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An Operations Evaluation of World Vision's Integrated Health and Nutrition Program in Central Plateau, Haiti

Progress Report

IFPRI-Cornell University - World Vision-Haiti Team

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Submitted to:
The Food and Nutrition Technical Assistance (FANTA) Project

October 1, 2003

This publication was made possible through the support provided to the Food and Nutrition Technical Assistance (FANTA) Project by the Office of Health and Nutrition of the Bureau for Global Health at the U.S. Agency for International Development, under terms of Cooperative Agreement No. HRN-A-00-98-00046-00 awarded to the Academy for Educational Development (AED). The opinions expressed herein are those of the authors and do not necessarily reflect the views of the U.S. Agency for International Development.

Financial support for this research is also provided by the Government of Germany, World Vision-Haiti, and the World Food Programme.

RECOMMENDED CITATION:

Loechl, C., Menon, P., Ruel, M.T., Pelto, G. (2003). *An operations evaluation of World Vision's integrated health and nutrition program in Central Plateau, Haiti.* Progress Report submitted to the Food and Nutrition Technical Assistance Project, Academy for Educational Development, Washington, D.C.

ACRONYMS USED

ADP	Area Development Program
BCC	Behavior Change Communication
FANTA	Food and Nutrition Technical Assistance
FDP	Food Distribution Point
IHE	*Institut Haitien de l'Enfance*
IFPRI	International Food Policy Research Institute
MC	Mothers Club
MCH	Maternal and Child Health
MSPP	Ministère de la Santé Publique et de Planification (Ministry of Health)
ORS	Oral Rehydration Salt
RP	Rally Post
SFB	Soy-Fortified Bulgur
USAID	United States Agency for International Development
WSB	Wheat-Soy Blend
WV	World Vision

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1. BACKGROUND

This progress report describes the operations evaluation to assess the quality of implementation and delivery of World Vision's maternal and child health (MCH) program in the Central Plateau region of Haiti. This research is part of a larger evaluation being conducted by IFPRI and Cornell University in collaboration with World Vision-Haiti to compare two models for delivering integrated food and nutrition programs with a take-home food ration component. The two models to be implemented by World Vision-Haiti, are: 1) the traditional *recuperative* approach, whereby children under 5 years of age are targeted to receive food supplements, nutrition counseling and follow-up when they are identified as being underweight for their age; and 2) the *preventive* approach, which targets food supplements and other preventive interventions to all children below 2 years of age, irrespective of their nutritional status.

In addition to conducting the impact and operations evaluations of the two program models, the IFPRI-Cornell team also provided World Vision-Haiti with technical assistance for the development and refining of the program models. The focus of the technical assistance was the strengthening of the education and communication component of the integrated program. Thus, following an intensive formative research study in 2002 (see Menon et al., 2002a; Menon et al., 2002b) the IFPRI-Cornell team worked with World Vision staff to develop a Behavior Change Communication (BCC) strategy, and define the implementation of this BCC strategy within the separate contexts of the two program models being compared: the *recuperative* and the *preventive* approaches (see Loechl et al. 2003a; Loechl et al. 2003b).

The full field-based implementation of the BCC strategy in conjunction with the other program components, i.e., the food distribution and preventive health care services, started only in May 2003. Since it was important that the program be fully operational before the commencement of data collection for the operations evaluation, the research activities for the evaluation could not be started until July 2003 and were completed in September 2003. The data from the operations evaluation have now been entered and analysis has commenced. However, results from this phase of the evaluation will not be available until the end of 2003.

2. OBJECTIVES AND DESIGN OF THE OPERATIONS EVALUATION

2.1 Objectives

The main purpose of the operations evaluation reported here was to gather information on the effectiveness of delivery of the different components of the program and to determine whether the program was operating as planned. This first round of operational evaluation was designed primarily as a "troubleshooting" exercise; i.e. its main purpose was to identify bottle-necks or operational constraints and to identify possible solutions to ensure smooth implementation of the program and its various intervention components. A second round of operations evaluation, planned for 2004, will focus on other aspects such as: 1) identifying programmatic factors that might contribute to differences (or lack thereof) in impact and cost-effectiveness between the preventive and recuperative program models; and 2) assessing the intra-household use of the donated food commodities.

The specific objectives of the first round of operational evaluation were:

1) To evaluate the implementation of the program, using operations research methodologies to identify operational constraints and to provide recommendations on how to improve program operations.

2) To evaluate the quality of delivery of the intervention with respect to the planned delivery system (for example, quality of the different services provided by the local staff, quality of the food distributed, quality of the education provided, etc.).

3) To explore the perceptions of different stakeholders toward the program with a special emphasis on their perceptions regarding its effectiveness and the quality of services provided.

2.2 Design of the operations evaluation

The first steps in designing an operations evaluation are: 1) to identify the specific system to be analyzed and its different components; and 2) to identify the various program actors and stakeholders involved and the ways in which these individuals and groups can influence program operations and impact. These two steps are described below.

2.2.1 Identification of the system to be analyzed

The World Vision MCH program (both preventive and recuperative) offers services at five major points of contact between program staff and participants. These are: (1) the *Rally Posts*, where beneficiaries are identified and health education, growth monitoring, and preventive health care are provided; (2) the *Mothers' Clubs*, where beneficiary mothers and children come together in a small group setting to discuss issues related to infant and young child feeding, hygiene, family planning, or HIV/AIDS; (3) the *Pre- and Postnatal Consultations*, where pregnant and lactating women receive preventive health care and education; (4) the *Food Distribution Points*, where beneficiaries receive their food rations for the month; and (5) the *Home Visits*, where beneficiary households with a newborn infant, a severely malnourished child, or a child with growth faltering are visited by the World Vision health staff.

