreciate the education sessions given at the rally posts because they are taught how to take care of their children and, if they are sick, the colvols give them advice. However, among the interviewed mothers, a majority had not attended education sessions the last time they had taken their child to the rally post. The reasons for not attending reported by the mothers are the following:
    - They arrived late and the education session was finished by the time they arrived. In all rally-posts, education sessions are done before all other activities take place. The colvol waits until a certain number of mothers are present to start the session. Once done, he/she continues with the other activities and the education session is not repeated.
    - They were on time but there was no education session because too many mothers came late. The colvol had started right away with the other activities. Some mothers said that their child had already been weighed at the Aquin hospital where the education session is not usually done
    - They were absent. Some had their child taken to the rally post by somebody else, for the others, their children did not go at all.
    - The waiting time in the rally post is too long; this is why some mothers are not interested in coming early. Some mothers send their children ahead of time with somebody else and come later. This is a way for them to save time since they have many things to do at home.
- *Vitamin A*
  Mothers are very conscious of the importance of Vitamin A for their children. This activity encourages them to take their children to the rally post.
- *Deworming medication*
  More children are present at the rally post when there is a distribution of deworming medication. According to the colvols, occasionally children who are completely vaccinated come to the rally posts only on the days there is a distribution of deworming medication.

Key informants and colvols validated the information provided by the mothers. In addition to the services offered, key informants and colvols reported **other factors** that motivate mothers to take their children to the rally post. Those factors are:

- Many colvols remind the mothers in the locality the day before or the day of the rally post (this is done by home visits or with a megaphone). Mothers say that this is a highly encouraging method since they have a tendency to forget the date. Moreover, when children hear the colvol making the announcement with the megaphone, even children who are old enough to understand (starting at 2 years) ask to go to the rally post. This seems to be an important means of motivation to take the oldest children to the post since mothers get pressure from them. Many colvols explain their success with that method of communication. One mother said that she likes it when the colvol comes around to remind the day of the rally post.

- *The colvols' "way of doing":* Some colvols are more patient than others and speak gently with mothers, inspiring trust. However, other colvols become angry when mothers do not understand the messages and some colvols resort to encouraging mothers by giving candy to their children.
- *The popularity of the colvols also has a positive effect*; it stimulates mothers to pay more attention to what the colvol is doing and saying. A key informant in Port a Piment reports that a colvol who is socially isolated does not have the same level of efficacy as one who is well-known around the community.
- *The level of socialization of the people in the community.* According to a key informant in Port a Piment, the more there are social activities in the locality, the more people are interested in participating in the rally post. This is the case of Baillet rally post.
- *The distance between the post and the place where mothers live.* Mothers are more encouraged to go to the rally post when it is near their home. According to some colvols in Aquin, a few rally posts are for mothers who live in the mountains; it is difficult for them to bring their children (especially in Modis, Bois Jean Ba, Nan Bel Air). According to the colvols in Port a Piment, It seems that the distance is not a problem since the longest time the mothers have to walk to go to a rally post is 20 minutes. Mothers who do not live near the rally post will only take the youngest one to the post if they have more than one child less than 5 years old. Distance is also an issue for pregnant women if they have to carry a young child.
- *Small gifts:* Many years ago, some mothers remember being given soap or cups in the rally posts. This was an effective motivation strategy.
- *Food supplements:* In Aquin, some women and colvols reported that the food supplementation program for lactating women is one of the factor motivating mothers to take their babies (less than 12 months old) to the post. For example, when there is a shortage of commodities in the center, the number of participants to come to the posts significantly decrease (for example 10 instead of 30 or 60 instead of 136). When the child gets older than 12 months, the mother is less interested in doing as much for her child especially since he has received all his vaccines and his chances of surviving are perceived as greater.
  In Port à Piment, the food supplement does not seem to be a determining factor in the motivation of the mothers. Interviewed mothers showed a real enthusiasm for the rally posts. The colvols report that mothers are highly motivated. Colvols report that some mothers refuse to take their children to the center when they are referred for nutritional recuperation because of the weight loss. Those mothers consider this as a disgrace and do not want to be seen as mothers who are not feeding their child adequately and prefer to take care of child with their own means.

According to the key informants and the colvols, mothers of children more than 12 months old need more incentive to take their children to the post. Although lack of motivation of this group of mothers is somewhat related to the fact that the program no longer provides them with a food supplement, the drop in participation is also directly linked with the perception that children who have received all their vaccinations are at less risk.

What should be improved in the rally posts?

- Mothers report that too much time is wasted when they have to wait for the latecomers for the rally post activities to begin. Some suggest weighing should begin as children arrive and that education could be done when a certain number of mothers are present. Following the education sessions, the colvol could then continue with the other activities.
- Mothers consider that the education session is done for too many people at the time. It is sometimes difficult to hear as children cry and parents talk to each other. According to key informants, colvols do not have the time to repeat the education session for different groups since they are alone to do all activities in the post.
- Key informants suggest that at the level of the rally post, the education session could be organized the same way it is organized in the mothers' club. The colvols could be trained for that and receive the same training material.
- Key informants consider that in some rally posts; there should be more people to carry out the activities. At the beginning, there was supposed to be 30 children per colvol. Now, some rally posts have more that 75. Moreover, colvols who are trained to do vaccination have additional work to do.

- Mothers say that in some posts, there are not enough seats, especially on days when vaccinations are conducted. They wish there could be more seats available. This was also reported by the key informants.
- In some posts, there is not enough shade. Mothers wish they could have a "covered" site.
- Mothers would like there to be ORT packets regularly available in the rally posts. The same suggestion was made by colvols.
- Some mothers think that children have fever after having receiving the vaccines because the "person who gave the vaccine was not patient enough". (This should be investigated in order to find out if mothers are not well informed of the side effects of vaccines or if the method used by the person who gives the vaccine should be examined).
- All groups that were interviewed would like vaccinations to be done in rally posts on a regular basis because distances to get to the health center are too long.
- Some mothers think that more demonstrations should be done in the rally-posts such as for oral rehydration salts and AK-1000.
- Many colvols believe that resuming household latrine building program would encourage mothers to come to the rally posts.

b. Why are there fewer women to deliver at the hospital than expected?

The majority of women recognize the advantages of delivering the baby in a health institution, especially for rapid care in case of an emergency. However, results of Phase I show that there are fewer women than expected that deliver in a health institution. Reasons reported during the interviews are the following:

- The distance between the home and the health institution: some women who had taken the decision to deliver in the health institution report not too have had the time to get there (delivery with too rapid progress, transportation problems).
- Conditions for delivery at the hospital:
  - Women are afraid of the delivery table that they call "ti bourik" (a Creole word for donkey). The position is not comfortable, their intimacy is not respected and they are exposed to everybody else to see. They are left without surveillance on the table and they are afraid that their baby falls when they are pushing.
  - They are scared of the episiotomies, the "scissors" as they said.
  - They cannot get the support from their spouse the way they would receive it when they deliver at home (they cannot rest their back on him)
  - They cannot deliver in the position they would like to.
  - They do not have the encouragement and assistance they get from the traditional birth attendant; they say they feel alone.
  - The delivery at the hospital is expensive: in addition to the fees for the bed, women must pay the medicines. At the Aquin hospital, it costs much more than anywhere else for the bed. They pay five times the amount requested in neighboring institutions (250 gourdes compared to 50 gourdes) and they must buy everything including the gloves for the staff. If they deliver at the hospital, they have to pay all expenses.
  - They must have nice clothes for the baby and for themselves as they would not like on-lookers to see their socio-economic status. At home, they can wear what they have without fear of being judged about their appearance.
  - The health professional staff's bed-side manner is not always good or welcoming in the health institutions.
- There are some local customs/taboos they wish to continue to respect but cannot be respected if they deliver at the hospital. These customs include:
  - Leaving the doors closed after the delivery
  - Plugging their ears during delivery. "Do not take wind" (The expression in Creole to describe this is "pa pran van"),
  - Keeping the head of the baby covered
  - Taking hot water baths with herbal leaves

Health card:
All women who were interviewed report to have their health card. It is the same card used for all deliveries, except if they do not frequent the same health institution (each health institution provides its own card).

c. Food rations received by the pregnant and lactating women

Mothers report that the rations are the same for pregnant and lactating women and the quantities are:

- 4 marmites of wheat
- 2 marmites of beans
- ½ gallon of oil

However, it might happen that the ration is slightly decreased if there are more women than expected.

According to women, rations are distributed in a very irregular manner and most of the time, this is due to disruptions in the stock. However, in addition to stock disruptions, women in Aquin report other situations where they did not receive any rations. For example, many mentioned not having received any rations because the wait for consultations is long and by the time they come back from the consultation, the time scheduled for the distribution is over (in Aquin, the distribution usually stops at noon).

d. In the area of Aquin, why are there fewer mothers to do post natal visits compared to the other areas?

During Phase I, it was noted that significantly fewer women were attending the post natal clinic than in other zones. Reasons reported by the mothers to explain that finding are the following:

- According to the colvols and key informants, the main reason is that the Aquin hospital that provides health services in the area did not have food supplements for many months; therefore, lactating women do not receive food supplements the same way they do in other institutions. Some colvols report that some lactating women go to other institutions where food supplements are available. However, according to other colvols, it is not always easy for women to receive food supplements in an institution other than the one located in their area since they do not have a reference card issued by such an institution. Although the area covered by each institution is well defined, some women confirmed having two cards from two different institutions.
- Colvols also report that some women, especially the eldest, do not attend the postnatal clinic because it is not part of their tradition. They would go only if they would have a health problem. Within a group of six women who were interviewed, none had done a post natal clinic visit since the birth of their last child. Four said that they did not have to do a post natal clinic visit since they did not have any problems, but that they continue to bring their babies for check-ups at the clinic. Some acknowledged never having heard of post natal clinics.

The reasons listed above seem to be linked to one another. If women do not feel the need to go to a post-natal clinic, there must be other factors that may encourage them to go. The food supplements seem to be a motivating element.

According to key informants, the following reasons can explain why mothers do not go to the post natal clinic in Aquin hospital:

- The increase in the cost of services: an amount of 25 gourdes is requested just to look for their file and the medication is very expensive.
- The way patients are welcomed needs some improvement

CHAPTER 6 – MTE CONCLUSIONS

6.1 MAJOR RESULTS AND RECOMMENDATIONS FOR PROGRAM OPERATIONS

6.1.a Agriculture

Results	Recommendations for Program Operations
• All 11 indicators measuring the adoption of improved agricultural techniques by farmers and perceptions of farmers on women participation in farmers' associations met the MTE target (*)	• Continue project activities as currently structured and implemented by Caritas and CRS and extend in new zones using the same program strategy

(*) Note: Had the performance benchmarks been set higher, thus making it more challenging for the farmers to pass on the indicators, weaknesses in the project may have been revealed and hence, reinforced.

6.1.b Micro credit

i) Community Credit Program

Results	Recommendations for Program Operations
Phase I: • Targets met for issues related to group management, solidarity amongst members, selection process, literacy and numeracy levels • Even though no additional money spent on food for children, less food is used from the household production and food diversity is increased because of increased access to markets • Participants in Port-à-Piment area have more difficulty to reimburse their loans **Phase II:** • All people interviewed agree that the credit conditions offered by the Caritas-CRS credit program are more advantageous that the other credit programs. However, they believe that the interest is still too high since they have to use a large part of their profit to be able to pay the interest. • In Port a Piment where participants have difficulty reimbursing their loans: - Participants acknowledged the impact of the credit program on social capital, they learn how to work as a group, the credit allowed them to meet emergency without having to borrow from loan sharks. But the credit did not help them in improving their economic situation. - *Problems encountered:* extreme poverty, obligation to use part of the loan to satisfy family obligations, lack of past business experience, no other sources of income to cover part of the monthly interest payments, Port a Piment is not active trade area. - Many women had to abandon the credit program since their profits are not sufficient to make interest payment. Some women are still paying interest on a principle they are gradually reimbursing. - *Selection criteria*: participants not selected from rally-posts, selection criteria not correctly applied. Too much disparity among group members (less solidarity).	• CRS micro-finance staff together with its partner should immediately address the findings specific to credit groups in Port-à-Piment, formulate concrete recommendations for the continuation of the program in that area, specially for participants who experience difficulties, and ensure the recommendations are rapidly applied • CRS micro-finance field staff together with their partner field staff should conduct a rapid analysis of all other micro-finance women groups (a sample in each programmatic area) to verify if no other groups are experiencing situations similar to Port a Piment • With regards to on-going groups, CRS should work closely with its partner to: - Provide in-service training to their field staff (credit officer) on a regular basis - Ensure list of participants is always up to date - Examine current conditions of payments: interest rate and loan capital - Reinforce training programs for all participants (including how bankbooks work) - Enhance the involvement of group members in the decision making process - Ensure group committees share loan management information with all group members - Involve all group members in the selection of new participants to replace those who decide to quit the group and ensure new members fulfill group criteria - Enhance the involvement of the colvol in the selection of the new members and in the overall group management - Review program strategies to ensure autonomous groups continue to receive support from the credit officer

