Evaluation of the AgeUK / DEC funded HelpAge project in Haiti Phase 1 and Phase 2.1

"Emergency response and ensuring inclusion of the needs and capacities of older people in Haiti's reconstruction"

Project: Haiti Earthquake Response, Phases 1 and 2.1

Funding: provided by AgeUK through the UK Disaster Emergency Committee

Project period: February 2010 to July 2011 with a continuation of the project into a Phase 2.2 until July 2012

Evaluation period: October 2011

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An older women keeping shop in a Tabarre camp. Note the small containers of charcoal in front.

A few members of the Grand Goave communal OPA in front of their office

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Abbreviations and Acronyms

ADA	Age Demands Action
CARPA	Centre d' Accueil et de Récupération des Personnes du 3e Age (Haitian NGO)
CfW	Cash For Work ($50 per rotation of 10 work days)
CRH	Croix Rouge Haitienne - Haitian Red Cross
DASH	Développement des Activités de Santé en Haïti (4 communes health service membership association)
DPC	Département de la Protection Civile (Haitian Government's Civil Protection Agency)
DRR	Disaster Risk Reduction
EVI	Extremely Vulnerable Individual
FGD	Focus Group discussion
HAP	Humanitarian Accountability Partnership
IASC	UN Inter Agency Steering Committee
IBS	Individual Beneficiary Survey
IDP	Internally Displaced Person(s)
IGA	Income Generating Activity
IPESI	Institut de Promotion d'Etudes et de Soins Intégrés (Haitian NGO)
KII	Key Informant Interview
M&E	Monitoring & Evaluation
MoLSA	Ministry of Labor and Social Affairs
NFI	Non Food Items
OCHA	Office for the Coordination of Humanitarian Action (UN)
OP/OPA	Older Person / Association
PaP	Port-au-Prince
PS	Psycho-Social
RC-RC	Red Cross and Red Crescent movement
SHAA	Société Haitienne d'Aide aux Aveugles (Haitian NGO)
TRM	Trauma Resiliency Model
VFP	Vulnerable Focal Point
WWE	World Wide Emergency department (part of HELPAGE in London)

Acknowledgements
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Quote from an OP when asked about advocacy activities:

'Haitians are only interested in each other at election time'

Map of Haiti with the yellow arrows indicating the areas where HelpAge is intervening

1) Executive summary

Context

Following the earthquake of January 2010, the emergency response in Haiti has been particularly difficult due to the intensity of the disaster in a long term environmentally, educationally, economically and governance impoverished nation and which also directly affected those responsible for the response. HelpAge had had a regionally managed very small presence in Haiti for a year when the emergency shifted the management of the Haiti intervention to HelpAge's World Wide Emergency department.

Traditionally, DEC funding covers two phases of an emergency, Phase 1 for 6 months and a Phase 2 for up to one year. Due to the large quantity of funds raised, the Haiti response included a third phase, also for up to a year. HelpAge submitted proposals for each phase for a total of 30 months. This evaluation occurred during the 20th month and is effectively a midterm evaluation of what started as an emergency response but has evolved into a recovery and development phase as HelpAge intends to remain active in Haiti after the DEC response.

Phase 1, which ran for 6 months between February and July 2010 provided critical relief services to 24,000 OPs in 212 IDP 'camps' (out of the nearly 2,000) and to 417 OPs in the area's 8 nursing homes. The effort cost £816,874 from the DEC and £1,074,016 from other sources and concentrated on the delivery of food and NFIs, appropriate healthcare including mental health/psychosocial support and home care and support. This also included the production and broadcasting of radio programs, the training of medical and paramedical staff on OP care and distribution of 5,300 ToughStuff solar kits.

Phase 2.1 ran for 12 months between August 2010 and July 2011 and provided post relief services to more than 12,000 OPs in 68 camps in 12 communes through the creation of 101 OPAs and the use of 203 community HBCs. The effort cost £2,174,700 from the DEC and £43,988 from other sources and concentrated on the 3 objectives of providing increased protection and empowerment to advocate for OP rights and most pressing needs, improving OP livelihoods primarily through cash transfers and access to appropriate healthcare including mental health support primarily through contracted service providers. Additional activities included additional radio and TV programming, the distribution of 6,655 mobile phones, more training (DRR, psycho-social) and access to transitional shelters.

Phase 2.2 is underway for 12 months between August 2011 and July 2012 and has for objectives to strengthen and increase the self-reliance the OPAs, to increase the training, networking, advocating for and supporting of DRR activities, and access to shelter, healthcare and legal services. This includes the distribution of 3,634 additional ToughStuff kits.

The evaluation lasted one month and is based on the information acquired from project documentation, 171 sampled beneficiaries in and around camps in 4 localities, attendance at a day-long joint meeting of all the OPA committees, 4 focus group discussions with OPA committees, 6 FGD with OPA members, 7 HelpAge Haiti staff, 8 staff from the HelpAge London office and 6 external key informants in Haiti, 5 direct observations at OPA offices and in one camp.

Findings

The WWE strategic plan 2010-2015, finalised after the Haiti earthquake already addresses most of the global recommendations from this evaluation but are taking some time to put in place.