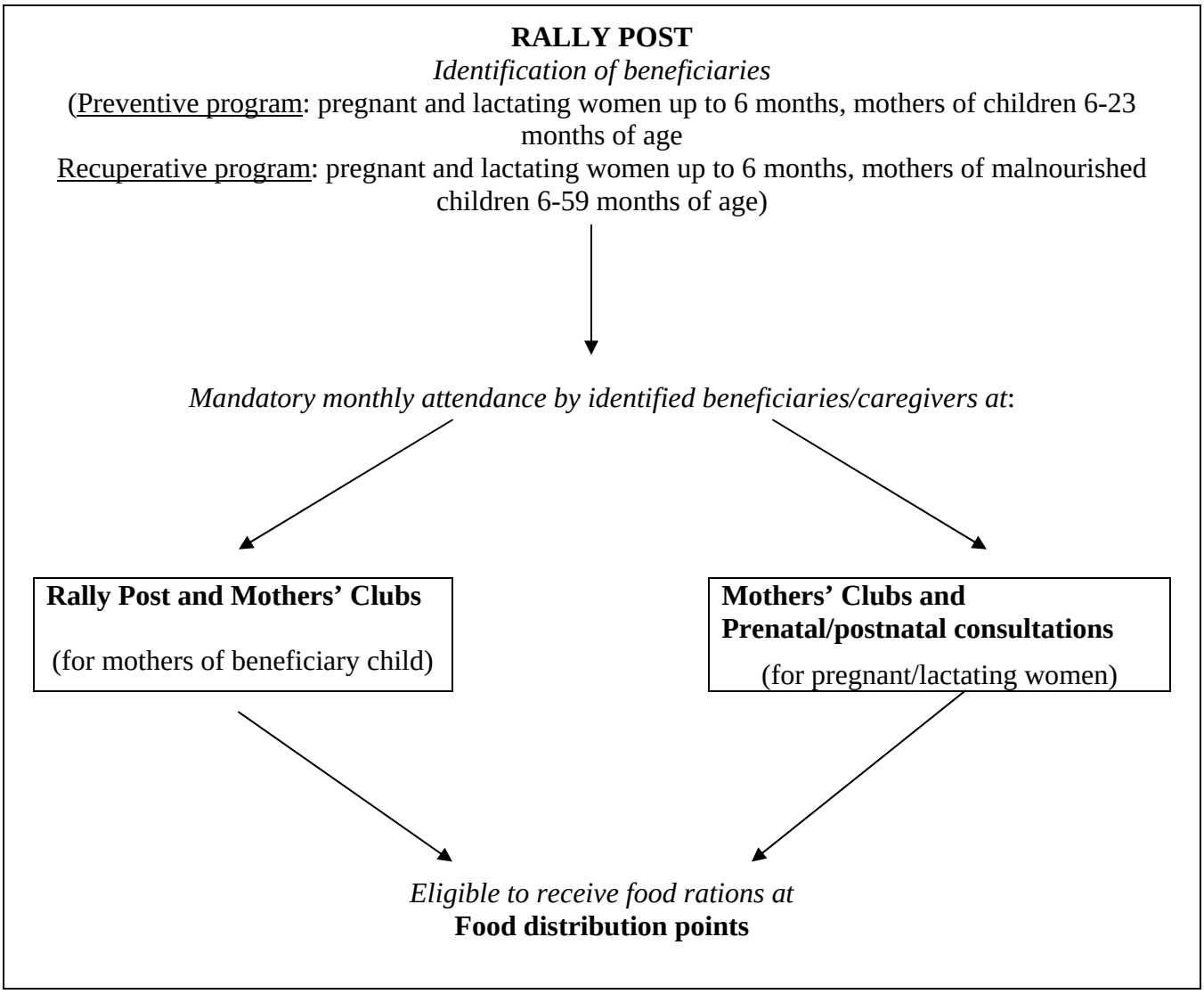
The main beneficiaries of the preventive MCH program are *all* children between 6 and 24 months of age who reside in the program areas, whereas the beneficiaries of the recuperative MCH program are *malnourished* children between 6 and 59 months of age who reside in the program areas. In both programs pregnant and lactating mothers (until their infant is 6 months old) are targeted as well.

The Rally Post is the entry point in both programs, and is used to refer beneficiaries to the appropriate program services. New beneficiaries are identified at the Rally Posts every month; eligible children are admitted into the program on a monthly basis, whereas pregnant and lactating women can enter the program only every four months. The upper age limit for admitting children into the preventive program is 18 months, to ensure that all children in the program receive food aid and other services for at least six months (up to 23 months of age). For the recuperative model, there is no defined upper age limit for admittance, although there is an

upper age limit for eligibility for program services. A child can be admitted at 58 months and exit the program only one month later when she/he reaches the age of 59 months.

For mothers of children 6-23 months old in the preventive program and mothers of malnourished children in the recuperative model, monthly attendance at the Rally Post and at Mothers' Clubs is mandatory to be eligible to receive the food donations offered by the program. Pregnant and lactating women are required to participate in Mothers' Clubs and pre- and postnatal consultations to be eligible for the food distribution, which takes place once a month (see Figure 1).

Figure 1: Beneficiary requirements for participation in the World Vision MCH program



The contact between the program and participants is established through health agents and *colvols* (program volunteers). Health agents are World Vision employees and receive a monthly salary. *Colvols* are community volunteers who assist the health agents in their duties. They receive a small monthly incentive from World Vision. Both health agents and *colvols* are supervised by nurses who work under the supervision of the assistant of the regional health coordinator in Hinche. This assistant is supervised by the regional health coordinator. The national health coordinator for World Vision is based in Port-au-Prince and oversees the activities in all the program areas of World Vision in Haiti. At the Food Distribution Points, the food monitors are responsible for distributing the food, and they are assisted by health agents and *colvols*. The food monitors are World Vision employees of the Commodities Section, and they are supervised by the field supervisors who work under the supervision of the commodities assistant. The commodities assistant is in turn supervised by the regional commodities officer in Hinche.

For the first round of operations research, it was determined that the system under study would begin with the services delivered at the Rally Posts, Mothers' Clubs and Food Distribution Points and would end with the beneficiary women being interviewed about two weeks after they attended a Mothers' Club meeting. Tables 1-3 summarize the different activities at these three service delivery points respectively.

Tables 1 and 2 show that the activities at the Rally Posts and the Food Distribution Points are identical for both programs, with the only differences being the mode of targeting and the maximum length that a child may benefit from the program. In the recuperative program, children are targeted based on their nutritional status, whereas in the preventive program the selection of beneficiaries is based on age. The maximum duration of a child's stay in the recuperative program is limited to 9 months, but can be twice as long in the preventive program (18 months), depending on the age at which the child enters the preventive program.