Results	Recommendations for Program Operations
• In Aquin where many groups are "autonomous" (they have reimbursed the loan principle): - All beneficiaries acknowledged the significant improvements in their living conditions since they joined the credit program - They learn how to work as a group and to better organize themselves, can meet emergency without having to borrow from loan sharks - Payment of monthly interest is not a problem; many women are "true" business women and Aquin is an active trade area. - Reimbursement of loan principle every six months (cycle) is the most difficult issue. To be able to reimburse the loan principle, they sell part of their products or an animal (if they have other small business) or borrow from friends. If all group members bring back their money on the same day, it is returned to them on the same day. If any participant does not return part of the loan, no one in the group receives their new loan. This strategy unduly penalizes those who have made sacrifices to bring back their money. - *Selection criteria:* No problem at the beginning, most participants selected from rally-posts using participation/credibility criteria. Problems arose when members started to quit the program and replacement process was not well defined (not from same community and group not consulted). Reimbursement problems often with those new members. • More food for young children: - *Aquin*: even though, no additional money is spent on food for children, less food is used from the household production and food diversity is increased because of increased access to markets - *Port a Piment*: credit did not directly contribute to better child feeding but women report dipping in their business inventory to feed their children. • Recommendations made by participants/key informants: - Review and apply participant selection criteria (credibility, authentic business women, same background) - All credit program participants should receive training on marketing issues to better identify their type of business - Decrease the interest rates - No requirement to reimburse the principle at the end of each cycle - More training and support from the credit officer - The whole group and the community colvol should be consulted when a member must be replaced - Management issues: bank book should be in the hands of the group and not the credit officer, information on bank transactions should be shared with the whole group (not only the committee), credit officer should continue to support "autonomous" groups, review the role of the committee (the group is kept out of the decision-making process) - In Port a Piment (not a commercial area), micro-credit loan could be used for small food processing projects	• With regards to new groups, CRS should work closely with its partner to: - Limit micro-credit programs to areas with active trade activities - Ensure guidelines for receiving credit are being correctly applied; types of investment, and past business experience are essential criteria - Ensure credit participants attend training on business development and training before receiving the loan - Apply all recommendations made for the on-going groups (listed above) • Partner's capacity building: - CRS staff should pursue and reinforce partner's capacity building on management of micro-finance programs - CRS micro-finance staff should increase supervision visits at the field level • Overall program strategies: - Based on the overall MTE findings and the above recommendations, CRS micro-finance staff, together with regional micro-finance advisors, local micro-finance partners and other micro-finance institutions should examine the current loan management conditions in the CRS micro-finance program (interest rates, reimbursement of the loan principle, types of business, length of the cycle) and make recommendations for potential changes that would allow better loan conditions for program participants leading to increased profit, thus contributing to the improvement of the overall socio-economic conditions in the DAP targeted areas.

ii) Colvol (Community Health Workers) Credit Program

Results	Recommendations for Program Operations
Phase I: • Targets met in issues related to loan management, group solidarity and credit program being an incentive for their work as a CHW • CHWs have more money to spend on things such as clothing, medical care and school fees but do not spend more money on food than before they received their loan **Phase II:** • Credit program management: colvols express concerns with CRS' decision to change the management from CRS to its partner, Caritas. Change will be at their disadvantage since interests will be returned to Caritas and they would have to reimburse the loan principle at the end of each cycle. For many years, Colvols have been managing their credit fund themselves under CRS supervision; the interest was reinvested in their loan. With the change of management, many colvols started paying the existing loans and plan on discontinuing their participation in the credit program. • Advantages of the credit program for the colvol: the credit program helped significantly improve colvols' living conditions, quality of life and self-esteem. • Impact of the credit program as an incentive for Colvol participation in MCHN activities: the credit program encourages the colvols to do their best in participating in the very demanding work expected of them in the MCHN program. The credit represents a small compensation for the volunteer services they provide to their communities. The colvol is the link between the hospital and the community and the most important worker in the health system. Key informants report that the health center's success is directly related to the colvols' presence. • Other elements to motivate the colvols: more training, learn how to give vaccines, have access to first aid kit, stretcher to transport urgent cases. Other benefits such as special rate for health services, identification badge, participate in large meetings of colvols from different centers to exchange ideas and share experiences.	• CRS programming team should immediately reconsider the decision of transferring the colvol micro-credit program to Caritas. CRS should first meet with the colvols (not only the committees), evaluate the success and weaknesses of their credit program and propose strategies that will benefit the colvols without negatively affecting their important volunteer work in their community. The micro-credit loan is an incentive for the colvols who are the core strength of the MCHN program. All important decisions and/or significant changes in the micro-credit program should be analyzed by the micro-finance team together with the MCH team. Meetings with colvols should be done for many groups at the same time to give them the opportunity to share ideas and experiences. • The MCH team should promote and organize (annual) regional meetings of colvols from different health centers to discuss issues that affect them, exchange ideas and share experiences. • The MCH team, in collaboration with the MOH staff, should continue to train more colvols in the administration of vaccines and analyze other strategies suggested by the colvols to increase their motivation. Small project proposals and diversification of health sector funding sources could support some of those special requests suggested by the colvols.

6.1.c Water and Sanitation

Results	Recommendations for Program Operations
Phase I: • School cisterns met all targets for condition and maintenance • Mixed results for school latrines: met targets for cleanliness but failed for some maintenance issues (doors closed, seat covers) • Capped springs: target met in 16 out the 20 indicators measuring the quality and maintenance of water points and fountain areas; positive efforts made for the reforestation of spring surroundings and behavior change associated with the capped spring	School latrines • Ensure all latrines follow construction standards set by CRS water and sanitation team, with special attention to functional locks on the doors, cover on the latrine seat and locks from the inside • Reinforce those aspects during training of PTAs and other local partners implementing water and sanitation projects • Reinforce school structure responsible for maintenance of school latrines

Results	Recommendations for Program Operations
Phase II: • Maintenance problems observed in school latrines not related to misunderstanding between PTA and school management staff but to lack of information and slight negligence	Capped springs: • Reinforce the importance of maintaining the spring area clean and keeping the drainage canals clear. Include those topics in the training targeting water committees, CHWs and rally post participants – for new spring cappings and for previously built systems.

6.1.d. Education

Results	Recommendations for Program Operations
Phase I: • PTA committee member: All four indicators measuring participation in school activities met the targets in four SAs • School director: Two indicators related to participation in managerial training met the benchmarks. Participation in Health, Hygiene and Nutrition training did not pass in one new SA where directors might not have yet received such training • School teacher: Two indicators related to participation in pedagogical training met the benchmarks. Participation in Health, Hygiene and Nutrition training did not pass in one new SA where directors might not have yet received such training • Female and male students: All indicators related to school canteen were met **Phase II:** • Causes of school dropout: primary cause associated with lack of financial means (increase in school fees and cost of living)– student returned home because of non-payment of school fees and periodic suspensions/ absences often leads to complete school drop out. • Use and assessment of training materials provided by CRS: high level of satisfaction with CRS work expressed by teachers, directors and PTA members. Number of pedagogical boards per school is insufficient. High rates of resignation of teachers after they received training sessions (transfer to other schools for salary issue). • PTA contribution to school development: through CRS training sessions, PTA and school directors gradually came to understanding with one another. PTA member implement numerous activities that contribute to the development of their school.	• Share Phase II results with field staff and partners: issues of school dropout because of non-payment of school fees and transfer of teachers who have received CRS training to non-CRS supported schools. • Include those issues for discussions in community meetings with PTAs, and federation of PTAs to propose concrete plans to address those issues at the school and community levels. • Emphasize advocacy training for PTAs and federation of PTAs and assist them in their fundraising efforts for community education activities.

6.1.e. MCHN

Results	Recommendations for Program Operations
Phase I: Breast feeding and Infant feeding practices: • Targets met for: giving only breast milk on day of birth and breastfeeding their infant within one hour of birth • Targets not met for: giving colostrum to infants, providing the adequate number of daily complementary feeds to children between 6 and 24 months; and providing children 6-24 months with the appropriate dietary diversity	Infant feeding practices: • The adoption of these practices (giving colostrum to infants, provide adequate number of daily complementary feeds to children between 6 and 24 months, and providing children 6-24 months with the appropriate dietary diversity) is crucial to reducing malnutrition rates and CRS should strive to better understand the constraints that may impede mothers from adopting those important practices and emphasize those practices in training of CHWs and health staff and in education sessions to caregivers
Diarrhea and diarrhea management: • Three aged groups failed the target on % without diarrhea in last two weeks • Most of the SAs passed the benchmark and the weighted average on diarrhea management but unequal performance levels across the SAs (37% children given ORS during diarrhea at the time of baseline and 60% at MTE)	Diarrhea and diarrhea management: • Should continue to emphasize the BCC messages on the importance of applying simultaneously all three components of appropriate treatment of diarrhea: ORS, increased liquids and same or more food
Health cards, Child Immunization and Vitamin A supplementation: • Thanks to joint action between CRS and the Ministry of Health, all targets met for all age groups for all indicators	
Pre-natal and Post natal Care: • Targets met for indicators dealing with immunization during pregnancy, the number of prenatal visits, the prenatal visit with trained provider before the third trimester of pregnancy and the postnatal visit within 45 days of delivery • Fewer mothers attend postnatal visits in the area of Aquin compared to other areas. Results of **Phase II** show that women in Aquin did not attend postnatal clinic because there was a disruption in food supplements for many months. Colvols report that youngest women attend the postnatal clinic more than the older women. • Results more successful for mothers of younger children: recent exposure might be associated with better performance (95.6% of mothers of children 0-6 months of age who received prenatal visit with trained provider before third trimester of pregnancy) • Target (35%) not met for mothers who gave birth in a health facility. Reasons reported not to deliver in a health institution (**Phase II):** distance too long between home and health center, not in agreement with some conditions for delivery at hospital (such as fear of delivery table, fees too high, nice clothes not available, no respect of local customs….)	Postnatal visits in Aquin: The MCHN team should ensure that the management staff in Aquin hospital implement program activities according to the norms and procedures. Delivery in health institution: share results of Phase II with hospital health staff, include those topics in health staff training and discuss concrete changes to improve the environment when women give birth in a health facility.
Participation in program activities: • Participation in rally-posts: participation of children and mothers met the benchmark in three SAs except in the area of Aquin and Grande Anse Factors that motivate mothers to take their children to the rally-posts (**Phase II**): vaccination, weighing, education	Participation in program activities: • Vaccination being the most important motivating factor for mothers to participate in the rally-post, CRS MCHN team should continue to support MCHN centers with strategies to increase vaccination activities in the rally-posts

Results	Recommendations for Program Operations
session, Vitamin A, deworming medicines, reminder by the colvol, colvol's "way of doing", popularity of the colvol, distance between post and household. Lack of motivation of mothers of children 12-24 months directly linked with the perception that children who have completed their vaccinations are at less risk. • Participation in mothers' clubs: All SAs passed the benchmark of 25% (40.2% among the youngest group) • Perceptions of mothers about CHWs' knowledge and skills: for mothers of children 0-6 and 6-12 months old, all of the SAs met the targets on five indicators; the area of Port a Piment, Roche a Bateau and Coteaux did not pass the target for 12-24 months old for the communication on the child's weight	• CRS staff and CHWs should emphasize the issue that children older than 12 months are still at risk and mothers should continue to take them to the rally posts • Recommendations from mothers in Aquin (Phase II-qualitative) to improve the rally-posts: reorganize and improve the logistics in rally posts to avoid mothers waiting too long; conduct education sessions for smaller groups to facilitate better participation
Food Supplementation Program during Pregnancy and after childbirth: • 82.5%, 100% and 72.5% of mothers (children 0-16, 6-12 and 12-24) received food supplements during their last pregnancy (note that the sampling was done at the population level) • Results on the "regularity" of food supplementation during pregnancy and after childbirth did not meet the expected targets • Food rations (**Phase II)**: mothers report receiving the correct amount of commodities. Irregularity due to disruptions in the stock is the major problem.	Food supplementation during Pregnancy and after childbirth: • CRS MCHN staff and Commodity Management Office should analyze issues of regularity of food deliveries and propose solutions to improve the situation
Knowledge, skills and participation of Community Health Workers: • All CHWs passed the benchmarks on five indicators measuring their perceptions of knowledge except for their ability to provide immunization • Results on their technical knowledge were mixed: passed on immunization and diarrhea management and ORT but did not pass on some infant feeding issues such as the number of times a on-year-old child should be fed each day and the criteria reference for malnourished children (note that the benchmark had been set at 95%) • CHWs in both SAs cleared the 75% benchmark for completion and submission of rally posts reports and 85% for participating in the monthly continuing education session	Knowledge, skills and participation of Community Health Workers: • Address critical gaps in CHWs knowledge via monthly continuing education sessions and formal refresher training courses • Use LQAS to monitor CHW's levels of knowledge in various SAs on a regular basis and after refresher training courses • Ensure CHWs have materials they need to carry out their responsibilities properly
Hand washing knowledge and techniques: • Safety Net program participants most knowledgeable on hand washing techniques, followed by the Education program and mothers participating in the MCHN program. CHWs met the targets for three indicators and failed on three. • "After using the toilet" and before eating" messages met the target but the indicator "before feeding children" failed in all groups • Correct hand washing techniques: all four groups in Safety Net program passed, some Education groups passed (school children did not pass), and all three groups of mothers failed to pass for the international method of hand washing techniques	Hand washing knowledge and techniques • Messages on hand washing should be reinforced in all programs, but specially so in the MCHN program for CHWs and mothers (improvements in hygiene behavior may present an opportunity for better child nutrition and health outcomes) • A standardization of messages across programs could be instrumental in improving hand washing knowledge and techniques

6.1.f. HIV/AIDS

Results	Recommendations for Program Operations
Safety Net Institutions with HI/AIDS training and with no HIV/AIDS training (management staff and children): • Both groups passed and failed same benchmarks on knowledge on "means of transmission" • Both groups have fairly good perception of "personal risk" • Both groups met the targets on "stigma and discrimination" Schools (PTA member, School director, Teacher, Female and Male children): • All three groups met targets on commonly known ways of avoiding HIV/AIDS transmission, on general knowledge of HIV/AIDS and notions of Personal risks and stigma and discrimination	• Transmission messages should be reinforced and expand upon the public health messages that are currently being spread by the media • Discrimination and stigmatization issues must be addressed with the youngest program participants in order to contribute to improved conditions for PLWA on the societal level • Reinforce the technical capacity of the local partner that are providing training to enable them to provide better quality training to the communities

6.1.g. Safety Net

Results	Recommendations for Program Operations
Indicators used as "baseline" • Management and staff can name 2 or more universal rights of children • Some centers failed to meet the benchmarks for cleanliness (kitchen area, toilets/latrines) (*) • Centers did not pass the 70% benchmark for % of centers without food shortages in the center canteen in the last months • Center staff met the target on maintenance of financial ledger • Both groups of female children met the targets on" going to school, having a birth certificate, having eaten a CRS supplied food and something other than a CRS supplied food in the last 24 hours	• Strengthen Health, Hygiene and Nutrition training in Safety Net institutions to underscore the critical links between cleanliness and good health • Create a checklist of regular cleaning tasks for centers' staff • Include cleanliness indicators in the supervision visits of CRS Safety net staff

* Note: indicators relating to centers' cleanliness should have been set higher (the MTE benchmark was 50%)

6.1.h. Civic Education

Results	Recommendations for Program Operations
13 indicators measured on 11 groups (from above programs) as baseline information: • Expected performance benchmarks were different for all groups and depended upon the perceived or verified levels of community and civic involvement, education levels and past CRS interventions with specific target groups • School directors passed all 13 questions	• Design civic education training programs that speak to the needs and constraints of each target group; particularly mothers, CHWs, PTA members and school teachers

6.2. Conclusion for Methodology Development

The FANTA team was very satisfied with the overall undertaking. As a pilot study, it confirmed LQAS's potential for the conduct of mid term evaluations; and highlighted the usefulness of the qualitative research in Phase II. However, several lessons were learned that should be applied in future such applications.