HelpAge could not work through local partners until past the emergency phase as the only two local NGOs with a mandate to assist OPs had institutional weaknesses that prevented them from being full implementing partners, although IPESI was able to provide training and advice. The HelpAge response did what it set out to do, especially for Phase 1, though some activities and their contextual grounding in Phase 2 needed a more thorough analysis for consolidation,

best impact and easier transition to better sustainability. Due to the previous experience in emergencies, HQ support and staff competence and motivation, the implementation of project activities has been of high quality with ongoing monitoring to promptly notice and correct gaps in quality.

The activities have addressed the more critical needs of post earthquake OPs (shelter solutions, income support, access to health services, more respect and self-respect) though the likely impact of some activities, such as the club media and the job centres remains unclear. The assessment and targeting of OPs was well executed, ensuring that the benefits were spread out to as many as possible with little opportunity for individual benefit accumulation. It is too early to be able to assess a global impact as most activities are still underway. However, the impact on individual beneficiaries has been clear and positive although it has also raised expectations about continued assistance such as the second distribution of ToughStuff kits in October/November 2011 and the continued payment of HBCs.

The specific objectives of Phase 1 to reach more than 24,000 OPs were met and involved the distribution of emergency relief (food and NFIs) to enable survival with dignity, the provision of appropriate healthcare including mental health/psychosocial support, supporting older people living in care homes to have an adequate standard of care in the emergency and recovery periods and the provision of home care and support to those living at home or in temporary shelter/accommodation.

The **Phase 2 first specific objective** of enabling 10,000 older person to experience increased protection and to be empowered to advocate for their rights and most pressing needs has been exceeded in quantity (11,000+) and is largely underway in quality but the advocacy and empowerment of the OPs through the OPAs are not yet demonstrated and are still in the early stages.

The **Phase 2 second specific objective** of enabling 10,000 older people to have improved their livelihoods through a social pension or through an active economic role has been achieved in quantity but the small amounts of cash transferred are too limited to be considered "improved livelihood", though they are of selective usefulness, depending on the intent(s) of the activity (i.e.: economic, social, learning and advocacy). The micro-credit activities (conditional grants) are likely to have only a small impact as they only cover 1,384 beneficiaries, do not involve much money ($100 as credit) and do not seek to be sustainable. As for other active economic roles, only the HBCs are benefitting from a regular monthly CfW payment of $50 from HelpAge (and thus not sustainable) and the newly established job centres have not yet demonstrated their usefulness and will likely struggle to so considering the very high and chronic un- and under-employment rate for all adults and the generally low skill and education level of OPs.

The **Phase 2 third specific objective** of enabling 10,000 older people to have received appropriate healthcare including mental health support has been exceeded in quantity and quality, primarily through the HBCs, access to free NGO provided treatment (at mobile clinics or health posts), through the contracted health service providers (7 public and private hospitals and clinics) and a primary health care insurance system (DASH) in 4 communes. This healthcare ranged from sensibilisations on hygiene and small physical and psycho-social assistance from the HBCs for most OPs, out-patient and in-patient services, ophthalmic consultations and glasses, Trauma Resiliency (TRM) therapy sessions and field trips as part of psycho-social care.

From the FGD discussions, it can be sensed that perhaps the best psycho-social support has been the small but constant social activities involving OPs, building up their self-respect and improving their social interactions rather than the day trips for 804 of them or the small amount of specific TRM training and therapy (203 OPs) without active monitoring. While providing access to health services to OPs in EQ zones during the first 6 months is part of the emergency response, the purpose of paying for such an unsustainable service for non-emergency purposes for a continuing 12 months as not been made clear. However, this access to healthcare has been well coordinated and closely monitored. HelpAge was very well

prepared for the response to the unplanned cholera epidemic by mobilising its medical team, HBCs and OPAs to particularly cover the needs of OPs.

As HelpAge has achieved much in a short time, starting without trained national staff in Haiti and without a community base during an extreme emergency, beneficiary participation has been adequate and there are now ongoing efforts to improve it. Feedback mechanisms have been good during specific activities but they are not mainstreamed.

HelpAge has provided good value for money efficiently at two levels: that of providing much needed products and services to OPs, creating the OPAs and especially the large but intangible value of giving OPs respect and self-respect and raising the profile of OPs locally and nationally. Gender and transparency issues have been consistently well addressed.

The specific strengths of the intervention have been:
1. Creative solutions (mobile phone cash transfers, health services contracting, use of community HBCs)
2. Assessment, beneficiary targeting and responding to expressed needs
3. Advocacy with OCHA, IASC and at cluster level
4. Mobilisation of OPs through OPAs and protection
5. Use of HBCs for health and social well-being and information sharing
6. Good field based coordination and cooperation with other agencies

Conclusion and Recommendations
The general conclusion is that this programme has been very successful, especially in Phase 1 with some creative solutions and but it needs to be consolidated into a longer term strategy with defined intentions and steps for better impact and sustainability. There have been a few implementation delays, due mostly to the difficult post-earthquake environment, but all DEC activities are on track to be finished by the end of Phase 2.2.