The Mothers' Clubs are organized the same way in both programs, except for the schedule of learning sessions (see Table 3). In the preventive program, the schedule is age-specific for all categories of beneficiaries in order to ensure that key behaviors are addressed by the program at the most appropriate learning moment for the beneficiaries. In the recuperative program, this age-specificity is only true for the pregnant and lactating women. For mothers of malnourished children, there is a fixed 9-month schedule that does not specifically take into account the age of participating children.

The other aspect in which the programs differ is the duration of attendance by mothers at the Mothers' Clubs and other BCC activities. Mothers in the preventive program may benefit from the BCC activities for longer than mothers in the recuperative program. For example, a mother who starts attending the Mothers' Clubs during pregnancy (as expected), continues to attend the clubs throughout her first six months of lactation and subsequently, for another 18 months as the mother of a beneficiary child between 6-23 months of age could attend the Club for up to 30 sessions.

In the recuperative model, this continuity of attendance is not present and women attend fewer education sessions. The maximum time of attendance of the BCC activities depends on

whether a woman has a malnourished child 6-59 months of age, or whether she is pregnant or lactating:

- Mothers of malnourished children in the recuperative program will normally attend the education sessions for only 9 months, unless they also become eligible for the benefits available to pregnant and lactating women. In that case, they could also attend Mothers' Clubs for pregnant and lactating women for up to 12 sessions.

- Pregnant and lactating women in the recuperative program may benefit from the BCC activities for a maximum of 12 months, if the women start attending the Mothers' Clubs during pregnancy (as expected), unless their child under 5 years of age becomes malnourished. In that case, they would be eligible to also attend the Mothers' Club for malnourished children for 9 months.

Thus, if a woman in the recuperative program group is eligible to receive program benefits available both to mothers of malnourished children *and* to receive benefits available to pregnant and lactating women, it is possible that she could attend a total of 21 BCC sessions at the Mothers' Clubs.

One stipulation about program attendance is that mothers are required to attend the Mothers' Clubs themselves and cannot send another family member to use this service. This ensures that mothers are directly targeted by the BCC activities. For Rally Posts or Food Distribution Points, however, substitute caretakers are allowed to attend instead of the mother.

Table 1: Interventions provided at the Rally Posts in the recuperative and preventive models

<table>
<tr><th>Recuperative Model</th><th>Preventive Model</th></tr>
<tr><td colspan="2">1) Education sessions:
Multiple sessions, each running for about 10 minutes with 10-15 persons
Calendar of monthly topics to be covered at the education sessions
Topics: immunization, pre- and postnatal care, preparation of child delivery, diet for pregnant and lactating mothers, weaning techniques, kwashiorkor and marasmus, hygiene and environment, diarrhea, preparation of oral rehydration salt, acute respiratory infections, family planning, and HIV prevention.</td></tr>
<tr><td colspan="2">2) Record keeping: health agents maintain individual records of nutrition/health status of all children measured as well as records of pregnant and lactating women.</td></tr>
<tr><td colspan="2">3) Screening of pregnant and lactating women:
IF IN SECOND OR THIRD TRIMESTER OF PREGNANCY OR LACTATING WITH INFANT <6 MONTHS OF AGE:
Referral to food supplementation program
Referral to pre- or postnatal consultations and Mothers' Club</td></tr>
<tr><td>4) Growth monitoring:
A. Weighing of all children
B. Screening of under nourished
(M2 or M3 for weight-for-age according to the Gomez classification)
C. IF BETWEEN 6-59 MONTHS OF AGE AND UNDER NOURISHED:
Individual counseling
Referral to food distribution point
Referral of mother to Mothers' Club</td><td>4) Growth monitoring:
A. Weighing of children
B. Screening of age and under nourished
(M2 or M3 for weight-for-age according to the Gomez classification)
C. IF CHILD IS 6-24 MONTHS OF AGE:
Referral to food supplementation program
Referral of mother to Mothers' Club
IF CHILD IS BETWEEN 24-59 MONTHS OF AGE AND UNDER NOURISHED (Only those children who are M3 for weight-for-age):
Individual counseling
Referral to food distribution point
Referral to meetings on malnutrition and recuperation</td></tr>
<tr><td colspan="2">5) Preventive activities:
A. Vitamin A supplementation (< 5 y old children every six months)
B. Administration of anti-helminthic tablets (24-59 mo children every 6 months)
C. Distribution of oral rehydration salt sachets (three sachets per month per household)
D. Information about family planning
E. Immunization (children < 5y, pregnant women, women 15-49 years of age)
F. Iodine supplementation (women 15-49 years of age; only if capsules are available through the Ministry of Health)</td></tr>
</table>

Legend: shaded areas highlight areas where the two models differ.

Table 2: Interventions provided at the Food Distribution Points in the recuperative and preventive models

Recuperative Model	Preventive Model
Activities: A. Verification of eligibility (malnourished child/ pregnant/lactating woman and mandatory attendance at MCH activities) B. Food distribution C. Final check by food monitor	**Activities**: A. Verification of eligibility (age of child/pregnant/lactating woman and mandatory attendance at MCH activities) B. Food distribution C. Final check by food monitor
PREGNANT WOMEN AND LACTATING MOTHERS receive individual (direct) and family (indirect) ration, 1/month. Exit criteria: infant is 6 months old. **Maximum time in program**: 12 months	PREGNANT WOMEN AND LACTATING MOTHERS receive individual (direct) and family (indirect) ration, 1/month. No exit: Mothers of 6 months old children continue to attend the program as mothers of children 6-24 months of age. **Maximum time in program (as pregnant and lactating beneficiaries)**: 12 months
UNDER NOURISHED CHILDREN 6-59 MONTHS OF AGE are eligible to receive one individual (direct) and one family (indirect) ration per month. Exit criteria: child received food for 9 months **Maximum time in program**: 9 months	ALL CHILDREN 6-24 MONTHS OF AGE are eligible to receive one individual (direct) and one family (indirect) ration per month. Exit criteria: child reaches 24 months of age **Maximum time in program**: 18 months UNDERNOURISHED CHILDREN (M3) BETWEEN 24-59 MONTHS OF AGE are eligible to receive one individual (direct) and one family (indirect) ration per month. Exit criteria: child received food for 9 months **Maximum time in program**: 9 months

Legend: shaded areas highlight areas where the two models differ.