Phase I (LQAS Surveys)

- The entire exercise consists in evaluating whether progress made corresponds to that expected. To do so, one must assume that LOA objectives are reasonable to start with. That, however, can be problematic: for many indicators we simply don't know how much improvement can be achieved in a given time frame; and a program's objectives (mid term and LOA) can easily be set too high, or too low. When interpreting results, the analyst should be wary of this and always ask whether initial objectives were too ambitious, or too modest. If need be, targets can be adjusted in light of the findings from the mid-term.
- Unlike final evaluations, the MTE focuses on beneficiaries, not on the population at large (unless they are one and the same). Because of this, MTE results may be far higher than LOA results, especially where a program is effective in changing outcomes among beneficiaries. The benchmarks might therefore be different, arguably, at those two time points. The interpretation of results should also be clear about whom inferences are made.
- A tension exists between the amount of detail to be provided by the evaluation, and the cost of collecting and analyzing the data. Two factors in particular play in this: (i) what questions should be asked; and (ii) who should answer them. On the first point, the M&E Officer must guard against overloading a survey with questions that do not lead to implementation recommendations. The preference is to concentrate on effect indicators. The inclusion of "lower" level indicators (outputs, processes) should be considered only when this information is (a) not readily available from other sources (e.g. the IPTT); and (b) considered essential to the project's functioning. On the second point, the multiplication of strata (e.g. teachers by grade; or mothers by age group of their child) rapidly leads to sample inflation, denying the benefits of LQAS. Here again, the M&E officer should exert caution so that the cost of using LQAS in the end does not exceed that of other methods (e.g. a 30x30 cluster survey). A few principles to apply here are: (a) define a new sample group only if this group is a particular target for the program; (b) consider parallel sampling if this is possible; (c) recall that SAs are themselves a stratifying device; if, say, 4 SAs are considered, defining any new group will add four new samples of n=19 (or whatever the sample size is) for interviews.

Lessons learned from Phase II (Qualitative research):

- The experience and quality of the qualitative study field staff is critical to its success. Contrary to common belief, qualitative research cannot be improvised. The person doing the data collection needs a strong sense of the objectives of the study so he/she can orient the discussion towards key problems and resolve those as they emerge. This person also needs to organize the materials in a way that explores and interprets the problem with objectivity, rather than simply narrates the findings. Such skills cannot be improvised and a specialist should be hired to do this piece of the work.
- Selecting the site for carrying out the qualitative research is critical to the findings. Unlike in Phase I where the selection of respondents is done in a random fashion, the selection of respondents for Phase II is purposive. It should focus on sites and population groups that were found to display the problem. If several groups/sites are found to fail, they should be also visited, as the reasons for failing may differ across context, and the richness of the interpretation will be enhanced by the diversity of findings.

APPENDIX 1

CRS/HAITI DAP Program Objectives

Program Goal:

To sustainably reduce the level of food insecurity in vulnerable communities of the Southern Peninsula with a focus in the South and Grande-Anse Departments.

To achieve this goal, CRS/Haiti will address four major sectors of interventions:

- ***Health and Nutrition comprised of three sub-sectors: Maternal and Child Health (MCH), HIV/AIDS and Water/Sanitation with complementary micro-enterprise activities to achieve objectives of food security***
- ***Agriculture***
- ***Education***
- ***Humanitarian Assistance***

Strategic Objective One (Health and Nutrition):

A. To improve the health and nutritional status of children under five, pregnant and lactating women by 2006

Intermediate Results:

1.1 Increased nutritional status of children 0-59 months in the project zone by 5% points above the baseline for height/age by 2006

Health activities :

- Growth Monitoring
- Screening at rally posts
- Food supplementation to malnourished children 6-59 months
- Training Community Health Workers (Colvols) in nutritional surveillance, participatory learning, adult education
- Technical assistance and supervision of Colvols
- Distribution growth chart/plastic covers to caregivers of 0-59 months.
- Support UCS development in referral system.
- Education/ training and support to health providers and communities for case management of severe malnutrition.

Micro-credit activities

- Targeting 1,800 new female clients in rally post; structure them in 300 community banks of 30 women each.
- Technical assistance in group animation/ organization and financial management of community banks
- Literacy and numeracy training in financial management to members of savings/credit groups
- Fund 60 community banks; Village banking: each group receives a collective loan from partner institutions, each client receives an individual loan from the committee for a 4-6 months credit cycle
- Financial/technical assistance to current beneficiaries of last DAP.
- Train in financial management for partner institutions.
- Implement of MAGI (Microfinance Alliance for Global Impact) Accreditation System for

monitoring Partner Institutions.

1.2 Increased availability and accessibility to quality health and nutrition services shown by increase in service use by 25% over the baseline

Health activities :

- Support and supervise rally posts
- Food supplementation to pregnant and lactating mothers in 26 heath facilities
- Training health providers in quality pre, peri and postnatal services
- Training Agent de Santé, Colvols in vaccination, deworming, ORT, Vitamin A distribution,
- Census of project zone and maintenance of census
- Support to UCS in vaccination coverage strategies
- Support to UCS in quality of care supervision of PR and Primary Care health facility.
- Support social marketing of ORT.
- Support UCS in management of stock (ie vitamin A, Iron-Folic pills and vaccines)
- Support to UCS in management of Health Information Systems
- Train Colvol in participatory education techniques and community maternal/child health
- Train and equip TBAs (matrons).
- Forum/meetings to discuss project strategies and progress.

Micro-credit activities :

- Target 2,400 CHWs attached to 58 health facilities in FY02 (900 in 18 health facilities in FY06).
- Organize them in groups and determine with them appropriate and profitable activities in which they can invest their credit funds.
- Train members of CHW micro-finance committees in financial management, group organization and animation.
- Financial and technical assistance to current beneficiaries of the last DAP.
- Annual forums, working meetings, and exchange visit to allow CHW groups to share experiences and address weaknesses.

1.3 Increased good health and nutrition knowledge, attitudes and practices of caregivers and communities by 25% over the baseline by 2006.

Activities

- Participatory Learning and Action methodology used for community management of malnutrition
- Adult education both at rally post and health facilities
- Ti-foyer
- Positive-deviant mothers peer educators.
- Support Social marketing of ORT activities.
- Development and/or reproduction of educational materials
- Support UCS in supervision of Colvols, and health service providers
- Pilot study on postitive deviant mothers and their feeding practices
- *Education (including food demonstrations)*

1.4 Increased availability and utilization of potable water in 50 schools and 75 communities and sanitation facilities in 50 schools/orphanages

Activities

- Participatory Leaning and Action methodology used to involve communities in community, family and personal hygiene.
- Construction of 75 capping springs
- Construction of 50 cisterns
- Construction of 50 compartment latrines in schools
- Education and maintenance follow up via latrine and water point committees.
- Construction of incinerators in 24 health facilities

- Training of staff at health facility in medical waste management

1.5 Increased food security (food availability, social network support and income access) of persons infected with HIV and PLWA by 2006 (majority of activities are non-DAP funded)

Activities

- Research and qualitative study on implementing IGA activities with PLWA.
- Income generating activities (IGA) with the caregivers of children of PLWA (including, training in IGA, access to credit)
- Community qualitative activities using PLA methodology to strengthen community support to PLWAs and their families.
- Form and train Peer Leader Groups to assist PLWA and their families and in HIV prevention
- Train # of health facility service providers in HIV and AID counseling.
- Coordinate with other national and international movements in support of PLWA.
- Food supplementation to PLWA and their families.
- Development or reproduction of appropriate IEC materials to support education sessions

Strategic Objective Two (Agriculture):

B. To increase access to food for 1,500 small holder farming families in targeted food insecure areas by 2006.

Intermediate Results:

2.1 Increased availability of bean and plantain for 1,500 families on 375 hectares of hillside land through biological soil conservation/fertility recovery methods and provision of improved seeds

Activities

- Acquisition and planting of 30,000 fruit and wood trees
- Implementation of natural resource management practices (live structures, organic fertilization, tree planting, grafting, soil preparation) on 375 hectares of hillside land
- Establishment of 3 revolving funds for distribution of 1,500 loans of bean seeds and plantain cuttings to plant on 375 hectares
- Reimbursement of loans
- Provision of training, management and extension services to farmers

2.2 Improved revenue and availability of animal proteins for 1,500 families through chicken and pig raising

Activities

- Order, purchase and distribution of 4,500 improved chickens to 1,500 farmers
- Order, purchase and distribution of 1,500 improved mature pig breeders to 1,500 farmers
- Establishment of a credit fund for supply to farmers with chicken food and pig food
- Provision of health, training and extension services to farmers

2.2 Increased revenue generated by assisted commercialization of two agricultural products by 1,500 families

Activities

- Identification of markets for crop commercialization
- Implementation of an economic survey
- Constitution and training of 3 pre-cooperatives

- Facilitation of products and facilitation between pre-cooperatives and identified buyers

Strategic Objective Three (Education):

C. To improve educational progress among primary school children in targeted zones and ensure structures are in place to address education needs in de-targeted zones

Intermediate results:

3.1 Sustainability: By the end of the DAP, 60% of phase out communities will have been engaged in at least two basic school support activities for two consecutive years after CRS withdraws

Phase out strategy
Participatory learning and Action training
Civic Education training
Support in development and implementation of small projects in support to schools

3.2 Access: 10% increase in access to quality education (gross attendance rate) in 157 schools

School Feeding
- Daily school-feeding
- Distribution of cook stoves in selected schools
  - Training of kitchen staff

Health, Hygiene and Nutrition Activities (DAP funded)
- Latrine building, cisterns and potable water.
- Health Education for pupils, including STD and HIV/AIDS awareness (last 3 years of program)
- PTAs training on Health/Hygiene and Nutrition
- Support for Health Days
- Distribution of de-worming medicine (non-DAP funded).

Support to Parents Teachers' Associations (non-DAP funded)
- Civic education training
- Training in Participatory Learning Action (PLA)
- Support to PTAs Forums (locality, district, department levels) and Federations for PTA motivation and experience sharing, contributing to their sustainability
- Sensibilization to respect performance contracts clauses
- Training on fundraising and small projects management for PTA in the targeted zones.
- Support in development and implementation of small projects in support to schools

3.3 PROGRESS: 20% increase in educational progress (cohort survival rate at grade 5 in FAE program Schools (from 55% MENJS/Ministry of Education data)

Quality of Education Package (non-DAP funded):
- Distribution of MENJS Curriculum and training of teachers
- Distribution of MENJS Guide Pratique d'Administration Scolaire and training of School Management staff
- Teaching staff training in specific teaching tools and techniques, using Ed2004 Teaching Curriculum and other materials
- Distribution of teaching aid material
- Distribution of distance education materials
- Coordination with radio station for program broad casting, and monitoring of distance

learning

Strategic Objective Four (Social Assistance):

D. To increase access to food for 17,500 highly vulnerable children and adults living or receiving care in Social Safety Net Institutions (SSNI) and hospitals by 2006.

Intermediate Results:

4.1 **Increased access to food for orphans, abandoned and street children cared for by Social Safety Net Institutions (SSNI) and for the physically and mentally disabled, and the chronically ill and aged persons cared for in hospitals and SSNI.**

Activities

- Food delivery to 65 children shelters on a quarterly basis
- Food delivery to 50 hospitals and nursing homes
- Food monitoring by program staff and CMO staff

4.2 **Increased access to formal education/vocational instruction for institutionalized children; including AIDS education.**

Activities

- Non-formal and formal educational opportunities to OCF centers as main criterion for participation
- Improvement quality environment : building cisterns and latrines
- Civic education for OCF directors

4.3 **Increased "children's shelters" managerial capacity through training, to improve the quality of services provided and to become more sustainable.**

Activities

- Training in small project design and implementation for centers directors
- Funds for Income-generating activities(DAP and private sources)
- Coordination with donors for support to institutions

4.4 ***Upgraded sanitary/safety conditions of "children's shelters".***

Activities

- Infrastructure projects: latrines, toilets, other sanitary improvements

EARLY WARNING SYSTEM:

During the 96-01 DAP, CRS had put in place an EWS. This system, which was temporarily closed due to limited resources and the lack of interest at the national level, was launched again with this new FY02-06 DAP in collaboration with the four CSs supported by the DAP (CARE/CRS/Save the Children/World Vision) and the National Council for Food Security (CNSA). The system is coordinated by the CRS/Agriculture Program and collects information on indicators selected by all CSs. After having conducted a pilot experiment in four localities of the South Coast during FY02 and FY03, CRS expanded the EWS in 3 additional DAP targeted areas. The system collects information on indicators selected by all CSs. Major indicators are rainfall and prices for charcoal and basic food stuff in local markets. Nutritional indicators (prevalence of severe malnutrition, new cases of Kwashiorkor) are also compiled from the health institutions located in the same agro-ecological zones selected for the EWS.