The main recommendations for HelpAge are to improve technical packages and guidance for different sectors on how to manage specific emergency responses with pre-defined priorities and planning for exit strategies and on-going development especially for longer term interventions, to include strong advocacy support from the beginning as staff on the ground are too busy with the day-to-day activities to take on the additional role of advocacy as an activity in itself and to coordinate on policies and projects with other international partners before deployment in order to maximise impact and optimise resource use.

The main recommendations for Phase 2.2 and beyond are to create an advocacy policy with clear goals and principles for HelpAge, its partners and the OPAs and provide specific training on advocacy to staff, partners and OPAs; to develop a clear path to OPA social and financial sustainability; to work more and through individual and group partners; to develop better methods for learning, from better information collection and analysis, through cross-cutting monitoring and to mini-impact evaluations.

2) Description of context, project and intervention

1. Haiti in 2011

a. Haiti is known to be one of the most corrupt societies in the Americas (ranked 146 out of 178 by Transparency International) presenting the challenge that this is pervasive (even inside NGOs) and needs to be taken into consideration into project design and implementation. Although there is a newly constituted government since October 2011, there has been a lack of effective government for a number of years and it will be, at best, slow to change.

b. The Haitian population is also known to be one of the least educated and significantly superstitious in the Americas (153rd out of 179 countries from a current UNESCO database) which means that presenting communities with choices and new solutions may take longer and needs a contextualized appropriate approach. A Cartesian logical approach based on assumed prior knowledge is unlikely to succeed. Education is largely private and centralized in urban areas and there are few signs that this will change in the immediate future.

c. Haiti was already the poorest country in the Americas and the earthquake damage is estimated to have cost between 100 and 110 % of the annual GDP, the highest ever of any worldwide national disaster, (Inter-American Development Bank), presenting the challenge that peoples' foremost preoccupation is with safety/security, shelter, food/water, health and work/money (Maslow Hierarchy of Needs) and generally have critical immediate needs which make it difficult to hold a longer term outlook.

d. Haiti has suffered from political instability and weak government for many years. There was a period of social unrest in late 2010 prior to the elections causing a general slowdown in project implementation. It took until October 2011 for a government to be constituted and it has not yet demonstrated an active management of the country's affairs, save for the first organised resettlement of 6 urban camps into 16 other communities. Haiti is the only country not at war that has a UN military presence since 2004, MINUSTAH, which is increasingly less tolerated, partly due to its bringing the cholera epidemic to Haiti and occasional local misbehaviour of its troops.

e. By its geographical location in the humid tropics, in the path of annual hurricanes and its nearly complete deforestation, Haiti suffers from frequent natural disasters such as high wind, high rain and flooding. One of the many challenges from this is that more vulnerable people have great difficulty establishing an increasingly stable and prosperous lifestyle. It also encourages greater aversion to risk and reduce investment in the future. It is also a challenge to both the practicalities of implementation (disruption to transport, field activities, physical damage) but also to the design of solutions which can reduce the risks and associated delays.

f. Haiti happens to lay on two roughly East-West tectonic fault lines, one along the north coast (Cap Haitien) and one along the southern coast of the Gonave Gulf (Léogâne, Port au Prince). Neither of these faults have moved significantly in more than a hundred years and the 2010 earthquake did not relieve much of the tectonic stresses. The USGS thus warns that there is a high risk of a yet larger earthquake in next few years, though it cannot be predicted (USGS).

g. There is a high NGO dependency. Between years of ineffective government and frequent natural and man-made disasters (deforestation, cholera epidemic), NGOs have attempted within their limited capacities to assist the suffering communities. But the challenge is that populations who feel abandoned by government structures expect most of their problems to be solved by NGOs as they are more present in the field to deliver products and services. This includes health and education, income generation (micro-credit, cash for work), infrastructure and more recently housing solutions, among many other aspects. This leads to a 'love-hate' relationship with NGOs and the difficulty of eliciting honest feedback from beneficiaries who are afraid to do so for fear of losing any real or imaginary

entitlement. People often misunderstand an assessment or study for a commitment to deliver products or services.

h. The size of the earthquake disaster and its response means that there is high competition for the same resources from response actors. As Haiti is a small, poor and deforested country, the pool of available resources for the large housing reconstruction, whether qualified technicians or construction materials, is limited and stretched. The few entrenched national suppliers have little inducement to reduce prices or provide better service though there has been some improvement over time.

i. The hundreds of 'camps', especially in the Port-au-Prince area will exist for many years to come for at least four simple reasons: 1) even before the EQ there were already about 200,000 people living 'in the streets', 2) the anaemic reconstruction effort builds mostly on one level, instead of the previous 2 or 3 storey buildings, 3) most of the emergency funding is focused on the Port-au-Prince area, so that even more people are moving in PAP from the regions (and often move into recently vacated makeshift shelters), 4) land ownership and its administration have been very problematic and many records were lost in the earthquake.

j. While the emergency response has been difficult and longer than usual, the recovery response has been slow and patchy for several reasons, not least due to the lack of government leadership and capacity, the proliferation of actors (more than 1,000 new organisations came to Haiti following the earthquake), weak coordination and a lack of enforcement of coordination decisions and good practice.

k. Between the weak education system, generalized corruption and weak government, local power structures are very important and entrenched. The process of improving governance at the local level will take much time and creativity.