Table 3: Interventions provided at the Mothers' Clubs in the recuperative and preventive models

Recuperative Model	Preventive Model
Education sessions in small group settings (15-20 mothers) facilitated by health agents or *colvols* (or both), 1/mo. Separate clubs for pregnant women, lactating mothers and mothers of malnourished children. Primary venue for BCC activities.	**Education sessions** in small group settings (15-20 mothers) facilitated by health agents or *colvols* (or both), 1/mo. Separate clubs for pregnant women, lactating mothers and mothers of children 6-23 months old. Primary venue for BCC activities.
Age-specific schedule of sessions for pregnant and lactating women. Fixed schedule of sessions for the 9 months of program attendance by mothers of malnourished children irrespective of their children's age. **Topics***:* - Infant and young child feeding - Malnutrition and recuperation - Diet for pregnant women - Danger signs during pregnancy and preparation for child birth - Diarrhea, Hygiene - Immunization - HIV/AIDS - Family Planning **Maximum time in program**: For pregnant and lactating women: *12 sessions*. For mothers of malnourished children: attendance of *9 sessions*. Mothers who become eligible for program benefits under both categories (i.e., as pregnant and lactating women and as mothers of malnourished children): up to *21 sessions*.	Age-specific schedule of sessions. **Topics**: - Infant and young child feeding - Diet for pregnant women - Danger signs during pregnancy and preparation for child birth - Diarrhea, Hygiene - Immunization - HIV/AIDS - Family Planning - Home gardening, use of *Moringa oleifera* **Maximum time in program**: If a woman starts attending Mothers' Clubs during pregnancy and continues until her child is 23 months old, she could attend for up to *30 sessions*.

Legend: shaded areas highlight areas where the two models differ.

2.2.2 Selection of key stakeholders

For the purpose of this evaluation, the main stakeholders included administration and field staff at different levels of the program as well as program beneficiaries and non-beneficiaries. The roles of these different stakeholders and their contributions to the operations evaluation are outlined below.

- *World Vision management staff at the national and regional levels in MCH and Commodities*: For the purpose of this operations evaluation, we identified three key informants: the national health coordinator at Port-au-Prince headquarters and the regional health coordinator and the regional commodities officer at the Hinche regional office. These three staff members oversee the implementation of the various activities in their respective sections either in all the program areas of World Vision in Haiti (national level) or in the Central Plateau (regional level). It was therefore considered important for the operations evaluation to gather information on the perceptions of the coordinators regarding the program and its different inputs and components, as well as aspects related to workload and the support they receive.

- *World Vision MCH and commodities field supervisors*: MCH supervisors are nurses responsible for the supervision of the health agents and *colvols.* The commodities field supervisors oversee the activities of the food monitors who implement the distribution of the food rations. The MCH supervisors generate monthly lists of beneficiaries eligible to receive the food rations based on lists of attendance prepared by the health agents for each service delivery point. They also verify the eligibility of these beneficiaries over time (for instance, by control-weighing the children). The Commodities Section uses these lists to program the food amounts needed per distribution point. Thus, the field supervisors are important for the operations evaluation because they can help assess the supply-side of the program and provide information about the flow of activities and their coordination. Furthermore, their perceptions about their responsibilities, workload and support received by the program are valuable information to help evaluate the functioning of the program

- *World Vision food monitors*: Food monitors are responsible for the distribution of the food rations at the Food Distribution Points and to ensure that only eligible beneficiaries receive the food. The beneficiary lists provided by the MCH supervisors are a helpful planning tool to determine the amount of food needed at the distribution points, but they do not substitute for verification on site. This verification is done mainly by consulting the beneficiary card, which contains information about the beneficiaries and indicates whether or not they have complied with their attendance requirements at the MCH activities. Again, information about the perceptions of the food monitors regarding the supply side of the program and other aspects such as their responsibilities, workload and support is important to assess the operational aspects of the program.

- *World Vision health agents and colvols*: The health agents and *colvols* are the direct implementers of the MCH programs in the field and thus, are the frontline staff in contact with the program participants. They are in charge of the interventions being delivered at the Rally Posts and Mothers' Clubs and of assisting the food monitors at the Food

Distribution Points. They attest to the attendance by beneficiaries at the different MCH activities (attendance at which is mandatory for beneficiaries to receive food rations). Thus, their perceptions about the program and suggestions on how to improve it are key to understanding implementation and operational aspects.

- *Beneficiaries*: Program beneficiaries eligible for the food rations are pregnant and lactating women and malnourished children 6-59 months old in the recuperative program areas and children 6-23 months old in the preventive program areas. The pregnant/lactating women and the mothers of the targeted children are the key recipients of all BCC activities. The program beneficiaries are located in 20 zones belonging to three communes: Hinche, Thomonde and Lascahobas. As described in the previous section, beneficiaries receive food rations, nutrition counseling and other preventive interventions. They must meet the conditions set by the program in order to benefit from the food rations (i.e., regular attendance at Rally Posts, Mothers' Clubs, Pre- and Postnatal Consultations). It is therefore crucial for the operations evaluation to gather information regarding the perceptions of the beneficiaries about the quality and usefulness of the services they receive, as well as their views concerning the requirements imposed by the program and their ability to comply with these obligations.

- *Non-beneficiaries*: Non-beneficiaries in the preventive program are mothers of children under 2 years of age who are eligible to participate in the World Vision MCH program but choose not to (i.e. they do not even attend the Rally Posts). Non-beneficiaries in the recuperative program are mothers of malnourished children (who may or may not know that their child is malnourished) who choose not to participate in World Vision's MCH program. Non-beneficiaries for both program types are important stakeholders because they determine the program's coverage and impact. Understanding the reasons for their lack of interest or their inability to participate in the program is particularly important because it provides insight into ways to improve the program and make it more accessible and more attractive to its targeted beneficiaries. However, for the purpose of this evaluation, only non-beneficiary mothers from the preventive program were interviewed. The reason for excluding non-beneficiary mothers from the recuperative program were purely practical: it was too time- and resource-consuming to find "eligible", non-participating mothers in the recuperative group because it required measuring their child's nutritional status. In other words, an eligible mother in the recuperative model is one that has a malnourished child; and in order to determine that the child is malnourished, weight measurements are required. For the preventive model, only information about age was required (i.e. that the child be 6-24 months of age), and therefore it was much more feasible to identify these mothers in the communities where the evaluation took place.