AREAS OF INTERVENTION (FY 02/03/04)

PROGRAM	SOUTH	GRANDE ANSE	NIPPES	SOUTH-EAST	WEST
MCHN				Côtes de Fer only	
TB/HIV/AIDS (food supplement)				Jacmel area	
WATER/SANITATION				Côtes de Fer area	
CREDIT			Through partners	Through partners	Through partners
AGRICULTURE (new program in DAP)					
FOOD ASSISTED EDUCATION				Côtes de Fer area	
SAFETY NET				Jacmel area	

Continuing FY2003 Phased out end at the end of FY2002

APPENDIX 2
TABLE OF INDICATORS AND SAMPLING GROUPS
CRS/FANTA DAP MID-TERM EVALUATION

AGRICULTURE INDICATORS *(p. 1 of 1)*	**BL Value**	**LOA target**	**MTE target**	**Farm (Observation)**	**Farmers**
Land Characteristics					
Percent of farm association members that have a dry and cool place for seed storage	n/a	90%	80%	√	
Percent of farm association member plots that use either green fertilizer or compost	n/a	80%	70%	√	
Percent of plots visited that use Level A/courbe de niveau techniques	n/a	90%	75%	√	
Percent of farm association members that planted beans in the plot of land used for CRS activities	n/a	95%	90%	√	
Percent of farm association member plots that use/used the promoted planting density for beans	n/a	80%	60%	√	(√)
Percent of farm association member plots that use the promoted planting density for plantains	n/a	80%	60%	√	
Percent of farm association member plots with one or more recommended anti-erosion systems (“ramp pay”, “clayonnage”, or live barrier)	n/a	90%	80%	√	
Percent of farm association member plots visited with one or more anti-erosion systems in place (“ramp pay”, “clayonnage”, or live barrier)	n/a	90%	75%	√	
Percent of farm association member plots that have at least 50 trees planted on them	n/a	60%	40%	√	
Gender issues within farmers’ associations					
Percent farm association members that report the inclusion of women was a guiding principle in the formation of their association	n/a	95%	90%		√
Percent of farm association members that think that women should be allowed membership in the groupement	n/a	90%	80%		√
Percent farm association members that can state one concrete benefit for the active involvement and membership of women	n/a	90%	80%		√

CREDIT – WOMEN/PARTICIPANT *(p. 1 of 1)*	BL Value	LOA target	MTE target	Credit-Part.
Participation in rally-posts				
Percent of credit participants who participated in a rally post before they joined the credit program	n/a		70%	√
Percent of credit participants who have participated in a Rally Post since they joined the credit program	n/a		50%	√
Percent of credit participants who have children less than 5 years old	n/a		70%	√
Selection process				
Percent of credit participants who feel the selection process for receiving micro-credit loans is fair and democratic	n/a		75%	√
Percent of credit participants who feel that the Steering Committee was selected in a fair and democratic manner	n/a		80%	√
Management of loans				
Percent of credit participants who would like to continue in the micro-credit program	n/a		85%	√
Percent of credit participants who think they are capable of managing their loan well	n/a		70%	√
Percent of credit participants who think they are capable of managing their business efficiently	n/a		60%	√
Percent of credit participants who made a profit from their business activities last month	n/a		80%	√
Percent of credit participants who have never had a problem paying any of the monthly loan payments	n/a		80%	√
Group Solidarity				
Percent of credit participants whose group has assisted a fellow group member when s/he had a problem paying back her/his loan	n/a		35%	√
Percent of credit participants who think that their group's Steering Committee does a good job managing the micro-credit program	n/a		80%	√
Literacy/Numeracy/Understanding Bank Books				
Percent of credit participants who know how to sign their name	n/a		30%	√
Percent of credit participants who feel confident in their addition and subtraction skills	n/a		30%	√
Percent of credit participants who report not having any difficulty in understanding how their bank book works	n/a		85%	√
Percent of credit participants who have read the financial agreement that they signed with the steering committee of the group in order to get their loan	n/a		20%	√
Changes in Household Wealth				
Percent of credit participants who never had to borrow money from another source since they received their loan	n/a		65%	√
Percent of credit participants who spend more money on food than before they received their loan	n/a		75%	√
Percent of credit participants who feel they have more money now to spend on things such as clothing, medical care and school fees/costs than before they received their loan	n/a		70%	√
Percent of credit participants who think that the amount of their loan was enough to improve their business activities as they would have liked	n/a		50%	√
Percent of credit participants whose school aged children all go to school	n/a		60%	√
Percent of credit participants whose school aged children were all going to school before they joined the credit	n/a		40%	√

program				

CREDIT – COLVOLs *(p. 1 of 1)*	**BL Value**	**LOA target**	**MTE target**	**Colvol**
Management of their loan				
Percent of Colvols who think they are capable of managing their loan well	n/a	90%	75%	√
Percent of colvols who think they are capable of managing their business activities efficiently	n/a	85%	75%	√
Percent of Colvols who made a profit from their business activities last month	n/a	70%	60%	√
Percent of Colvols who have never had a problem paying any monthly loan payments	n/a		70%	√
Group solidarity				
Percent of Colvols whose group assisted a fellow group member when s/he had a problem paying back their loan	n/a	50%	40%	√
Changes in Household Wealth				
Percent of Colvols who have never borrowed money from another source since their received their loan	n/a		60%	√
Percent of Colvols who state that they spend more money on food than they did before they received their loan	n/a	85%	80%	√
Percent of Colvols who feel they have more money now to spend on such things as clothing, medical care, and school fees/costs than before they received their loan	n/a	65%	60%	√
Percent of colvols who think that the amount of their loan was enough to improve their business activities as they would have liked	n/a	60%	50%	√
Percent of Colvols whose school-aged children all go to school	n/a	85%	80%	√
Percent of Colvols whose school aged children all went to school before they received their loan	n/a		65%	√
Credit program as an incentive to work as CHWs				
Percent of Colvols who think that the micro credit loan program is an incentive for them to work as a Colvol	n/a		50%	√
Percent of Colvols who report that they would continue to work as a Colvol even without the micro-credit program	n/a		60%	√

WATER and SANITATION – CISTERNS *(p. 1 of 2)*	BL Value	LOA target	MTE target	Cisterns	
				Observation	School Administrator
Percent of cisterns with walls intact	n/a	90%	70%	√	
Percent of cisterns without standing water	n/a	90%	80%	√	
Percent of cistern faucets equipped with a handle	n/a	95%	90%	√	√
Percent of cisterns without a leak/drip	n/a	90%	70%	√	√
Percent of cisterns with water flowing from the faucet	n/a	90%	70%	√	√
Percent of wash basins without garbage or debris	n/a	85%	65%	√	
Percent of wash basins without animal feces within 10 meters	n/a	85%	65%	√	

WATER and SANITATION - LATRINES	BL Value	LOA target	MTE target	Latrines	
				Observation	Student
Percent of latrines found to be clean (no trash lying on the floor, no feces visible)	n/a	75%	60%	√	
Per cent of latrines free of visible soiled toilet paper or other used paper	n/a	75%	60%	√	
Percent of latrines visited where all latrine doors were closed upon arrival	n/a	75%	60%	√	
Percent of latrines with functioning doors	n/a	95%	80%	√	
Percent of latrines with doors equipped with working inside locks	n/a	85%	65%	√	
Percent of latrines with seat covers in all stalls	n/a	75%	60%	√	√
Percent of latrines with all latrine covers down	n/a	75%	50%	√	
Percent of latrines that had at least one broom available	n/a	75%	40%	√	
Percent of latrines located at an appropriate distance from water source	n/a	90%	70%	√	
Percent of latrines located at an appropriate distance from the school	n/a	95%	70%	√	√
Percent of schools with very little garbage lying around	n/a	80%	70%	√	
Percent of schools where the garbage disposal is used	n/a	90%	80%	√	

WATER and SANITATION – TRASH DISPOSAL	BL Value	LOA target	MTE target	Schools	
				Observation	Student
Percent of sites with trash can easily accessible to school children	n/a	95%	80%	√	
Percent of schools without garbage lying around	n/a	85%	70%	√	
Percent of trash disposal areas with acceptable levels of garbage in them *where the level of trash in the garbage pit was below the level of the ground or surrounding wall)	n/a	85%	70%	√	

WATER and SANITATION – SPRING CAPPING *(p.2 of 2)*	BL Value	LOA target	MTE target	Capped Spring	
				Observation	Community Member
Spring capping area					
Percent of spring capping free of garbage or debris	n/a	75%	65%	√	
Percent of spring capping will walls intact	n/a	85%	70%	√	
Percent of spring capping covered by lid	n/a	85%	70%	√	
Percent of spring capping with lid firmly in place	n/a	85%	70%	√	
Percent of spring capping surrounded by a canal on three sides	n/a	85%	70%	√	
Percent of spring capping canals that are at least 20cm deep	n/a	85%	70%	√	
Percent of spring capping with front area free of standing water	n/a	95%	80%	√	
Percent of spring capping surroundings protected by vegetation	n/a	80%	50%	√	
Water point/fountain area					
Percent of water point/fountain free of garbage or debris	n/a	75%	65%	√	
Percent of water point/fountain surroundings free of standing water	n/a	90%	80%	√	
Percent of water point faucet or fountain pipe with water flowing	n/a	85%	75%	√	
Percent of water point/fountain where there are no animals within 5 meters	n/a	90%	80%	√	
Percent of water point/fountain where there are no animals feces within 5 meters	n/a	90%	80%	√	
Percent of communities with a spring capping that have a committee to manage the system	n/a	80%	65%		√
Percent of respondents who state knowing at least one member of the spring capping committee	n/a	80%	65%		√
Percent of respondents who state they have never seen the system dry	n/a	75%	60%		√
Percent of respondents who state they have never seen the system broken or damaged	n/a	75%	60%		√
Percent of respondents who state they have never seen people doing their laundry at the water point/fountain	n/a	75%	60%		√
Percent of respondents who state they have never seen people watering their animals at the water point/fountain	n/a	80%	65%		√
Percent of respondents who state they have never seen people bathing at the water point/fountain	n/a	80%	60%		√
Behavior change					
Percent of respondents who state that their family treats the water with bleach before drinking it	n/a	30%	20%		√
Percent of respondents who state that their family has less diarrhea since the construction of the spring capping	n/a	75%	65%		√
Percent of respondents who state using more water since the construction of the spring capping	n/a	80%	70%		√

EDUCATION *(p. 1 of 1)*	BL Value	LOA target	MTE target	Sampling Groups				
				Stud.		PTA	Dir./ Admin	Teacher
				F	M			
PTA committee members								
Percent of PTA members who attended at least one PTA meeting in the last 4 months.			50%			√		
Percent of PTA members who state that they participated in a health-related activity at school in the past six months		95%	60%			√		
Percent of PTA members who state that they personally participated in a PTA small project in the past 12 months		50%	30%			√		
Percent of PTA members who have participated in a training event given by CRS for PTA members			80%			√		
School directors								
Percent of School Directors who have ever received managerial or administrative training from CRS while an employee of their school			80%				√	
Percent of School Directors who feel that the training they received improved the overall quality of their management or administrative performance			40%				√	
Percent of School Directors who received any Health, Hygiene, and Nutrition training from CRS while the director at their school.			80%				√	
Teachers								
Percent of Teachers who have ever received pedagogical or teacher training from CRS while an employee of their school			75%					√
Percent of Teachers who feel that the training they received improved the overall quality of their teaching performance			40%					√
Percent of Teachers who received any Health, Hygiene, and Nutrition training from CRS while teaching at their school.			75%					√
Students								
Percent of students who state that they received a meal the last day they were at school		95%	80%	√	√			
Percent of students who state that the quality of the meal as good		70%	50%	√	√			

Percent of students who state generally eating all the food given to them at school.			80%	√	√			

MCHN - Mothers *(p. 1 of 3)*	**BL Value**	**LOA target**	**MTE target**	**Sampling Groups**		
				Mothers of Child. 0-6	**Mothers of Child. 6-12**	**M/CG of Child. 12-24**
Breast feeding and Infant Feeding Practices						
Percent of children (0-11.99 months) given breast milk only on day of birth	32.5%	50%	40%	√	√	
Percent of infants (0-11.99 months) breast fed within 1 hour of birth	6.2%	16.2%	20%	√	√	
Percent infants having received colostrum	53.0%	95%	80%	√	√	
Percent of children (0-5.99 months) currently being breastfed	95.8%	95%	95%	√		
Percent of children (6-11.99 months) currently being breastfed	98.5%	98.5%	95%		√	
Percent of children (12-23.99 months) currently breastfed	60.0%	70.0%	65%			√
Percent of infants (0-5.99 months) who are exclusively breastfed	16.8%	26.8%	20%	√		
Percent of children (6-11.99 months) who were fed the appropriate number of complementary feedings in the last 24 hours	55%	60%	60%		√	
Percent of children (12-23.99 months) who were fed the appropriate number of complementary feeds in the last 24 hours	41.1%	46.1%	45%			√
Percent of children (12-23.99 months) who received the 3 food groups (“constructeur, “energetique”, “protecteur”) in the last 24 hours	n/a	n/a	80%		√	√
Diarrhea Prevalence						
Percent of children (0-5.99 months) without diarrhea in the last two weeks	80.1%	85.1%	80%	√		
Percent of children (6-11.99 months) without diarrhea in the last two weeks	60.1%	65.1%	65%		√	
Percent of children (12-23.99 months) without diarrhea in the last two weeks	61.2%	66.2%	65$			√
Percent of children (6-23.99 months) with diarrhea who were given ORS	37.4%	60.0%	50%		√	√
Percent of children (6-23.99 months) with diarrhea who were given increased liquids during diarrhea	44.6%	n/a	50%		√	√
Percent of children (6-23.99 months) with diarrhea who were given the same or more food	27.4%	n/a	40%		√	√
Percent of children (6-23.99 months) with diarrhea receiving continued feeding during diarrhea	15.2%	25.2%	20.0%		√	√
Percent of children (6-23.99 months) with diarrhea receiving additional food after diarrhea episode	36.4%	46.4%	40%		√	√
Health cards, child immunization and Vitamin A supplementation						
Percent of children (0-23.99 months) with health card or birth certificate with date recorded	n/a	n/a	90%	√	√	√
Percent children (6-23.99 months) receiving Vitamin A capsule in last six months	45.7%-46.4%	80%	60.0%		√	√
Percent of children (12-23.99 months) fully immunized (3 doses polio)	26.7%	36.7%	35%			√