2. HelpAge's presence in Haiti before and after the earthquake

In 2009, HelpAge recruited one Haitian staff with the goal for HelpAge to establish a DRR programme with partners for the near annual natural disasters, mostly from hurricane and flooding, with the view to eventually open an office in Haiti. This initiative was managed by the Caribbean Regional office with technical support from London. The WWE DRR specialist was due to arrive in Haiti the day after the earthquake to lead an assessment for this programme.

Regional offices, such as the Caribbean Regional office based in Jamaica, also have the mandate to respond to emergencies in their geographical areas but the scale of the earthquake emergency shifted the management of the Haiti intervention to the World Wide Emergency department in London. The WWE department of HelpAge finalised in July 2010 a 2010-2015 strategy with the assistance of specialist advisors.

In country, the programme was supervised by the Emergency Program Manager (an expat). Each project (by objective) had its own project manager (national staff), one each for protection, livelihood and health and the first two were merged for Phase 2.2. Each project manager is then assisted by one office assistant and several field agents (Community Agents and Nurses). The Emergency Program Manager also supervised a few additional staff for IEC (primarily internal and external media activities) and Data collection and Information Management (primarily relating to keeping the beneficiary database well informed and up to date).

The Community Agents and Nurses are field based and work primarily through the OPA committee members and the HBCs. The Community Agents have their office in the OPA offices. There has been a significant reduction in staffing at the end of Phase 2.1.

d) The DEC funded project

Phase 1 objectives (Feb – July 2010)

- Older people affected by the earthquake receive emergency relief (food and NFIs) to enable survival with dignity.
- Older people affected by the earthquake receive appropriate healthcare including mental health/psychosocial support.
- Older people living in care homes have an adequate standard of care in the emergency and recovery periods.
- Very vulnerable older people living at home or in temporary shelter/accommodation receive home care and support.

Item	Beneficiaries	Comment
Food distribution	6,092 OPs	Food supplies provided by World Vision, IOM, ALA (a Dominican Republic partner)
Cash transfer of $50	5,636 OPs	Through Unitransfer (a local bank)
NFI kits	6,020 OPs	Kitchen, hygiene.
Shelter material	1,000 OPs	Tarps and tents
Tough Stuff Sets	5,300 OPs	Includes a 1W solar panel, phone charging jack, a rechargeable battery and a 4 LED light and a radio.
Additional distributions to 8 Nursing Homes	417 OPs	Food, NFIs, medication, health supplies, staff training and salary support. 1 public and 7 church-based
Vulnerable Focal Points	12	one VFP per commune directly affected by the earthquake in cooperation with other agencies (Handicap, etc.)
HBCs	208 OPs	OP living in 93 camps and willing to assist other OPs
30 min weekly radio shows		Started in June ’10 , with and for older people
Free medical consultations	4,002 OPs	in 60 camps with doctors and nurses hired by HelpAge or by one of the four partner operating mobile clinics
Health Services Referrals	266 OPs	Financial and technical support to CENSHOP, a public hospital providing specialised and quality health care for OPs.
Free ophthalmology visits and glasses	829 OPs	
Day-trips	804 OPs	to the beach or to the mountain. Part of PS activities.
Specialised trainings by partner IPESI	93 medical staff	. 20 participants came from the CENSHOP Hospital, the Asile Communal and other nursing homes outside Port-au-Prince. .Training programs included- for Nurses: global care for older people; for Nurse Aides: Specialized care for older people; for Aid Workers: Infection Prevention and Hygiene.
Transport to existing health services	270 OP	Less demand than planned due to the use of mobile clinics
Total	24,080 OPs	

Phase 2.1 Objectives (August 2010 – July 2011)

- Within 1 year, 10,000 older persons will experience increased protection and are empowered to advocate for their rights and most pressing needs.
- Within 1 year, 10,000 older people will have improved their livelihoods through a social pension or active role.
- Within 1 year, 10,000 older people receive appropriate healthcare including mental health support

A number of camps closed during the period.

Item	Achievements	Comment
OPAs established	101 OPAs with about 11,000 members	in 68 camps and 19 neighbourhoods in 12 communes reaching at least 15,000 older people; OPs have access to one community centre in each of the 12 communes
Training in advocacy, media and communication skills	64 OPs	Skills utilised in producing and participating in TV and radio shows geared towards older people. 27 radio shows and 16 TV shows were produced and aired on 15 different Haitian radio channels and 2 TV channels
Facilitating access to Transitional Shelters	1,008 OPs	However, due to land issues and large amounts of debris still to be removed, transitional shelter (TS) construction (and allocation) was slow
Mobile telephones	7,329 OPs	To receive money, improve communications and provide a small light
Cash Transfer	4,389 OPs	Aged 65 years and over received the equivalent of five monthly payments of $17 per month. The cash transfer pioneered mobile phone technology to transfer cash.
Conditional grants	1,384 OPs	$151. 66% of the beneficiaries were women starting in June 2011. $51 is a grant and $100 is a loan. Each beneficiary had to produce a 'business' plan to be approved by the OPA committee and HelpAge staff.
Cash for Work	2,629 OPs	($50 each) with 60% of beneficiaries being women. Mostly for taking care of children (no change in activities).
Employment Centres	2,729 OPs	Completed an application form. 66% of beneficiaries were women. Only operational at end of period.
DRR activities	12 communes	Community agents (CAs), home-based carers (HBCs) and OPA committees' members routinely conducting information, education and communication (IEC) activities about hurricane preparedness, and relaying various alert messages from the Civil Protection Agency (DPC). Identification of identifying extremely vulnerable older people (EVIs).
Advocacy and Coordination	UN clusters RC-RC NGOs National Government Local government	Staff participated in the livelihood, health, nutrition, protection, and humanitarian coordination cluster meetings and encouraged other agencies to disaggregate data by sex and age, and to include older people into their programming by providing relevant information about older people primary concerns. Staff in various coordination mechanisms led by government agencies in health, social services, cholera response and DRR, for instance, providing assessment in disaster such as hurricanes. Advocated at the international and national level, for the implementation of the IASC's recommendations: "Humanitarian Action and Older Persons: an essential brief for humanitarian actors.
Total	**12,000+ OPs**	**In 68+ camps**