3. METHODS

The operations evaluation used a variety of research methods, including both qualitative and quantitative approaches. These included: 1) structured observations at the different program delivery points; 2) structured interviews with beneficiaries; 3) semi-structured interviews with different stakeholders, including national and regional health coordinators and regional commodities officers, health agents, and beneficiary and non-beneficiary women; and 4) focus group discussions with World Vision program staff. A description of each of these approaches is provided below.

The structured observations as well as the semi-structured individual interviews and the focus groups with program staff were used to identify bottlenecks and constraints in the implementation of different program activities. Likewise, these methods helped to determine the efficacy of the delivery of the interventions (first objective of the evaluation).

In order to evaluate the quality of delivery of the interventions (second objective of the evaluation), structured observations and semi-structured interviews with beneficiaries were used.

Finally, qualitative methods, such as focus groups and semi-structured interviews with program staff, beneficiaries and non-beneficiaries, as well as structured interviews with beneficiaries were used to explore attitudes, opinions and the level of satisfaction of the different stakeholders (third objective of the evaluation).

3.1 Structured observations

3.1.1 Observations at Rally Posts

A tracking form was designed to follow randomly chosen caregivers who were accompanying a food aid beneficiary child through the different services provided at the Rally Post. The main focus was to observe the implementation of the different activities that took place in the Rally Posts, the quality of services, and the duration and sequence of the activities from the respondent's perspective. Therefore, we concentrated on the following aspects:

1) *Time allocated to the different activities*: the field workers noted each activity of the respondent and the start time of this activity. Activities recorded included both program activities (registration, education, child weighing, deworming, immunization, etc.) as well as non-program activities (feeding the child, cleaning the child, talking to a friend, etc.).

1) *Unused services and reason for non-usage*: Using a checklist of all program services that are supposed to be offered at the Rally Posts, the field workers checked off each of the services not used by the respondent on the day of observation and indicated the reason for non-usage. Some of these reasons could have been that a particular service was not offered that day, that a child was already fully immunized or not due for any immunization that day, that a respondent arrived too late for a certain service, etc. The field workers verified information in the health agents' registers if necessary in order to determine the reasons or to verify the accuracy of the caregivers' response.

2) *Weighing/growth monitoring*: the observation of this activity focused on the following aspects: who was involved in this activity, the assessment of the quality of method of measurement, the reweighing of the child on an electronic scale to assess the extent of measurement error and misclassification (into malnourished/vs. well-nourished child), the assessment of whether the plotting was done accurately, and the assessment of the type and quality of interaction of the health agent or *colvol* with the caregiver.

3) *Education session*: the purpose of observing the education sessions was: (1) to document some technical aspects such as who conducted the session and whether any communication materials were used for the session; and (2) to assess the quality of the education/communication session by observing the interaction between the educator and the mothers (e.g. whether the educator was engaging and dynamic, whether he/she asked questions and was successful in soliciting responses, etc.), and observing the overall general ambience in which the session was conducted (noise level, distractions, etc.).

4) *Status of beneficiary cards*: the field workers checked whether the beneficiary mothers had their health card and their beneficiary ration card for the child. They then verified the content of the cards, more specifically, assessed the following aspects: (1) whether the weight of the child was entered, whether it was properly plotted, and whether information on vitamin A, vaccination and deworming was entered on the health card; and (2) whether information was properly entered regarding the type of beneficiary the child was, and whether the attendance at the Rally Post was noted on the card. If information on vitamin A and deworming was not entered on the card, the field workers used the health agent's register to verify the last date on which the child received a Vitamin A capsule and/or a deworming tablet

An additional observation sheet was used to capture the general ambience at the Rally Post. For example, observations were made regarding the venue where the Rally Post was held, where the different activities took place, the types of activities that appeared to create bottlenecks to participant movement through the Rally Post, and how many health agents and *colvols* were present. Finally, information was also obtained on attendance, either through observation or through consulting the health agents' daily reports of the Rally Posts. The following data were recorded: the total number of adult participants per education session, the number of pregnant and lactating women, the total number of children under 5 years and under 24 months who attended the Rally Post, and the number of malnourished children identified.

3.1.2 Observations at Food Distribution Points

An observation form was designed (1) to capture the general organization and ambience at the Food Distribution Points, and (2) to assess the quality of the food commodities distributed. Observation of the general organization and ambience included the following aspects: the location of the food distribution; the number of food monitors, health agents, *colvols*, MCH supervisors and commodities field supervisors present at the distribution point; the number of beneficiaries planned for and the number present; whether the beneficiaries from different localities were asked to come to receive food at the same time or at different times; whether the

food, food monitors and health agents arrived at the time communicated to the beneficiaries (if not, the interviewers asked them the reasons for the delay); and the start time of the distribution.

Observation of the food quality focused on the following aspects: visible infection of the food commodities with insects or worms, visible moisture in the different food commodities and/or any visible color change. This observation was done before the food was distributed to the beneficiaries. In addition, 5 bags of WSB, SFB and lentils were randomly checked at each distribution point to see whether the bags appeared humid from the outside and to check their expiration date. The expiration date of 5 containers of oil at each distribution point was also verified.

3.1.3 Observations at Mothers' Clubs

The objective of the observations at the Mothers' Clubs was to assess the quality of education provided at this delivery point. It was particularly important to evaluate the education at this point because the Mothers' Clubs are intended to be the primary venue for the BCC activities of the MCH program. The observation instrument was designed based on an observation checklist developed by Freedom from Hunger (FFH) for use with their *Credit for Education* programs in Haiti. The checklist focused on the following aspects: technical content, session management and organization, facilitation and teaching skills (small-group management, open-ended questions, visual materials), attitudes displayed and atmosphere at the learning session. This form was appropriate to adapt for this evaluation because the BCC materials and BCC approach developed for the World Vision MCH program Mothers' Clubs were based on the model used by Freedom from Hunger.

A separate form was used to obtain general data on the venue for the Mothers' Club, the size of the group, the number of mothers arriving late and the number of mothers who were absent. We were also interested in knowing who else attended the Club meeting and how many of them were present. Furthermore, the field workers also observed whether the meeting started at the scheduled time and what kind of time burden the running of one Mothers' Club meeting (from the time the first participant arrived through until when the last participant left) had for the health agent

3.2 Structured interviews with beneficiaries

Questionnaires were designed to conduct exit interviews with beneficiaries at the different delivery points about access to the delivery points, the services used at the different delivery points and their perceptions of these services. Beneficiaries were also asked to provide suggestions on how the program could be improved. Details about the exit interviews at each delivery point are provided below.