MCHN *(p. 2 of 3)*	BL Value	LOA target	MTE target	Sampling Groups		
				Mothers of Child. 0-6	Mothers of Child. 6-12	M/CG of Child. 12-24
Pre-and post-natal care						
Percent mothers (children 0-5.99 months) who have a health card	58.7% (*)	n/a	80%	√		
Percent mothers (children 6-11.99 months) who have a health card	59.5%	n/a	80%		√	
Percent mothers (children 12-23.99 months) who have a health card	60.6%	n/a	80%			√
Percent mothers (children 0-5.99 months) who received at least 1 tetanus shot	83.8% (*)	n/a	70%	√		
Percent mothers (children 6-11.99 months) who received at least 1 tetanus shot	71.4%	n/a	70%		√	
Percent mothers (children 12-23.99 months) who received at least 1 tetanus shot	80.3%	n/a	70%			√
Percent mothers (children 0-5.99 months) fully vaccinated against tetanus during last pregnancy (received 2 shots or was already fully vaccinated)	63.8% (*)	73.8% (*)	70%	√		
Percent mothers (children 6-11.99 months) fully vaccinated against tetanus during last pregnancy (received 2 shots or was already fully vaccinated)	49.1%	73.8% (*)	70%		√	
Percent mothers (children 12-23.99 months) fully vaccinated against tetanus during last pregnancy (received 2 shots or was already fully vaccinated)	57.9%	73.8% (*)	70%			√
Percent mothers (children 0-5.99 months) with at least 3 prenatal visits with a trained provider	79.6% (*)	84.6% (*)	80%	√		
Percent mothers (children 6-11.99 months) with at least 3 prenatal visits with a trained provider	83.8%	84.6% (*)	80%		√	
Percent mothers (children 12-23.99 months) with at least 3 prenatal visits with a trained provider	78.5%	84.6% (*)	80%			√
Percent of mothers (children 0-5.99 months) who received pre-natal visit with trained provider before third trimester of pregnancy (7 months)	81.4% (*)	n/a	80%	√		
Percent of mothers (children 6-11.99 months) who received pre-natal visit with trained provider before third trimester of pregnancy (7 months)	78.5%	n/a	80%		√	
Percent of mothers (children 12-23.99 months) who received pre-natal visit with trained provider before third trimester of pregnancy (7 months)	78.5%	n/a	80%			√
Percent of mothers (children 0-5.99 months) who had a trained health provider assist the delivery	32.3% (*)	37.3% (*)	70%	√		
Percent of mothers (children 6-11.99 months) who had a trained health provider assist the delivery	31.0%	37.3% (*)	40%		√	
Percent of mothers (children 12-23.99 months) who had a trained health provider assist the delivery	35.3%	37.3% (*)	40%			√

* Not all indicators were collected on the age groups at the baseline; those baseline results and LOA targets are those of mothers of children 6-59.9 months old all combined

MCHN *(p. 3 of 3)*	BL Value	LOA target	MTE target	Sampling Groups		
				Mothers of Child. 0-6	Mothers of Child. 6-12	M/CG of Child. 12-24
Pre-and post-natal care (cont'd)						
Percent of mothers (children 0.5.99 months) who gave birth in a health facility	9.7% (*)	n/a	35%	√		
Percent of mothers (children 6-11.99 months) who gave birth in a health facility	14.5%	n/a	35%		√	
Percent of mothers (children 12-23.99 months) who gave birth in a health facility	11.3%	n/a	35%			√
Percent of mothers (children 0-5.99 months) who made at least one postnatal visit with a trained health provider within 45 days of delivery	19.1% (*)	24.1% (*)	25%	√		
Percent of mothers (children 6-11.99 months) who made at least one postnatal visit with a trained health provider within 45 days of delivery	18.7%	24.1% (*)	25%		√	
Percent of mothers (children 12-23.99 months) who made at least one postnatal visit with a trained health provider within 45 days of delivery	18.1%	24.1 (*)	25%			√
Participation in program activities (rally posts and mothers' club)						
Percent of children who have participated in a Rally Post in the last month	n/a	90%	80.0%	√	√	√
Percent of mothers who have participated in a Rally Post in the last month	n/a	80%	70.0%	√	√	√
Percent of mothers who participated in an educational session at a Rally Post in the last month	n/a	80%	70.0%	√	√	√
Percent of mothers who are members of a Mothers Club	n/a	50%	25%			
Participation in program activities (perceptions of mothers on CHW''s knowledge on Health Issues and Communication skills)						
Percent mothers who think educational sessions provide practical information	n/a	n/a	70%	√	√	√
Percent mothers who think immunization provided by the health facility is valuable	n/a	n/a	95%			
Percent mothers who think growth monitoring services that Colvol provides are useful	n/a	n/a	95%	√	√	√
Percent mothers who know if child's weigh increased or decreased in the last month	n/a	n/a	70%	√	√	√
Percent mothers who think information provided by Colvol is easy to understand	n/a	n/a	75%	√	√	√
Percent mothers who think Colvols are knowledgeable about nutrition information	n/a	n/a	80%	√	√	√
Participation in program activities (health facility- food supplementation)						
Percent of mothers (0-11.99) who received food supplementation during last pregnancy	n/a	80%	80%	√	√	
Percent of mothers (12-23.99) who received food supplementation during last pregnancy	n/a	80%	70%			√
Percent mothers who report receiving rations regularly each month during pregnancy	n/a	n/a	80%	√	√	√
Percent of mothers who received food supplementation regularly since birth of child	n/a	n/a	80%	√	√	
Percent mothers reporting receiving the correct ration from the health center	n/a	n/a	95%	√	√	√

Distance to water source and source of water						
Percent mothers reporting water collection taking 30 minutes or less	74.2%	n/a	75%	√	√	√
Percent mothers that fetch their water from a protected water source	56.2% (*)	66.2%	55%	√	√	√

* Not all indicators were collected on the age groups at the baseline; those baseline results and LOA targets are those of mothers of children 6-59.9 months old all combined

MCHN– COLVOLs (Knowledge, skills and participation) *(p. 1 of 1)*	**BL Value**	**LOA target**	**MTE target**	**Colvol**
Perceptions of knowledge and skills				
Percent of Colvols who feel totally confident in their skills to provide quality health services to their communities	n/a		90%	√
Percent of Colvols who feel confident in their ability to provide nutritional messages to their communities	n/a		90%	√
Percent of Colvols who feel confident in their ability to provide maternal health messages to their communities	n/a		90%	√
Percent of Colvols who feel confident in their ability to measure a child's weight	n/a		90%	√
Percent of Colvols who feel confident in their ability to record a child's weight on the Road to Health cards	n/a		90%	√
Percent of Colvols who feel confident in their ability to provide immunizations	n/a		60%	√
Technical knowledge				
Percent of Colvols who can identify the vitamin deficiency which causes bad vision (Vitamin A)	n/a		90%	√
Percent of Colvols who know how many times a day a one-year old child should be given something to eat	n/a		60%	√
Percent of Colvols who state that it is okay for a mother to breastfeed when she has a fever	n/a		70%	√
Percent of Colvols who can recognize the symptoms of scabies when given a description of the condition	n/a		75%	√
Percent of Colvols who know that a child with a weight for age below -3 standard deviations should be referred to a health center immediately	n/a		95%	√
Percent of Colvols who mention using at least one Adult Participatory Learning technique during their educational work	n/a		95%	√
Percent of Colvols who feel that the trainings they received in the social marketing of ORT has been useful to their work with mothers in their communities	n/a		90%	√
Availability of materials and supplies				
Percent of Colvols who, in the last 30 days, have not had a shortage of any of the supplies or materials they needed to do their job correctly	n/a		60%	√
Percent of Colvols who, in the last six months, have not had any difficulties providing the expected services to their communities due to inadequate supplies or materials	n/a		60%	√
Participation in monthly activities				
Percent of Colvols who brought their report to the last Colvol meeting they attended	n/a		75%	√
Percent of Colvols who attended the Continuing Education session at the last Colvol meeting they attended	n/a		80%	√
Percent of Colvols who discussed the micro-credit program at the last Colvol meeting they attended	n/a		75%	√
Percent of Colvols who correctly state it is not okay to give a 5 month old child ORT	n/a		80%	√
Percent of Colvols who correctly state that when a child has diarrhea the mother should give the child more food than usual	n/a		80%	√

HAND WASHING KNOWLEDGE AND TECHNIQUES – Cross sectoral (MTE target for each group)							
KNOWLEDGE: % who know when to wash their hands							
When should you wash your hands?	**Health and Nutrition**		**Credit**	**Food Assisted Education**		**Safety Net**	
	CHWs	**Mothers of children (0-6, 6-12 and 12-24 mo.)**	**Community Members**	**PTA Members**	**School Directors, Teachers, Female & Male Students**	**Directors & Staff**	**Females and Males <12 and >12**
a. after using the toilet	80%	70%	70%	80%	80%	70%	70%
b. after changing babies' diapers	20%	20%	20%	20%	20%	20%	20%
c. before preparing food	80%	70%	70%	20%	20%	70%	20%
d. before eating	80%	70%	70%	80%	80%	70%	70%
e. before feeding children	80%	70%	70%	20%	20%	70%	20%
f. working in the garden/coming home from school or market	20%	20%	20%	20%	20%	70%	20%
g. after playing	NA	NA	NA	NA	20%	NA	70%
All key messages combined	a, c, d, e	a, c, d, e	a, c, d, e	a, d	a, d	a, c, d, e, f	a, d, g
Benchmark for all key messages combined	70%	50%	50%	70%	70%	60%	60%
TECHNIQUES – washing hands							
% who used correct hand washing techniques (baseline method)	70%	60%	70%	70%	70%	70%	70%
% who used correct hand washing techniques (international method)	70%	60%	70%	70%	70%	60%	60%

HIV/AIDS – Cross Sectoral – Adults *(page 1 of 2)*	**LOA target**	**MTE target**	**Samples**				
			ED PTA	**ED – DIR.**	**ED – TEACH.**	**SSNI – DIR.**	**SSNI - STAFF**
Means of HIV/AIDS Transmission							
Percent of adult respondents that can state one can avoid acquiring HIV/AIDS		75%	√	√	√	√	√
Percent of adult respondents that state one can avoid HIV/AIDS by abstaining from sex		40%	√	√	√	√	√
Percent of adult respondents that state one can avoid HIV/AIDS by using condoms		40%	√	√	√	√	√
Percent of adult respondents that state one can avoid HIV/AIDS by limiting sex to one partner		40%	√	√	√	√	√
Percent of adult respondents that state one can avoid HIV/AIDS by avoiding unprotected sex with prostitutes		40%	√	√	√	√	√
Percent of adult respondents that state one can avoid HIV/AIDS by avoiding unprotected sex with persons who have many sex partners		40%	√	√	√	√	√
Percent of adult respondents that state one can avoid HIV/AIDS by remaining faithful to one partner		40%	√	√	√	√	√
Percent of adult respondents that state one can avoid HIV/AIDS by avoiding unprotected sex with persons who inject drugs intravenously		40%	√	√	√	√	√
Percent of adult respondents that state one can avoid HIV/AIDS by avoiding infected blood		40%	√	√	√	√	√
Percent of adult respondents that state one can avoid HIV/AIDS by avoiding the use of syringes, razors, straight edges		40%	√	√	√	√	√
Percent of adult respondents that state one can avoid HIV/AIDS by avoiding contact with blood		40%	√	√	√	√	√
Percent of adult respondents that state that a pregnant woman can give the HIV virus to her child during pregnancy		60%	√	√	√	√	√
Percent of adult respondents that state that a mother can give the HIV virus to her child during child birth		60%	√	√	√	√	√
Percent of adult respondents that state that a mother can give the HIV virus to her child via breast feeding		60%	√	√	√	√	√
General knowledge on HIV/AIDS							
Percent of adult respondents that have been tested for HIV		20%	*NA*	*NA*	*NA*	√	√

Percent of adult respondents that state that the HIV virus can take up to six months to show up as positive on a blood test.		60%	√	√	√	√	√
Percent of adult respondents that state that there are no cure for people who have HIV		60%	√	√	√	√	√
Percent of adult respondents that state that HIV/AIDS has been discussed at their PTA meetings		55%	√	√	*NA*	*NA*	*NA*

HIV/AIDS – Cross Sectoral – Adults *(page 2 of 2)*	**LOA target**	**MTE target**	**Samples**				
			ED PTA	**ED – DIR.**	**ED – TEACH.**	**SSNI – DIR.**	**SSNI - STAFF**
Perception of Personal Risk							
Percent of adult respondents that state that you do not get HIV by shaking hands with someone who has HIV/AIDS		60%	√	√	√	√	√
Percent of adult respondents that state that you do not get the HIV virus by sharing a bathroom/toilet with someone who has HIV/AIDS		60%	√	√	√	√	√
Percent of adult respondents that state that you do not get the HIV virus by hugging someone who has HIV/AIDS		60%	√	√	√	√	√
Percent of adult respondents that state that a woman can refuse to have sex with her husband if he has a sexually transmitted infection		70%	*NA*	*NA*	*NA*	√	√
Percent of adult respondents that state that it is not OKAY if he husband/boyfriend has sex with his wife/girlfriend even if she said “no” to his sexual advances		70%	*NA*	*NA*	*NA*	√	√
Percent of adult respondents that state that a man can refuse to have sex with his wife if she has a sexually transmitted infection		70%	*NA*	*NA*	*NA*	√	√
Percent of adult respondents that think it is not okay for a man to have sexual relations outside of his marriage		70%	√	√	√	√	√
Percent of adult respondents that think it is not okay for a woman to have sexual relations outside of her marriage		70%	√	√	√	√	√
Percent of adult respondents that think it is not acceptable for a man/woman to have sexual relations in exchange for the payment of household bills or school fees, for example		70%	√	√	√	√	√
Stigma and discrimination							
Percent of adult respondents that state knowing someone with the HIV virus		40%	√	√	√	√	√
Percent of adult respondents that state they are friends with someone infected with HIV, or suffering from AIDS		40%	√	√	√	√	√
Percent of adult respondents that state that if a friend of theirs was diagnosed as HIV positive, they would continue your friendship with that person		70%	√	√	√	√	√