Phase 2.2 Activities (August 2011 – July 2012)

- Strengthening the HBCs, including support to EVIs
- Strengthening and increasing self-reliance of the OPAs, including with group IGA, job centres, media and advocacy work ('club media'), social and informational activities
- Continue with networking, advocating for and supporting DRR and shelter solutions
- Continue with networking, advocating for and supporting affordable healthcare for OPs, including cholera prevention, ophthalmological and psycho-social care
- Support training activities, especially to medical personnel about caring for Ops
- Provide some support for accessing legal services in matters of rights abuse, replacing lost or stolen title deeds, thefts, inheritance rights and including to obtain their national ID card.
- More Tough Stuff kits (mobile phone charging only)

3) Evaluation Methodology

The evaluation was conducted by an external evaluator with 18 months' experience in Post-Earthquake Haiti during 7 other missions with 5 other INGOs and selected by the HelpAge office in London. The field work of the mid-term evaluation took place during three weeks between the 18th October and the 4th November 2011, three months after the official end of Phase 2.1 but during the beginning of the continuing Phase 2.2.

The analysis is based on the information acquired from project documentation, 171 sampled beneficiaries in and around camps in 4 localities, attendance at a day-long joint meeting of all the OPA committees,
4 focus group discussions with OPA committees, 6 FGD with OPA members, 7 HelpAge Haiti staff, 8 HelpAge staff from the London office and 6 external key informants in Haiti, 5 direct observations of OPA offices and one camp.

All these tools were used jointly to ensure the validity and triangulation of the information collected. See Annex 7 for the evaluation timeline.

The beneficiary survey, key informant interview and focus groups were conducted using standard questionnaires to ensure that everyone answered the same questions (see Annexes 2, 3 and 4).

The four enumerators (two men and two women), were all Créole speaking Haitian people who had previous experience in conducting surveys for other NGOs.

Key activities

1. A beneficiary survey of 171 beneficiary OPs (45 men-27%, 126 women-73%) out of about 11,845 beneficiaries listed on the HelpAge database in 4 camps (two in Léogâne and two in Port au Prince) yielding a Confidence Interval or Margin of Error of 15% (±7.5%) at the 95% Confidence Level. After the end of the survey, there was a debriefing to collect additional information on the experience of the survey and to clarify the results of the survey analysis.

2. Key Informant Interviews of 15 HelpAge staff (in London and Haiti)

3. 10 Beneficiary Focus Groups (4 OPA committees and 6 OPA members) – 40% in Port-au-Prince and 60% outside.

4. Key Informant Interviews of 6 partners in Haiti

5. The evaluator spent 5 days in the field in Léogâne, Jacmel, Petit et Grand Goave and Port-au-Prince for Survey Management, Focus Group discussions, Key Informant Interviews and Direct Observations.

6. A presentation of findings to the senior management in Haiti.

7. A presentation of findings to the senior management in HelpAge London.

The 25 female residents at the Sacré Coeur nursing home in Port-au-Prince.

Beneficiary Survey

This survey was only meant as a complement to other evaluation activities in providing a modicum of quantitative information, some qualitative information and not meant to cover all aspects of the TORs. It was not meant to follow a rigorous statistical process and did not cover household socio-economic information.

The survey was conducted over a period of 4 days covering only 4 of the 67 camps where HelpAge was currently operating. The surveyors could complete an average of 10 questionnaires each per day and the sites were chosen partly for their larger size to enable the surveyors to find enough beneficiaries. 2 camps were located in the urban section of the town of Léogâne and 2 were inside Port-au-Prince. None of the camps surveyed were in a rural zone.

The 40 questions were a mix of closed questions (e.g. yes/no or definite choices) and open questions which later had to be coded for analysis (e.g. what do you do when there is a hurricane warning?). There were grouped in 5 sections, 4 to cover the health, livelihood and social aspects of the project and the first to cover very basic social information. The sixth and final section was factual observations of the surveyors. The questionnaire is in Annex 2 and the detailed results of the survey in Annex 1.

The questionnaire was written in French and its oral interpretation in Créole was agreed by the group. At the end of each day, they also validated each other's questionnaire to ensure legibility and completeness. Questionnaires were entered into an excel spreadsheet on the following day.