3.2.1 Exit interviews at Rally Posts

At the Rally Posts, two different types of exit interviews were conducted:

1) *Exit interviews with the tracked respondents*: these interviews targeted those beneficiaries who had been involved in the tracking observations described above. In

the exit interview accompanying the tracking, the respondents were asked questions about access to the Rally Post (type, time and cost of transport), perceived importance of the different services at the Rally Post, and suggestions for program improvement.

2) *Exit interviews with randomly chosen caregivers who were accompanying a food aid beneficiary child*: this interview included a larger number of topics than the exit interview with the tracked respondents. In addition to the questions related to access and perceived importance of the different services at the Rally Post, the caregivers were also asked how the child was related to them. If the respondent was not the mother of the child, further questions were asked to explore whether the respondent usually brought the child to the Rally Post, where the child's mother was and what she was doing when the respondent brought the child to the Rally Post. Information regarding the child's date of birth and nutritional status (according to the health card) was also collected. Finally, the respondent was asked to list the services that the child had received that day and the reason for non-usage of certain services.

3.2.2 Exit interviews at Food Distribution Points

Exit interviews were conducted with randomly chosen caregivers who were accompanying beneficiary children at the food distribution point. These interviews included questions related to access to the Food Distribution Point, the information noted in the beneficiary ration card, the use of the food rations, the amount of food received, the caregivers' perceptions of the quality of the food rations and the time spent at the Food Distribution Point. The specific information collected for each of these aspects was the following:

1) *Access to the Food Distribution Point*: the respondents were asked about transport to the Food Distribution Point: how long it took, how they came and what the cost was (if any).

2) *Beneficiary ration card*: the information collected concerned the type of program beneficiary that the child was, how long the beneficiary had been receiving food rations (according to the respondent's recall and the card), the number of direct and indirect beneficiaries in the household, and the type of indirect ration received on the day of interview.

3) *Use of food*: the types of questions asked regarding the use of food were the following: how long the different food commodities usually lasted, what types of recipes families usually prepared using this food, and which family members usually consumed the recipes. The respondents were asked if they added different ingredients (for example: eggs, goat milk, breast milk, cows milk, beans, groundnuts, dried fish, meat, liver, etc.) to the recipes prepared for the beneficiary child/children using the food aid commodities, and if so, how frequently they added the different ingredients.

4) *Amount of food received*: In order to verify whether the respondents were receiving the correct amount of donated food rations, the field workers reweighed the foods that the respondents had received that day, using an electronic scale.

5) *Perceptions of the food quality*: the respondents were asked whether they ever faced problems with the quality of the food and if so, what kinds of problems.

6) *Time spent at the Food Distribution Point*: the respondents were asked how much time they had spent at the Food Distribution Point that day and how much time they usually spent there on previous visits.

Finally, information was also collected on the relationship between the beneficiary child and respondent, and the birth date of this child (comparing the information from the respondent and the beneficiary ration card).

3.2.3 Exit interviews at Mothers' Clubs

The exit interviews at Mothers' Clubs were done with randomly chosen program beneficiaries, as they were about to leave the Club. Again, participants were asked questions related to access to the Club, and their perceptions regarding the importance of various topics discussed at the Mothers' Clubs. They were also asked how many times they had attended this Mothers' Club, and to recall the most and the least important topics they had heard about at the club, and to explain the reasons for these choices. Finally, the birth date of the child was obtained from the ration card and from the respondent.

3.3 Semi-structured interviews

Semi-structured interviews were conducted with several types of stakeholders, namely, the national and regional health coordinators and regional commodities officers, the health agents at Rally Posts, Food Distribution Points and Mothers' Clubs, and beneficiary and non-beneficiary (in preventive program area only) women.

3.3.1 National and regional health coordinators and regional commodities officers

The objective of these individual interviews was to gather information about their perceptions related to their current responsibilities, the constraints on their performance, the supervision structure in the program, the coordination between Commodities and MCH staff, and to gather their suggestions for program improvement.

3.3.2 Health agents at Rally Posts, Food Distribution Points and Mothers' Clubs

These individual interviews with the health agents were held at the end of the sessions at each of the delivery points. The objective was to obtain information about their perceptions and opinions regarding the three service delivery points, the types of problems they faced and, for the Rally Posts, their opinion about the supply situation (vaccines, vitamin A capsules, ORS packets, deworming tablets, health cards, ration beneficiary cards). They were also asked whether they had any suggestions on how to improve the delivery of the services at the different delivery points.

3.3.3 Beneficiary women

In-depth interviews with beneficiary women were used to capture their perceptions about program services, their relative importance for them, and the types of constraints they faced (if any) in using the services. The following topics were explored regarding the different services provided by the program:

1) *Rally Posts*: the respondents were asked about the education session at the last Rally Post they attended, whether they remembered topics, whether the ideas and information were new, interesting and useful to them. They were also asked whether they were able to use the advice received at the Rally Posts and if not, why not. Mothers were also asked to comment on the child weighing done at the Rally Post: whether the health agent/*colvol* communicated the weight of the child to them and informed them of whether the child was growing adequately or not, whether they gave them advice about their child and if so, whether it was useful, and finally, whether they liked to find out about their child's weight when they came to the Rally Post.

2) *Use of food received from the program*: the questions asked to the respondents included the following: what kind of food they had received, what types of recipes they had prepared with these food commodities, who consumed these foods, whether they liked it and whether they faced any problems with the commodities. They were also asked about the food distribution process: whether they had encountered any problems and whether they had any suggestions on how this process could be improved.

3) *Sharing and selling of food received from the program*: our main interest here was to find out whether beneficiary families shared, sold or exchanged the donated food they had received. If the respondent indicated that they felt that they had to share the food, they were asked with whom they shared it, which types of foods they did share, how much of the food they shared and what were the reasons for sharing. If the respondent admitted selling or exchanging the food commodities, they were asked which foods and how much of the foods they had sold or exchanged, and what they did with the money or the services received in exchange.

4) *Mothers' Clubs*: the main focus of the interviews with participants in the Mothers' Clubs was to find out about their knowledge of the topics that were taught. Mothers were asked to recall some of the topics that were covered in the session of the last Mothers' Clubs meeting (spontaneously and prompted) and whether the ideas or information were new, interesting and useful to them. They were also asked about the feasibility of using the advice received at the Mothers' Clubs and possible constraints to using the advise they received at the Clubs.