Percent of adult respondents that state they would be willing to take care of a family member that is infected with the HIV virus in their own home		70%	√	√	√	√	√
Percent of SSNI adult respondents that state that they would accept a child into the center that they know to be HIV positive		70%	*NA*	*NA*	*NA*	√	√
Percent of adult respondents that state they do not believe that people who have the HIV virus deserved getting the disease because of their past behavior		70%	√	√	√	√	√
Percent of adult respondents that state they do not believe that people who have the HIV virus deserved getting the disease because they are bad religious people		70%	√	√	√	√	√

HIV/AIDS – Cross Sectoral – Children (page 1 of 2)	**SSNI**				**Education-schools**		
	MTE target	**Female 8-12**	**MTE target**	**Female 13& up**	**MTE target**	**Fem. student**	**Male student**
Means of HIV/AIDS transmission							
Percent of children that can state one can avoid acquiring HIV/AIDS	30%	√	60%	√	*NA*		
Percent of children that state one can avoid HIV/AIDS by abstaining from sex	30%	√	50%	√	*NA*		
Percent of children that state one can avoid HIV/AIDS by using condoms	30%	√	50%	√	*NA*		
Percent of children that state one can avoid HIV/AIDS by limiting sex to one partner	30%	√	50%	√	*NA*		
Percent of children that state one can avoid HIV/AIDS by avoiding unprotected sex with prostitutes	30%	√	50%	√	*NA*		
Percent of children that state one can avoid HIV/AIDS by avoiding unprotected sex with persons who have many sex partners	30%	√	50%	√	*NA*		
Percent of children that state one can avoid HIV/AIDS by remaining faithful to one partner	30%	√	50%	√	*NA*		
Percent of children that state one can avoid HIV/AIDS by avoiding unprotected sex with persons who inject drugs intravenously	30%	√	50%	√	*NA*		
Percent of children that state one can avoid HIV/AIDS by avoiding infected blood	30%	√	50%	√	*NA*		
Percent of children that state one can avoid HIV/AIDS by avoiding the use of syringes, razors, straight edges	30%	√	50%	√	*NA*		
Percent of children that state one can avoid HIV/AIDS by avoiding contact with blood	30%	√	50%	√	*NA*		
Percent of children that state that a pregnant woman can give the HIV virus to her child during pregnancy	50%	√	50%	√	60%	√	√

Percent of children that state that a mother can give the HIV virus to her child during child birth	50%	√	50%	√	60%	√	√
Percent of children that state that a mother can give the HIV virus to her child via breast feeding	50%	√	50%	√	60%	√	√
General knowledge on HIV/AIDS							
Percent of children that state that the HIV virus can take up to six months to show up as positive on a blood test.	*NA*		60%	√	60%	√	√
Percent of children that state that there are no cure for people who have HIV	*NA*		60%	√	60%	√	√

HIV/AIDS – Cross Sectoral – Children (page 2 of 2)	**SSNI**				**Education-schools**		
	MTE target	**Female 8-12**	**MTE target**	**Female 13& up**	**MTE target**	**Fem. student**	**Male student**
Perception of personal risk							
Percent of children that state that you do not get HIV by shaking hands with someone who has HIV/AIDS	50%	√	60%	√	60%	√	√
Percent of children that state that you do not get the HIV virus by sharing a bathroom/toilet with someone who has HIV/AIDS	50%	√	60%	√	60%	√	√
Percent of children that state that you do not get the HIV virus by hugging someone who has HIV/AIDS	50%	√	60%	√	60%	√	√
Percent of children that think it is not okay for a man to have sexual relations outside of his marriage	50%	√	70%	√	70%	√	√
Percent of children that think it is not okay for a woman to have sexual relations outside of her marriage	50%	√	70%	√	70%	√	√
Percent of children that think it is not acceptable for a man/woman to have sexual relations in exchange for the payment of household bills or school fees, for example	*NA*	√	70%	√	*NA*	√	√
Percent of children that state one can avoid HIV/AIDS by remaining faithful to one partner	30%	√	50%	√	*NA*	√	√
Stigma and discrimination							
Percent of children that state knowing someone with the HIV virus	20%	√	20%	√	20%	√	√
Percent of children that state they are friends with someone infected with HIV, or suffering from AIDS	50%	√	20%	√	20%	√	√

Percent of children that state that if a friend of theirs was diagnosed as HIV positive, they would continue your friendship with that person	50%	√	60%	√	60%	√	√
Percent of children that state they would be willing to take care of a family member that is infected with the HIV virus in their own home	*NA*	√	60%	√	60%	√	√
Percent of children that state they do not believe that people who have the HIV virus deserved getting the disease because of their past behavior	50%	√	60%	√	60%	√	√
Percent of children that state they do not believe that people who have the HIV virus deserved getting the disease because they are bad religious people	50%	√	60%	√	60%	√	√

SSNIs *(p. 1 of 1)*	**BL Value**	**LOA target**	**MTE target**	**Samples**					
				Mgmt	**Observation**	**Female children**		**Male Children**	
						8-13	**13 &up**	**8-13**	**13 & up**
Management									
Percent of staff that can state two or more universal children's rights		90%	85%	√					
Percent of center management staff that have attended a meeting in the last 6 months with their Ruche - independently from CRS		80%	20%	√					
Hygiene conditions									
Percent of centers that were found to be clean and relatively free of trash		80%	50%		√				
Percent of center kitchens that were found to be clean and free of trash		80%	50%		√				
Percent of center kitchens without uncovered food out on the counters		90%	75%		√				
Percent of kitchen food preparation areas found to be smooth/free of sticky substances		80%	50%		√				
Percent of kitchen food preparation stations found to have no evidence of pests or rodents		85%	70%		√				
Percent of kitchens with soap available at the closest water point to the kitchen		80%	50%		√				
Percent of centers in which latrine/toilet areas found to be clean		80%	50%		√				
Percent centers with doors on all of the latrines/toilets		80%	60%		√				
Percent of centers in which all latrine/toilet doors close completely		80%	50%		√				
Percent of centers in which latrines/toilets provide adequate		50%	30%		√				

				Samples					
						Female children		Male Children	
superstructure									
Canteen management									
Percent of centers with no food shortages in the center canteen in the last month		90%	70%	√					
Percent of centers with financial withdrawal or deposit that is dated within the last 30 days in the bookkeeping ledger		80%	50%	√					
School attendance, birth certificate and meals									
Percent of children that state they are currently going to primary school		95%	80%			√		√	
Percent of children that state they are currently going to school o receiving any training		95%	80%				√		√
Percent of children with birth certificates (or equivalent)		95%	80%	√					
Percent of children that state they ate SFB, cornmeal or lentils (put local preparation names) in the last 24 hours		95%	90%			√	√	√	√
Percent of children that state they ate something other than SFB, cornmeal or lentils (put local preparation names) in the last 24 hours		60%	30%			√	√	√	√

CIVIC EDUCATION – cross sectoral *(p. 1 of 1)*	**LOA target**	**MTE bench mark**	**SAMPLES**				**LOA target**	**MTE bench mark**	**SAMPLES**		
			Education –schools			**Health**			**Health**	**Credit**	**Agric.**
			PTA member	**School Director**	**School teacher**	**Colvol (CHW)**			**Mothers (0-6/6-12/12-24 mo)**	**women**	**Associ-ation member**
% who know that the state is founded on 3 principles – property, government, citizenry	80%	30%	√	√	√	√	50%	20%	√	√	√
% who know that "Deputes" are elected for two-year terms	80%	30%	√	√	√	√	50%	20%	√	√	√
% who know the name of the tribunal in their commune	90%	80%	√	√	√	√	80%	50%	√	√	√
% who know that political parties gain political office by winning elections	90%	80%	√	√	√	√	80%	50%	√	√	√
% who know they have the right to form an association or social group	90%	80%	√	√	√	√	80%	50%	√	√	√
% who know they have the right to form a political party	90%	80%	√	√	√	√	80%	50%	√	√	√
% who know that Senators can propose laws	90%	80%	√	√	√	√	80%	50%	√	√	√
% who believe that the state and the population are both responsible for taking care of the environment	90%	80%	√	√	√	√	80%	50%	√	√	√
% who know that a "majistra komenal" (Mayor) obtains his/her position by winning elections	90%	80%	√	√	√	√	80%	50%	√	√	√
% who know that KASECS obtain their position by winning elections	90%	80%	√	√	√	√	80%	50%	√	√	√
% who know that ASECS obtain their position by winning elections	90%	80%	√	√	√	√	80%	50%	√	√	√
% who know that another name "maman lwa peyi a" (the constitution) is “La Loi Mere”	90%	80%	√	√	√	√	50%	20%	√	√	√
% who know that there are three branches of government – Executive, Legislative and Judiciary	90%	80%	√	√	√	√	50%	20%	√	√	√

APPENDIX 3 – Sample questionnaire

MCHN – 0 - 5.99 MONTHS (M1)

(12 pages)

Necessary Materials :

- *A piece of paper to map households*
- *Random Number Table*

Commune:	**Supervision Area #:**
Section Communale:	**ID # Sample:**
Localite:	**Enumerator Code:**
Date: **DAY** **MONTH** **YEAR**	**Supervisor Code:**

INSTRUCTIONS FOR THE RANDOM SELECTION OF MOTHER'S OF CHILDREN :

1) *When you arrive in the community, walk around in order to determine where the center of it is. Ask several community members to assist you in doing this.*

2) *Once you have identified the center of the community go there and spin a bottle. Walk in the direction that the bottle points in – walking in a straight line as much as possible. Walk until you come to the edge of the community in that direction, mapping out and labeling - with a number - all of the houses that you find along the way. Walk back to the town center where you began.*

3) *Using the Random Number Table, pick a number between 1 and the number of houses you counted. Go to that house.*

4) *If there is a child in the desired age range in that household, ask if the biological mother of that child is available for interviewing.*
   - *If the mother of that child is available and willing, conduct the interview.*
   - *If the biological mother of that child is not available or is unwilling to be interviewed, do not conduct the interview. Go to the next closest household.*

5) *If there is no child in the age range you are looking for in that neighboring household, go to the next household in the direction determined by the bottle (moving away from the town center.)*

6) *Continue moving in the direction determined by the bottle – away from the center - until you find a child in the desired age range whose biological mother is available for interviewing.*

NOTE : You are only interviewing the biological mother of the child. Do not interview anyone else.

***If you come to a household with more than one child in the desired age range**, identify which of these children have mothers that are available for interviewing. If there is more than one child (6-11.99 months) whose mother is available for interviewing, randomly select one of these mothers to interview.*

***If there is no child in the household of the desired age**, do not begin the interview. Thank the person you spoke with and continue on to the next household – or until you find a child of in the desired age range whose biological mother is available for interviewing.*

CRS/HAITI MID-TERM EVALUATION
QUESTIONNAIRE MCHN - MOTHERS OF CHILDREN 0 – 5.99 MONTHS (M1)

Q #	QUESTIONS		Q #	RESPONSES	
M1-001	**Are there any children aged 0 – 5.99 months living in this household?** *If YES (Y), randomly select one child aged 0 – 5.99 months.* *If there is more than one child 0 – 5.99 months, and the mothers of these children are available, randomly select one of them for interviewing. Write the name of the selected mother's child below in M1-002.*		M1-001	Y	N
M1-002	**Name of the selected child 0 – 5.99 months**	M1-002 _____	*You will refer to the child by name throughout the proceeding questionnaire. When you see "<NAME>" in the questionnaire, use the child's name.*		
M1-003	**Does the child have a health card or a birth certificate with birth date recorded?** *Mark YES (Y) if the mother says that the child has a health card or birth certificate (even if she does not have them available to show them to you).*		M1-003	Y	N

Instructions for questions M1-004 and M1-005:

DO NOT FILL OUT BOTH M1-004 and M1-005. ***You are only filling in ONE of these answers****. The answer you fill in depends on whether the mother :*

- *Is able to provide you with the child's health card or birth certificate – in which case you would use the health card or birth certificate to fill in M1-004 ; OR*
- *Is unable to provide you with the child's health card or birth certificate – in which case you would ask her to merely tell you the child's date of birth and use that information to fill in M1-005.*

M1-004	**Child's birth date according to record (d/m/y)**	M1-004 _____ / _____ /_____ day / month / year	***The child will have to have been born between****:* *June (today's date) 2004 and December (yesterday's date) 2004.*
M1-005	**Child's birth date according to recall (d/m/y)**	M1-005 _____ / _____ / _____ day / month / year	

Read this introduction to the following section to the respondent :

The following questions relate to the early weeks/months of your child's life.
Most of the questions that I would like to ask you have to do with what the child was fed during that time.