The surveyors were trained and coached in the following subjects during the first day:

1. Introduction to the project, the evaluation and the process of collecting information;
2. Personal introduction to the beneficiary;
3. Understanding the questionnaire and the techniques for eliciting the best information possible from the respondent;
4. Office practice of administering the questionnaire;
5. Field practice of survey questionnaire in Camp des Victimes in Tabarre.

The enumerators were instructed to only seek people 50 years and older in a random pattern.

Focus Group Discussions

A total of 10 FGD were conducted with 6 OPAs and were carried out in Creole with 6 to 12 participants. There was no separation of men and women as all were encouraged and able to speak freely. The semi-structured questionnaire used about 16 questions as guidelines to elicit group discussion focusing on three main themes: 1) specific issues facing older people (as compared to adults generally), 2) their understanding of the role and responsibilities of the OPAs and HelpAge currently and the future, 3) their interpretation of the more and less positive aspects of the project. They were a few more specific questions for the committees. The questionnaire is in Annex 3.

Key documents reviewed

1. Proposals, expenditure and narrative reports sent to the DEC (Phases 1, 2.1 and 2.2)
2. Internal monthly reports
3. *OPA handbook in emergencies*, HelpAge.
4. *Humanitarian Action and Older Persons: an essential brief for humanitarian actors* by HelpAge and WHO, August 2010.
5. *Recherche sur la situation socio-économique des personnes âgées en Haïti*, Calixte Clerisme, Octobre 2001. Sponsored by HelpAge.

6. *Responding to earthquakes 2008, Learning from earthquake relief and recovery operations,* ALNAP

7. *Haiti Earthquake Response Context Analysis*, July 2010, ALNAP

8. *Response to the humanitarian crisis in Haiti following the 12 January 2010 earthquake, Achievements, challenges and lessons to be learned*, IASC (no date)

Key Informant Interviews

Individual interviews based on a questionnaire (in Annex 4) were held with 14 HelpAge staff and 6 external informants. The key informants interviewed were:

Help Age staff

International Headquarters (London)

1	Jessica Dinstl	Programme Officer, Haiti
2	Frances Stevenson	Head of Emergencies
3	Alex Bush	Assistant Director of Programmes
4	Jonathan Barden	Emergency Programme Coordinator
5	Jane Scobie	Director of Advocacy and Communications
6	Asif Anwar	Head of Finance
7	Martha Newman	Head of HR
8	Lucy Blown	Programme officer, WWE

National Office (Haiti)

9	Judith Larivière	Country Representative
10	Bertin Méance	Program Support Manager
11	Jude Patrick Louis	Protection and Livelihood Manager
12	Luc Herby Messadieu	Health Manager
13	Claudel Victor	IEC Officer
13	Gaétan Duhamel	Emergency Program Manager
14	Tefera Mekonnen Tesema	Finance Service Support Manager

External

1	Mme Suze Nlemba	IPESI Director	ipesi@hotmail.com Tél: 3611 6997	in person
2	Claire Perrin Houdon,	Handicap International, Disability Coordinator	coordo.handicap@handicap-international-haiti.org Tél 3170 4813	by phone
3	Elsa Le Pennec	Coordination Protection Cluster Coordinator	lepennec@un.org Tél : 3818 0073	by phone
4	Mme Férus	Hopital Eliziard Germain Administrator	37 48 65 64	in person
5	Sister Alida	Sacré Coeur Nursing home co-manager	38 68 73 48	in person
6	team	British Red Cross		in person

4) Key Findings

The findings are based on the beneficiary survey, the FGD, the KII, the document review and personal observations and seek to address the evaluation TORs. The detailed results of the survey are in Annex 1.

1. Overview

This evaluation should be seen as mid-term evaluation encompassing all three phases of the DEC project.

The prime focus of the evaluation is on Phase 2.1 (finished since 3 months), how it evolved from Phase 1 since February 2010 and has evolved into Phase 2.2 until July 2012.

HelpAge had only one staff for about a year in Haiti with a view to establish a DRR programme when the earthquake precipitated the decision. At the time there were only two local NGOs with a mandate to assist OPs but both had weaknesses that prevented them from being full implementing partners. CARPA is very small and focuses primarily on health issues and IPESI, whose main two activities are training and research/documentation with assistance to OPs as a third sector.

Although HelpAge Haiti does not yet have a long term formal strategy, it's key sectors of activities can be defined as (and ranked in perceived level of importance as there is no strategy to define its goals):

1. Advocacy, Networking and Communication (Ministries and local government, INGOs and LNGOs, UN and RC-RC, national media)
2. Protection and Social development (largely through the OPAs)
3. Health (primary, ophthalmology, psycho-social and cholera prevention)
4. Livelihood (individual and group, cash and material distributions)
5. DRR (prevention and alleviation, primarily for hurricanes)
6. Training (partners, OPAs, staff, service providers)

Items 2, 3, 4 and 5 have a direct impact on beneficiaries while items 1 and 6 have an indirect and longer term impact.

Phase 1 lasted 6 months in the initial primary emergency and could not be evaluated separately more than a year later due to the continuation of similar activities of the consequent Phases 2.1 and 2.2 based on the experience acquired from Phase 1. Furthermore, due to the turnover of staff since, information was available from only one person still member of staff in Haiti and the programme has been well documented and assessed. For beneficiaries there is no separation of the different phases, just a continuation of activities. However, it can be ascertained that considering the scale of the disaster and HelpAge starting from nearly nothing in Haiti, the response was very successful.