5) *Suggestions for program improvement:* similar to other stakeholders, beneficiary mothers were asked to provide their suggestions regarding how the different components of the program could be improved, either from the point of view of the effectiveness of service delivery or the quality of services.

3.3.4 Non-beneficiaries

The objective of the individual interviews with non-beneficiaries in the preventive program area was to understand why mothers with children under 2, who are eligible for the program, did not participate. It particular, it was important for the research team to understand if the reasons for non-participation related to time/employment constraints, lack of trust, lack of satisfaction with service delivery/quality, lack of interest or awareness, or other factors. These interviews were designed to help understand the specific incentives and disincentives of the program for the targeted beneficiaries.

3.4 Focus group discussions

Focus group discussions were organized separately with five different groups: health agents, *colvols*, MCH supervisors, food monitors, and commodities field supervisors.

The focus groups were the only approach used to interview *colvols*, MCH supervisors, food monitors and commodities field supervisors. For all groups the objective was to gather information about the perception of these program staff about their current responsibilities, workload and time constraints, the supervision structure in the program and the support they receive from the program. They were also asked for their perceptions about the coordination between Commodities and MCH staff and the constraints on their performance, as well as their suggestions for program improvement.

In the focus group discussions conducted with the food monitors and the commodities field supervisors, an additional discussion point was their experience with the food distribution, whether they experienced any problems and if yes, what types of problems.

The focus groups with the health agents, *colvols* and the MCH supervisors were also used to obtain information on their perception of the training (and re-training) that they received in 2003. In addition, information was gathered about their perception of the three service delivery points, the types of problems they face and, for the Rally Posts, their opinion about the supply situation (vaccines, vitamin A capsules, ORS packets, deworming tablets, health cards, ration beneficiary cards).

4. FIELD WORK LOGISTICS, GEOGRAPHIC AREA AND SAMPLE

4.1 Research staff and training

The operations research was undertaken in the 20 zones of the evaluation project located in the Central Plateau region in Haiti. The field team for the data collection included the following staff:

1) *Two supervisors*: Cornelia Loechl (postdoctoral nutritionist) and Arsène Ferrus (IFPRI consultant). A. Ferrus was also responsible for the semi-structured interviews with the health agents at the Rally Posts and Food Distribution Points as well as the collection of general data and observation at these two service delivery points.

2) *Two observers* responsible for the quantitative data collection at the Rally Posts and Food Distribution Points: Remy Lafalaise and Mathieu Honoré.

3) *Two field workers* experienced in qualitative research methods and responsible for conducting the focus group discussions and in-depth interviews with beneficiaries and non-beneficiaries: Josianne Loredan and Dominique Pierre Lenz. They were also responsible for the semi-structured interviews with the health agents at the Mothers' Clubs.

4) *A World Vision nurse,* Elisabeth Elysée, to observe the education sessions at the Mothers' Clubs. The person responsible for this task had to be extremely familiar with adult learning principles for effective communication and with the adapted communication materials on infant and young child feeding used in the study. Since it was not possible to identify a person external to the program who met these conditions, we decided to assign this responsibility to a member of the World Vision staff, in spite of the fact that she was part of the implementation team. She was an excellent person for this task, having participated in all training of trainers sessions on the new communication strategy and the adapted communication materials. Also, as part of the trainers' team, she had been directly involved in the training of health agents and *colvols* in the use of the infant and young child learning sessions and thus, had a clear idea of what to evaluate when observing an education session.

The training of the team, including the field-testing of questionnaires and interview guides, was done in June 2003 and data collection took place between July and September 2003.

Ethical approval for the study activities was obtained from the Cornell University Commission on Human Subjects. Informed consent was obtained from all study participants before any data collection was conducted.

4.2 Geographic area and sample

The operations research took place in the intervention area of the IFPRI-Cornell-World Vision evaluation project, which covers 20 zones or clusters in three communes: Hinche, Thomonde and Lascahobas. The clusters were defined at the beginning of the evaluation project by taking into account the potential number of child beneficiaries at each of the Rally Posts, and ensuring that the health agent responsible for each cluster would only have to cover about 75 children. Therefore, in each cluster, the MCH program is implemented by one health agent who is assisted by 1-3 *colvols*. The number of *colvols* depends on the number of localities per cluster and the distance of the localities within the cluster. Ten pairs of clusters were constituted that matched for distance to main road, access to a dispensary, type of terrain and access to World Vision's private sponsorship program arm (called the Area Development Program). The type of MCH program, i.e., preventive and recuperative, was then randomly assigned to one cluster in each pair. Thus, the preventive program is being implemented in 10 clusters and the recuperative program in another 10 clusters, each one matched with a preventive cluster. A list of the 20 clusters with the type of program model they were randomized to is provided in Annex 1.

The operations evaluation studied one program delivery point, i.e., Rally Post, Mothers' Club and Food Distribution Point, for each health agent (see protocol in Annex 2). A total of 19 Rally Posts, 20 Mothers' Clubs and 10 Food Distribution Points were observed. One Food Distribution Point covers several clusters and the 10 Food Distribution Points observed covered all 20 clusters of the project area. The Mothers' Clubs included in the sample reflected the different categories of Mothers' Clubs, i.e., Mothers' Clubs for pregnant women and Mothers' Clubs for lactating mothers (in both programs), Mothers' Clubs for mothers of children 6-23 months of age (in the preventive program) and Mothers' Clubs for mothers of malnourished children (in the recuperative program).

For the semi-structured interviews with program beneficiary women, appointments with two women were fixed at 15 Mothers' Clubs during the exit interviews. The interviewers scheduled these appointments 1-2 weeks after the Mothers' Club attendance, in the women's homes. The study took place during the rainy season. Therefore, appointments for in-depth interviews could not be scheduled in clusters with very difficult access. The total number of in-depth interviews was 30 (see Annex 2).

Semi-structured interviews with non-beneficiaries were conducted in only two of the ten preventive clusters, because it was only in these two clusters that the health agents/*colvols* could identify mothers who had eligible children but were not participating in any of the World Vision services. No such mothers could be identified by the health agents/*colvols* of the other clusters. This could have been because the program is being newly implemented and the health agents and/or *colvols* are not yet familiar with the communities they cover. Most health agents do not live in the communities they serve, but *colvols* live in or near their program communities.