M1-006	**What did you give < NAME > on the day of birth?** *(More than one answer is possible.)* *(Do not read the answers to the respondent)* **Anything else?** *(If lòk is not mentioned by the respondent, ask specifically if it was given to the child on the day of birth.)* *Mark all of the items mentioned by the respondent as YES (Y) and all of those NOT mentioned as NO (N).*	a.	Lòk	M1-006 a	Y	N
		b.	Tea	M1-006 b	Y	N
		c.	Sugar Water	M1-006 c	Y	N
		d.	Breast Milk	M1-006 d	Y	N
		e.	Boiled Water	M1-006 e	Y	N
		f.	Bottle	M1-006 f	Y	N
		g.	Nothing	M1-006 g	Y	N
		h.	Does not Remember	M1-006 h	Y	N
		i.	Other	M1-006 i	Y	N
	Make sure that all of the answers listed above are marked as either YES (Y) or NO (N) before proceeding to the next section. THIS IS VERY IMPORTANT!					

CRS/HAITI MID-TERM EVALUATION QUESTIONNAIRE MCHN - MOTHERS OF CHILDREN 0 – 5.99 MONTHS (M1)				
Q #	**QUESTIONS**	**Q #**	**RESPONSES**	
M1-007	**How long [ ][ ] was it until you put < NAME > to your breast <u>for the first time</u>?** *Convert the [ ][ ] mother's answer into hours.* ▪ *If the respondent began breast feeding the child within the first hour of birth (0-60 minutes), write <u>01</u> in the box to the right.* ▪ *Between 1 and 2 hours (61-120 minutes), then write <u>02</u>;* *Between 2 and 3 hours, write <u>03</u>, etc.* *NOTE: You are always rounding the time up to the nearest hour.* ▪ *If the respondent did not breast feed the child within the first 24 hours, then write <u>00</u> in the box to the left.*	M1-007	# hours after birth	
M1-008	**Did you give < NAME > the first yellow milk (colostrum)?** *Mark YES (Y) if the respondent gave the colostrum to the child.* *Mark NO (N) if the respondent did not give the colostrum to the child, if she discarded it or if she doesn't remember.*	M1-008	Y	N
M1-009	**Is < NAME > still being breast fed?**	M1-009	Y	N
M1-010	*If < NAME > is no longer being breast fed, ask the respondent the following question:* **For how ma[ ][ ] did you breast feed < NAME >?** ▪ *If t[ ][ ]nt breast fed the child for less than 1 month, then write <u>01</u> in the box to the right.* ▪ *If she breast fed between 1 and 2 months, then write <u>02</u>;* *Between 2 and 3 months write <u>03</u>, etc.* *NOTE: You are always rounding the amount of time up to the next month.* ▪ *If the respondent has not breast fed the child at all since birth, then write <u>00</u> in the box.* *: "Write 99 if the mother is still breast feeding."*	M1-010	# months breast fed	
M1-011	**Yesterda[ ][ ]e day and at night, how many times did you give < NAME > solid food, semi-solid foo[ ]ke porridge?**	M1-011	# times	
M1-012	**Yesterda[ ][ ]e day and at night, how many times did you give < NAME > snacks (like fig, mango, a[ ]ndy, "marinad")?**	M1-012	# times	

CRS/HAITI MID-TERM EVALUATION
QUESTIONNAIRE MCHN - MOTHERS OF CHILDREN 0 – 5.99 MONTHS (M1)

Q #	QUESTIONS	Q #	RESPONSES

Instructions for questions M1-013 below:

1) Ask the respondent if she has started feeding the child the particular food items listed below.

2) If the respondent answers:

a. YES - *that she HAS begun feeding the child that particular food item - then follow up by asking her how old the child was (in months) when she began to feed her/him it – recording the number of months in the box to the right.*

- *If the respondent began feeding the child a specific food item within the first month of birth, write 01 in the box to the right.*
- *Between 1 and 2 months = 02, between 2 and 3 months = 03, etc.*

NOTE: You are always rounding the amount of time up to the next month.

b. NO – *that she HAS NOT begun feeding the child that particular food item - then write 00 in the box to the right and proceed to the next food item.*

M1-013	**Have you [ ][ ]ng < NAME >:** ***If YES:*** **How many months old was < NAME > when you starte[ ][ ]r/him this?**	**a. Liquids other than breast milk (like tea, sweet water, etc.)?**	M1-013 a	# months (child)
		b. Milk (other than breast milk) and/or cheese?	M1-013 b	# months (child)
		c. Semi-solid foods (like porridge, soup, etc.)?	M1-013 c	# months (child)
		d. Starches (like rice, potatoes, maize, etc.)?	M1-013 d	# months (child)
		e. Meat, Fish, or Herring?	M1-013 e	# months (child)
		f. Eggs?	M1-013 f	# months (child)
		g. Fruit and vegetables?	M1-013 g	# months (child)
		h. Food prepared with fat, oil and/or butter?	M1-013 h	# months (child)
	Make sure that all of the answers listed above are marked as either YES (Y) or NO (N) before proceeding to the next section. THIS IS VERY IMPORTANT!			

CRS/HAITI MID-TERM EVALUATION
QUESTIONNAIRE MCHN - MOTHERS OF CHILDREN 0 – 5.99 MONTHS (M1)

Q #	QUESTIONS	Q #	RESPONSES

The section below is meant to be more conversational between you and the respondent.

You will be talking about what < NAME > ate yesterday – from when the child woke up in the morning yesterday to when s/he woke up this morning (that means during the day yesterday and during the night last night).

Instructions for question M1-014:

1) *Ask the respondent what she fed the child for all of the meals and snacks yesterday (from when the child woke up in the morning to when s/he woke up this morning.)*
2) *Ask the respondent to explain what she put in the meal – for example, if she made porridge, what did she use to prepare it? Cereal? Milk? Butter? Mark as **YES** (Y) all of the ingredients that the respondent mentions (given to the child to eat) in the boxes to the right.*
3) *At the end of the questioning for this section, return to the list and mark as **NO** (N) all of the food items that were NOT mentioned (items that were not given to the child to eat) by the respondent, in the boxes to the right.*

Make sure that all of the food items that ARE mentioned are marked as YES (Y) and that all of the food items that are NOT mentioned are marked as NO (N) before proceeding to the next section. THIS IS VERY IMPORTANT!

M1-014	**What did you give < NAME >:** ▪ **When s/he first woke up in the morning yesterday?** ▪ **For Breakfast yesterday?** ▪ **For Lunch yesterday?** ▪ **In the afternoon yesterday?** ▪ **For Dinner yesterday?** ▪ **As a snack anytime during the day or evening yesterday?** ▪ **To drink (liquids)?**	a. Breast milk?	M1-014 a	Y	N
		b. Commercially produced infant formula?	M1-014 b	Y	N
		c. Any other milk, such as tinned, powdered, or fresh animal milk?	M1-014 c	Y	N
		d. Plain water?	M1-014 d	Y	N
		e. Fruit juice?	M1-014 e	Y	N
		f. Any other liquid (sugar water, carbonated drinks, soup broth, coffee, tea, etc.)	M1-014 f	Y	N
		g. Cereal or food made from grains (like rice, maize, sorghum, etc.)?	M1-014 g	Y	N
		h. Pumpkin or yellow/orange fleshed squash, carrots or yellow/orange fleshed sweet potatoes?	M1-014 h	Y	N
		i. Any starches or any food made from roots or tubers (like potatoes, cassava, manioc, etc.)?	M1-014 i	Y	N
		j. Legumes or any food made from beans, peas or lentils (like cowpeas, pink beans, black beans, chick peas, lentils, peas, etc.)?	M1-014 j	Y	N
		k. Dark green leafy vegetables (like cassava leaves, bean leaves, kale, spinach, pepper leaves, taro leaves, amaranth leaves, etc.)?	M1-014 k	Y	N
		l. Ripe mango or ripe papaya?	M1-014 l	Y	N
		m. Any other fruit or vegetable?	M1-014m	Y	N
		n. Any beef, goat, pork, lamb or rabbit meat?	M1-014 n	Y	N
		o. Chicken, guinea hen, duck or other bird?	M1-014 o	Y	N
		p. Fresh or dried fish or shellfish?	M1-014 p	Y	N
		q. Any organ meats (like liver, kidney, etc.)?	M1-014 q	Y	N
		r. Eggs?	M1-014 r	Y	N
		s. Cheese or yoghurt?	M1-014 s	Y	N
		t. Any food prepared with fat (like lard, butter or oil)?	M1-014 t	Y	N
		u. Groundnuts, peanuts or any other nut?	M1-014 u	Y	N
	Make sure that all of the answers listed above are marked as either YES (Y) or NO (N) before proceeding to the next section. THIS IS VERY IMPORTANT!				

CRS/HAITI MID-TERM EVALUATION
QUESTIONNAIRE MCHN - MOTHERS OF CHILDREN 0 – 5.99 MONTHS (M1)

Q #	QUESTIONS			Q #	RESPONSES	
M1-015	**If < NAME > is sleeping when her/his food is ready, what do you do?** *Mark as YES (Y) the answer given by the respondent.* *Mark as NO (N) all of the answers that were not given by the respondent.*	a.	Let the baby continue sleeping	M1-015 a	Y	N
		b.	Wake up the baby	M1-015 b	Y	N
		c.	The child doesn't eat prepared "food" yet	M1-015 c	Y	N
		d.	Other	M1-015 d	Y	N
	Make sure that all of the answers listed above are marked as either YES (Y) or NO (N) before proceeding to the next section. THIS IS VERY IMPORTANT!					
Read this introduction to the following section to the respondent : **I would like to ask you a question about diarrhea.**						
M1-016	**Has < NAME > had diarrhea in the last two weeks?** *The definition for diarrhea is three or more runny stools per day.*			M1-016	Y	N
Read this introduction to the following section to the respondent : **Now, I would like to ask you about your vaccination history during your pregnancy with <NAME> – what vaccines you received, how many times, etc.**						
Directions for questions M1-027 to M1-030 about her vaccination history. *Ask the mother if she has a health card for herself.* ▪ *If she <u>has a health card</u>, then use the health card to mark the boxes to the far right accordingly (TT vaccination.)* ▪ *If she <u>does not have</u> a health card, then ask her about her immunization history directly.*						
M1-017	**Do you (mother) have a health card?**			M1-017	Y	N
M1-018	**When you were pregnant with < NAME >, did you get any vaccinations in the arm/shoulder to avoid the child getting tetanus – which is when the body is permanently tense?**			M1-018	Y	N
M1-019	*If the mother has a health card, ask her to see it in order to confirm her TT vaccination history.* *If the mother is not able to show you the health card for whatever reason, or does not have a health card, just ask her to recall the information and mark the box accordingly.* *If she did not receive any TT vaccinations, mark NO (N) in the box to the right.* **Did you receive two vaccinations against tetanus (TT) during your pregnancy with < NAME >?** *Mark as YES (Y) if the respondent received TWO TT vaccinations when she was pregnant with this child. Mark all of the answers in M1-020 as NO (N) and continue on to question M1-021.* *Mark as NO (N) if the respondent did not receive two tetanus vaccinations. Continue on to M1-020 below.* *If the respondent did not receive vaccinations during her pregnancy with the child, ask her the next set of questions:*			M1-019	Y	N
M1-020	**Why didn't you get TWO vaccinations for Tetanus when you were pregnant with < NAME > ?** *Mark as YES (Y) any of the answers that ARE mentioned by the respondent.* *Mark as NO (N) all of the answers that are NOT mentioned by the respondent.*	a.	There was a shortage of TT vaccinations at Health Facility	M1-020	Y	N
		b.	She was already fully vaccinated.	M1-020	Y	N
		c.	She did not go in to the Health Facility to get the full (2) vaccinations	M1-020	Y	N
	Make sure that all of the answers listed above are marked as either YES (Y) or NO (N) before proceeding to the next section. THIS IS VERY IMPORTANT!					

CRS/HAITI MID-TERM EVALUATION
QUESTIONNAIRE MCHN - MOTHERS OF CHILDREN 0 – 5.99 MONTHS (M1)

Q #	QUESTIONS			Q #	RESPONSES	
Read this introduction to the following section to the respondent : **In the following section, I will ask you about the health care you received during your pregnancy with < NAME > and the time immediately following the delivery of < NAME >.**						
M1-021	**Who did you consult with during your last pregnancy?** *Mark as YES (Y) all the people that the respondent MENTIONS that she consulted with.* *Mark as NO (N) all of the people that the respondent DOES NOT MENTION consulting with.*	a.	Doctor	M1-021 a	Y	N
		b.	Health Agent	M1-021 b	Y	N
		c.	Nurse	M1-021 c	Y	N
		d.	Auxiliary	M1-021 d	Y	N
		e.	Colvol	M1-021 e	Y	N
		f.	Trained Birth Attendant (TBA)	M1-021 f	Y	N
		g.	Untrained Birth Attendant	M1-021 g	Y	N
		h.	Traditional Practitioner	M1-021 h	Y	N
	Make sure that all of the answers listed above are marked as either YES (Y) or NO (N) before proceeding to the next section. THIS IS VERY IMPORTANT!					