For HelpAge, older people are defined as those aged 50 years and above (the pension age in Haiti is 55 years). In context, the original survey in 93 camps with a combined population of about 276,000, nearly 9,000 OP (more than 50 years old) were registered by HelpAge, or 3.23% of total, although some camps had proportions as high as 43% of OP and 11 of them had more than 10% of OP. Other sources of demographic information estimate the 2011 proportion of OP 65 years and over in Haiti as 3.9% with a ratio of 62 males to 100 females and a life expectancy at birth of 60.1 years for men and 63.5 years for women[1].

Some activities were solely implemented during Phase 1, such as the distribution of food, NFI kits, tents, tarps and the direct support to 8 nursing homes.

[1] www.indexmundi.com/haiti/demographics_profile.html

Other activities started in Phase 1 but evolved into longer lasting forms for better impact and sustainability through Phases 2.1 and 2.2, such as:

1) The development of the OPAs, especially the 12 communal OPAs
2) The support to HBCs
3) The provision of health services through referrals and mobile clinics
4) Radio and television shows for and about OPs
5) Partnership with IPESI for training
6) Livelihood support such as grants and microcredit
7) Developing partnerships, such as the OP platform

One recurring issue is that of the definition of 'emergency' or 'relief' and all of that implies in this specific context. In Haiti before the earthquake, many people, if not most, already had a very low level of access to food, potable water and sanitation facilities, shelter, income, health and education services and the earthquake has certainly made the situation worse but more in a matter of degree rather than kind. A significant number of the people now living in the camps are actually better off than before, particularly all those who were previously invisible 'on the street' and who are now visible in the camps (estimated between 100,000 to 200,000).

Strengths

1. Organisational expertise on a neglected vulnerable group, i.e. older people
2. Committed staff
3. Creative solutions (mobile phone cash transfers, health services contracting, use of community HBCs)
4. Previous emergency experience in various countries
5. Visibility and credibility
6. Ongoing advocacy at international level with humanitarian actors to address OP issues
7. Commitment to develop a longer term programme in Haiti

Weaknesses (current)

1. Transport (use of second hand vehicles requiring frequent repairs)
2. Limited analysis of activities in context, evidence based documentation and information management
3. Social sustainability, particularly HBCs, who ought to continue with activities for which they have been paid for many months.

Opportunities

1. First and only INGO working with and for OPs in Haiti
2. Consolidating the coordination and cooperation with INGOs, LNGOs and other international and national actors during the on-going recovery phase
3. The partnership of 4 communes at commune level (Léogâne, Gressier and the two Goâves)
4. A new government with international backing and the first lady is leading a commission on OP issues

Threats

1. Interest in assisting OPs is weak considering the overall needs of the country, starting with primary and secondary education, weak health care system and generally high unemployment

Did well

7. Assessment, beneficiary targeting and responding to expressed needs

8. Advocacy with OCHA, IASC and at cluster level

9. Mobilisation of OPs through OPAs and protection

10. Use of HBCs for health and social well-being and information sharing

11. Cash transfers (grants) using mobile phones

12. Mobilisation of health agencies to deliver services to OPs

13. Use of contracted health service providers (health insurance and treatment centres)

Could have done better (note that items 3-7 are inter-related)

1. operational collaboration with Handicap International, the British Red Cross and other natural partners from the beginning

2. Staff induction/orientation and training (brief and unsustained)

3. Undefined direction beyond the immediate emergency response (the first Haiti strategy is being defined in November 2011)

4. Analysis of activities in context, such as the rationale for and the testing of activities, the choice of indicators, which expected results (to match which hypotheses, risks, assumptions, sustainability issues, alternatives). For example calling a 5 month cash transfer project a 'pension' at such an early phase which raised false expectations and made for more work.

5. Better use of the database. It is held in MS Access and is difficult to manipulate. While it has been used for the selection of beneficiaries and for monitoring outputs, it does not seem to have been used to build even a small understanding of the beneficiaries.

6. Capitalising on successes, beyond use in media work (especially for motivation and learning for future project activities)

Undetermined, to be ascertained after July 2012

1. OPA sustainability, social and economic, as HelpAge has provided a high level of material and intellectual content without a realistic vision of what is sustainable in the longer term and how the transition is to be made

2. Activities for livelihood (such as micro-credit and micro-projects). What is their intent and impact?

3. Appropriateness and impact of job centres for OPs in the current Haitian context

4. The use and appropriateness of the 'club media' (with relatively 'high tech' equipment) in each communal OPA and role of media work in advocacy generally

5. The two distributions of ToughStuff solar kits (complete and partial sets) along with the mobile phones. While the rationale for the distribution of both products has merit, the impact of each separately and together has not been thoroughly analysed (such as issues of technical quality, beneficiary understanding and use of the products and services, completeness of the whole approach, cost/benefit and alternative solutions)

2. Significant results from the OPA Focus Group Discussions

Note: the concept of advocacy in English does not translate simply in French and even less so in Créole language and culture. Thus, the beneficiaries' concept of advocacy includes 'respect' (self or external) and 'advocacy' ("plaidoyer").