The focus groups were planned in conjunction with the assistant of the regional health coordinator and the regional commodities assistant. Two focus group sessions were organized with health agents and *colvols*, and one focus group was planned with each of the following groups: MCH supervisors, food monitors and commodities field supervisors. A total of 7 focus

groups were held. Annex 3 lists the different focus groups and presents details about the composition of each group.

5. NEXT STEPS

The next steps of the operations evaluation include the analysis of the data gathered using the quantitative assessments and the various interview techniques, and the dissemination of the findings of the operations evaluation.

Data analysis approach: The emphasis of the data analysis will be to evaluate the overall implementation of the MCH program, since the primary objective of this phase of operations research was to identify bottlenecks to implementation of the program models, and not so much to evaluate the differences in evaluation of the two program models. A preliminary comparison of the two program models will be made, however, mainly with the objective of identifying issues to investigate in the next round of operations research planned for 2004.

Data entry of the quantitative information gathered through the operations evaluation has been conducted by the *Institut Haitien de l'Enfance* (IHE). Standard statistical software packages (e.g., SPSS and STATA) will be used for the analyses of these data. The transcripts of the focus group discussions, the semi-structured interviews with the health agents and the in-depth interviews with beneficiaries and non-beneficiaries will be analyzed using a qualitative data analysis software package called Atlas-ti.

Dissemination of findings: The findings from the operations research will be disseminated through submission of a report to FANTA and to World Vision-Haiti by the end of 2003. The report will also be shared with other USAID Cooperating Sponsors in Haiti. A workshop will also be conducted in Haiti in early 2004 to present the results of the operations evaluation to World Vision-Haiti, USAID and other interested participants and to discuss solutions to implementation problems that might be identified by the operations evaluation. Finally, the results will also be presented to key program stakeholders at all levels within World Vision, with a focus on developing and implementing solutions to improve the program services.

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ANNEXES

1. **List of clusters**

2. **Protocol for the operations research**

3. **Details of different focus groups**

1. List of clusters

Cluster #	Zone	Commune	Preventive (P) or Recuperative (R)
1	Marmont	Hinche	R
2	Madame Brun	Hinche	P
3	Bassin Zim	Hinche	P
4	Marialapa	Hinche	R
5	Cherival	Hinche	P
6	Pablocal	Hinche	P
7	Bintourib	Hinche	R
8	Carrefour Ledans	Hinche	R
9	Casse	Thomonde and Lascahobas	P
10	Pareidon I	Lascahobas	R
11	Pareidon II	Lascahobas	P
12	Salmadere	Lascahobas	R
13	Tierra I	Thomonde	R
14	Laloimassouse	Thomonde	P
15	Locaret	Thomonde	R
16	Locorbe	Thomonde	R
17	Tierra II	Thomonde	P
18	Ananas	Thomonde and Lascahobas	P
19	Rode/Beganabe	Hinche	R
20	Wanniqueter/Moruque	Hinche	P

2. Protocol for the operations research

No.	Sample	Module	Method	PLANNED sample size	ACHIEVED sample size	Sampling
1	Rally Posts (RP)	General Data Collection Form	Observation + Consulting health agents daily reports	20	19	1 Rally Post per health agent in 19 clusters of the evaluation project area
		General Exit Interview	Structured individual interview	2-3 per RP Total: 40-60	59	
		Respondent Tracking Form	Observation + structured individual interview	2 per RP Total: 40	38	
		Interview with Health Agent	Semi-structured individual interview	20	19	
2	Mothers' Clubs (MC)	Observation of Mothers' Club	Observation	20	20	1 Mothers Club per health agent in all 20 clusters: 5 MCs with pregnant women, 5 MCs with lactating mothers, 6 MCs with mothers of 6-24 months old children, 4 MCs with mothers of malnourished children)
		General Exit Interview	Structured individual interview	2-3 per MC Total: 40-60	41	
		Interview with Health Agent	Semi-structured individual interview	20	20	
3	Food distribution points (FDP)	General Data Collection Form	Observation + Structured individual interview of health agents/food monitors	10	10	The 10 distribution points are covering all 20 clusters of the evaluation project area
		General Exit Interview	Structured individual interview	4-5 per FDP Total: 40-50	45	
		Interview with Health Agent	Semi-structured individual interview	20	20	

No.	Sample	Module	Method	PLANNED sample size	ACHIEVED sample size	Sampling
4	Program beneficiary women	In-depth Interviews with program beneficiary women	Semi-structured individual interview	30	Total of 30: 5 pregnant women 10 lactating mothers 9 mothers of 6-23 mo children 6 mothers of malnourished children	Selection of women at Mothers' Clubs in 15 clusters
5	Program non-beneficiaries	In-depth Interviews with non-beneficiaries	Semi-structured individual interview	about 5	3	In 2 preventive clusters
6	*Colvols*/health agents/health supervisors/ food monitors	Focus group discussions with program staff	Focus groups	2 groups with health agents 2 groups with *colvols* 1 group with supervisors 2 groups with food monitors	2 groups with health agents 2 groups with *colvols* 1 group with MCH supervisors 1 group with food monitors 1 group with Commodities field supervisors	The program staff involved is working in the 20 clusters of the evaluation project area
7	Health coordinators and commodities officer	Interview with the regional and national health coordinators and regional commodities officer	Semi-structured individual interview	3	3	The program staff involved is covering either the Central Plateau (regional) or all World Vision intervention areas in Haiti (national)

3. Details of the different focus groups

Participants	Location of focus group	Number of participants	Remarks
Health agents	Casse	7	Health agents of the evaluation project area in the communes of Thomonde and Lascahobas
Health agents	Hinche	9	Health agents of the evaluation project area in the commune of Hinche
Colvols	Casse	11	*Colvols* of the evaluation project area in the communes of Thomonde and Lascahobas
Colvols	Hinche	9	*Colvols* of the evaluation project area in the commune of Hinche
MCH supervisors	Hinche	6	Supervisor nurses of the evaluation project area and the assistant of the regional health coordinator
Food monitors	Hinche	9	Food monitors covering the evaluation project area
Commodities supervisors	Hinche	6	Commodities field supervisors, warehouse coordinator, commodity tracking system coordinator and commodities assistant