CRS/HAITI MID-TERM EVALUATION
QUESTIONNAIRE MCHN - MOTHERS OF CHILDREN 0 – 5.99 MONTHS (M1)

Q #	QUESTIONS	Q #	RESPONSES

Instructions pour questions M1-022 – M1-028

ONLY the following medical people ARE CONSIDERED TRAINED PROVIDERS of prenatal and postnatal services :

- *Doctors*
- *Health Officers*
- *Nurses*
- *Auxiliaries*

The following people are NOT CONSIDERED TRAINED PROVIDERS of prenatal and postnatal services :

- *Colvol*
- *Trained Birth Attendant (**NOTE : This person IS considered a trained person for deliverys ONLY)***
- *Untrained Birth Attendant*
- *Traditional Practitioner*

*NOTE : The ONLY EXCEPTION to this instruction concerns assistance during delivery (M1-024) – **Trained Birth Attendants are considered trained providers of delivery services**. If a Trained Birth Attendant was at least one of the people present during the delivery of < NAME >, then mark question M1-024 as YES (Y).*

M1-022	**How ma[ ][ ] visits did you have with a trained health provider (a doctor, nurse, health officer and/or a[ ]ring your pregnancy?** *If the respondent CONSULTED WITH AT LEAST ONE of the trained health providers mentioned above left, then write the number of times they were consulted.* *If the respondent DID NOT CONSULT WITH AT LEAST ONE of the trained health providers mentioned above left, then write 00 in the box to the far right.* *If the respondent did not consult with anyone during her pregnancy with < NAME >, then write 00 in the box.*		M1-022	# pre-natal visits to trained health provider	
M1-023	**How many months pregnant were you with < NAME > when you went for your first pre-natal visit?** *If the respondent CONSULTED WITH AT LEAST ONE of the trained health providers mentioned above left, then writ[ ][ ]r of months pregnant she was in the box to the right.* *If the res[ ][ ] NOT CONSULT WITH any of the trained health providers mentioned above left, then write 00 [ ][ ] the far right.* *NOTE: If the respondent gives an uneven amount of time (like 1 ½ months) then round up the amount of time to the next month (for example, 1 ½ months will get rounded up to 2 months – and 02 gets written in the box to the right).*		M1-023	# months pregnant – first pre-natal visit to trained health provider	
M1-024	**Who delivered < NAME >?** *Mark as YES (Y) , if at least ONE OF THE TRAINED HEALTH PROVIDERS mentioned above left assisted in the delivery of < NAME >.* *N**OTE: TRAINED BIRTH ATTENDANTS ARE CONSIDERED TRAINED PROVIDERS OF DELIVERY SERVICES and should be marked as YES (Y) in the box to the right.***		M1-024	Y	N
M1-025	**Where did you deliver < NAME >?** *Mark as YES (Y) the answer that is mentioned by the respondent.* *Mark as NO (N) all of the other answers that are NOT mentioned by the respondent.* *You will only mark ONE ANSWER as YES (Y).*	a. At her home	M1-025 a	Y	N
		b. In another person's home	M1-025 b	Y	N
		c. In a health facility (health center, a clinic, dispensary or hospital)	M1-025 c	Y	N
		d. Other	M1-025 d	Y	N
	Make sure that all of the answers listed above are marked as either YES (Y) or NO (N) before proceeding to the next section. THIS IS VERY IMPORTANT!				
M1-026	**How many days after the birth of < NAME > was it until YOU went to a health facility (health center, clinic, hospital, etc.) for your first post natal visit?** *If the res[ ][ ]s not been to a health facility AT ALL since the birth of the child, write 00 in the box to right.*		M1-026	# of days after birth – first post-natal visit	

CRS/HAITI MID-TERM EVALUATION
QUESTIONNAIRE MCHN - MOTHERS OF CHILDREN 0 – 5.99 MONTHS (M1)

Q #	QUESTIONS			Q #	RESPONSES	
M1-027	**When you went in for your first pre-natal visit, who were you examined by?** *Mark as YES (Y) all of the answers that ARE mentioned by the respondent.* *Mark as NO (N) all of the answers that are NOT mentioned by the respondent.* *If the respondent has not been for a post-natal visit, mark all of the answers as NO (N).*	a.	Doctor	M1-027 a	Y	N
		b.	Health Agent	M1-027 b	Y	N
		c.	Nurse	M1-027 c	Y	N
		d.	Auxiliary	M1-027 d	Y	N
		e.	Colvol	M1-027 e	Y	N
		f.	Trained Birth Attendant (TBA)	M1-027 f	Y	N
		g.	Untrained Birth Attendant	M1-027 g	Y	N
		h.	Traditional Practitioner	M1-027 h	Y	N
	Make sure that all of the answers listed above are marked as either YES (Y) or NO (N) before proceeding to the next section. THIS IS VERY IMPORTANT!					
M1-028	***If the respondent was examined by a trained medical provider (mentioned above left) of post-natal services (YES (Y) in M1-027 a-d above), ask :*** **How many days after the delivery of < NAME > was it until you were examined by a trained health provider (a doctor, nurse, auxiliary or health agent) for the first time?** *If the re examined by one of the trained health providers mentioned above left - within 45 days of the number of days in the box to the right.* *dent was examined the first day after birth, then write 01 in the box.* *If the respondent was NOT examined by one of the trained health providers mentioned above left within 45 after the birth, write 00 in the box to the right.* *If the respondent DID NOT consult with a trained medical provider (see the list above to the left) of post-natal services AT ALL, write 00 in the box to the right.*			M1-028	# of days after delivery	

Read this introduction to the following section to the respondent :

In this next section, I will be asking you about the Rally Post, the services you receive from the Colvol and the food rations you received when you were pregnant and since the delivery.

M1-029	**Has < NAME > been taken to the Rally Post in the last month (30 days)?**	M1-029	Y	N
M1-030	**Have you participated in a Rally Post in the last month (30 days)?**	M1-030	Y	N
M1-031	**Have you participated in an educational session at the Rally Post in the last month (30 days)?**	M1-031	Y	N
M1-032	**The last time you participated in an educational session at the Rally Post, did you find the information practical?**	M1-032	Y	N
M1-033	**In general, do you think that the immunization services that the Colvol provides you with are valuable?**	M1-033	Y	N
M1-034	**In general, do you think that the growth monitoring services that the Colvol provides you with are useful to raising a healthy child?**	M1-034	Y	N
M1-035	**Last month, did your child increase or decrease in weight?** *Mark as YES (Y) if the respondent is able to answer this question.* *Mark NO (N) if the respondent is unable to answer this question or does not know.*	M1-035	Y	N
M1-036	**Do you think that the information given to you by the Colvol is said in a way that is easy to understand?**	M1-036	Y	N
M1-037	**Do you think that the Colvol is knowledgeable about the nutrition information that s/he provides to you?**	M1-037	Y	N

CRS/HAITI MID-TERM EVALUATION
QUESTIONNAIRE MCHN - MOTHERS OF CHILDREN 0 – 5.99 MONTHS (M1)

Q #	QUESTIONS	Q #	RESPONSES	
M1-038	**Are you a member of a Mother's Club?**	M1-038	Y	N
M1-039	**How ma[ ][ ]pregnant were you with < NAME > when you received your first food ration?** *If the res[ ][ ] NOT receive food rations during her pregnancy with < NAME >, then write 00 in the box to the right.*	M1-039	# months pregnant	
M1-040	**After you received your first food ration, did you continue to receive them regularly each month during your pregnancy with < NAME>?** *If the respondent DID NOT RECEIVE FOOD RATIONS AT ALL during her pregnancy with < NAME >, or, if she did not receive them regularly, then mark as NO (N).*	M1-040	Y	N
M1-041	**Have you received food rations every month (you never missed a month) since the delivery of < NAME >?** *Mark as NO if the respondent never received food rations since the delivery of the child or if she did not receive them regularly.*	M1-041	Y	N
M1-042	**The last time you went to the health center to receive your food rations, did the health center give you the correct ration amount of each product and the correct type of ration for you?** *(2 "marmites" of bulgar, 1 "marmite" of beans, 4 bottles of oil)*	M1-042	Y	N
M1-043	**How lon[ ][ ]ke you to fetch water (round trip – R/T - including any amount of time that you normally[ ][ ]ait in order to get the water at the water point)?** *Calculate this amount of time in minutes.*	M1-043	# minutes R/T	
M1-044	**Is this water source capped?** *Mark YES (Y) if the respondent mentions that there is a pipe or capped spring.* *Mark NO (N) if the respondent answers that they get their water from a well or an uncapped spring.*	M1-044	Y	N

Read this introduction to the following section to the respondent :

CRS is going to begin civic education trainings. The following questions relate to democracy, and your understanding of it in Haiti.

Questions M1-045 – M1-057 concern the respondent's knowledge of civic issues.
The enumerator will mark either YES (Y) or NO (N) depending on whether the answer provided by the respondent matches the one provided in italics.

M1-045	**What are the three principals on which the state was founded?** *Mark YES (Y) if the respondent can name "the state," government" and "territory".* *Mark NO (N) if the respondent cannot name all three of these principles mentioned above.*	M1-045	Y	N
M1-046	**How long are "Depites/Depute" elected for?** *Mark YES (Y) if the respondent answers "4 years."* *Mark NO (N) for all other answers or if the respondent does not know.*	M1-046	Y	N
M1-047	**In each "Commune" there is one tribunal. What is the name of this tribunal?** *Mark YES if the respondent answers "Tribunal de Paix".* *Mark NO (N) for all other answers or if the respondent does not know.*	M1-047	Y	N
M1-048	**In a democracy, how do political parties gain political office?** *Mark YES (Y) if the respondent answers that in a democracy political parties gain political office via elections.* *Mark NO (N) for any other answer or if the respondent answers that s/he doesn't know.*	M1-048	Y	N
M1-049	**As a Haitian, do you have the right to form an association or social group?** *Mark YES (Y) if the respondent answers that s/he has the right to form an association or social group.* *Mark NO (N) for any other answer or if the respondent answers that s/he doesn't know.*	M1-049	Y	N

CRS/HAITI MID-TERM EVALUATION QUESTIONNAIRE MCHN - MOTHERS OF CHILDREN 0 – 5.99 MONTHS (M1)				
Q #	**QUESTIONS**	**Q #**	**RESPONSES**	
M1-050	**As a Haitian, do you have you have the right to form a political party?** *Mark YES (Y) if the respondent answers "Yes" s/he does have the right to form a political party.* *Mark NO (N) for any other answer or if the respondent answers that s/he doesn't know.*	M1-050	Y	N
M1-051	**Can Senators propose laws?** *Mark YES (Y) if the respondent answers "Yes".* *Mark NO (N) if the respondent answers "No."*	M1-051	Y	N
M1-052	**Who do you think is responsible for protecting the environment?** *Mark YES (Y) if the respondent answers that it is "everybody's responsibility" or that it is BOTH the government's and the people's responsibility to protect the environment.* *Mark NO (N) if the respondent says that it is the government's responsibility but DOES NOT mention the people's responsibility or her/his own responsibility.* *Also mark NO (N) if the respondent provides any other answer than those provided above.*	M1-052	Y	N
M1-053	**In a Haitian democracy how does a "majistra kominal" obtain his/her position?** *Mark YES (Y) if the respondent answers that in democracy a "majistra kominal" gains political office via elections.* *Mark NO (N) for any other answer or if the respondent answers that s/he doesn't know.*	M1-053	Y	N
M1-054	**In a Haitian democracy, how does a KASEC obtain his/her position?** *Mark YES (Y) if the respondent answers that in a democracy a "CASEC" gains political office via elections.* *Mark NO for any other answer or if the respondent answers that s/he doesn't know.*	M1-054	Y	N
M1-055	**In a Haitian democracy how does an ASEC obtain his/her position?** *Mark YES (Y) if the respondent answers that in a democracy a "ASEC" gains political office via elections.* *Mark NO for any other answer or if the respondent answers that s/he doesn't know.*	M1-055	Y	N
M1-056	**What is the other name for "maman lwa peyi a"?** *Mark YES (Y) if the respondent answers "constitution."* *Mark NO (N) for any other answer or if the respondent answers that s/he doesn't know.*	M1-056	Y	N
M1-057	**In a democracy, there are three divisions of power. What are these three divisions?** *Mark YES (Y) if the respondent answers all of the following: "Executive"," Legislative", and "Judicial".* *Mark NO (N) if the respondent cannot name all of the three divisions listed above or if the respondent answers that s/he doesn't know.*	M1-057	Y	N

CRS/HAITI MID-TERM EVALUATION
QUESTIONNAIRE MCHN - MOTHERS OF CHILDREN 0 – 5.99 MONTHS (M1)

Q #	QUESTIONS	Q #	RESPONSES

Read this introduction to the following section to the respondent :

These are the last two questions that I would like to ask you today. I thank you for your patience and willingness to speak with me. Before we finish, I have just two more question which are about hand washing.

For this section, ask the respondent the following questions about their hand washing behaviors.
DO NOT PROMPT THE RESPONDENT AT ALL DURING THIS PART OF THE INTERVIEW.

Instructions for questions M1-058 and M1-059 :

1. *Ask the respondent when s/he washes her/his hands (M1-058).*
   - *If the respondent provides any of the answers provided to the right, mark those particular answers as YES (Y).*
2. *Ask the respondent if s/he would please wash her/his hands while explaining to you her/his procedure (M1-059).*
   - *If the respondent demonstrates a particular technique that is listed to the right, then mark that technique as YES (Y).*
3. *As soon as the respondent has finished washing her/his hands and explaining the process to you, return to the answers to make sure that they are marked correctly.*
   - *Mark YES (Y) for all of the answers given and the techniques demonstrated by the respondent.*
   - *Mark NO (N) for all of the answers NOT GIVEN or techniques NOT DEMONSTRATED by the respondent.*

Make sure that all of the answers listed above are marked as either YES (Y) or NO (N) before finishing the questionnaires.
THIS IS VERY IMPORTANT!

M1-058	**When do you wash your hands?**	***a. After using the toilet/latrine***	M1-058 a	Y	N
		b. After changing a babies' diapers	M1-058 b	Y	N
		c. Before preparing food	M1-058 c	Y	N
		d. Before eating	M1-058 d	Y	N
		e. Before feeding children	M1-058 e	Y	N
		f. After working in the garden / coming home from school / market	M1-058 f	Y	N
		g. After playing	M1-058 g	Y	N
M1-059	**Could you please show me how you wash your hands, explaining the procedure to me while you do it?**	***a. Uses clean water*** *If there is no water faucet, the respondent should pour water over their hands.* *They <u>should not</u> dip their hands in water - if they do this, then mark this technique as NO (N) in the box to the right.*	M1-059 a	Y	N
		b. Uses soap/ash	M1-059 b	Y	N
		c. Washes both hands	M1-059 c	Y	N
		d. Rubs hands together at least three times.	M1-059 d	Y	N
		e. Dries hands in a hygienic manner – air drying or uses a clean cloth.	M1-059 e	Y	N
	Make sure that all of the answers listed above are marked as either YES (Y) or NO (N) before finishing this questionnaire. *THIS IS VERY IMPORTANT!*				

<u>THE END</u>