a) OPA committee members were involved with the information gathering to fill the beneficiary database, with the selection of more vulnerable OPs for specific distributions and with the selection of the conditional grant beneficiaries. OPA members were satisfied that the correct beneficiaries were selected and the selection process was perceived as fair.

b) There is a strong appreciation for the HBCs and the Agents Communautaires (HelpAge staff)

c) There is also a strong appreciation for the new sense of OP respect and self-respect

d) The role and purpose of the OPAs are perceived to be the field extension of HelpAge and often members do not understand the different mandates between a local OPA, the communal OPA and HelpAge. (HelpAge tries to explain, but the OPAs are young (8 months at most), its members have grown with the top-down model of NGO assistance – reinforced during the emergency phase - and the current implementation approach by HelpAge has reinforced this high dependency mode - such as the many and on-going distributions, provision of 'expensive' offices and equipment and a very directed project design and implementation.

e) But when asked about the single most important aspect of HelpAge's effort for their OPA, the results varied from OPA to OPA indicating the need for a flexible approach. Two OPAs singled out advocacy/respect, one livelihood and one health.

f) This is a very small sample but it does indicate that each OPA has its strength and weaknesses and it and its members will have preferences which should be respected.

3. Significant results from the IBS

The detailed results are in Annex 1. Because this survey only covered 4 camps out of many, the information presented is not globally representative but suggests trends or where better information should be sought (*marked in italics)*. The information is based only on a gender disaggregated basis. No attempt has been made to disaggregate further by age group or location as the sample is neither large nor representative enough. The sample covers 100 women and 41 men aged over 55.

a) Resettlement distance: more than 2/3 have moved from just within the same neighborhood.

b) Greatest needs expressed are: livelihood (89%), shelter (79%), health insurance and services (70- 85%) and food (41%).

c) Health services: 59% of women and 67% of men have benefitted from HelpAge health services. 43% of men receive OPA/HBC help for health matters vs. 30% of women. 7% have received some form of health equipment (glasses, mobility aid, etc.).
It seems that men have had greater use of health services and women expressed a greater need. Could it be related to the fact that two thirds of HBCs are men?

d) Food intake in the previous week (the norm in Haiti is to eat 2 meals/day): nearly 50% of men and women spent an average of nearly 2 days without eating. Nearly 100% averaged 6 days of one meal/day. Less than 15% had access to two meals per day. 75 % ate no portion of protein, 15% had one, 8% had two, 2% had more than 2 portions/week.
Although there are small differences between the sexes which could be further investigated, it is clear that both the quantity and quality of food intake in the elderly is generally inadequate. However, when asked if the elderly suffered from a food apportionment discrimination inside the family, the answer was that the whole family was food poor and all shared equally what was available. A nutritional survey among the OPs would be instructive but need to be considered with care so as not to unduly raise expectations and with a view of the possible responses to the findings.

e) Medication: 80% of respondents claimed to need medication regularly.

f) HBCs: 100% received visits from HBCs and the purpose of the HBC visits was very similar for both: 82% for information sharing, 13% for assistance to get to a health facility, 7% for socialising. Nearly 100% received information on hygiene and cholera and about 70% had received information on cyclone DRR.

g) Livelihood: 12% of men and 23% of women have some means of livelihood now as against 100% previously. Women have primarily been traders (86% previously and 21% now). Men primarily had manual skill jobs (60% previously and 5% now). 10% of men previously had more professional jobs and 0% now.

h) Indebtedness: 64% of women and 72% of men have debts. Whereas the percentage of women with debt decreases smoothly with increasing amounts, it is very uneven for men. In both cases 59% of loans were from friends, from family (13% women, 3% men), from money lenders (14% men, 5% women), from traders (14% women, 10% men) and from microcredit institution (7%).

i) ToughStuff solar kits: the results are quantitatively unclear but a qualitative interpretation can still be made. 66% had received it. 38% of men were using it as against 20% of women, 6% of women claimed it was broken against 0% of men. 100% claim that it saves them money (primarily for phone charging) and 100% claim not to earn any money from it. *When considering that the enumerators observed that there was a 15% difference between men's and women's phone still working, it seems that women may have more difficulty in using these technologies.*

j) Small cash transfers:
- Phase 1 $50 grant: 10% men and 7% women received it
- Phase 2 $50 CfW: 10% men and 17% women received it

In both cases, the majority was used for food: 57% women and 50% men, for trading (31%), to repay debts (17% men and 5% women) and only 5% of women spent it on health.

- the 5 monthly instalments of $17: 55% of women and 65% of men have received it and only 2% profess to have had problems receiving the transfer. In both cases the majority was used for food: 72% men and 65% women, for trading (18% women, 10% men), to repay debts (16% women, 7% men), for health (7% men and 2% women).

- the conditional loan of $100: 12% of women and 2% of men have received it and nearly all used it for trading (it was tied to an economic activity and women are more engaged in trading than men) and one used it for health.

k) Begging: 2% of women admitted to begging a few times a month to help feed themselves against 0% for men. The enumerators felt that the people responded without hesitating or trying to minimise it.

l) Living arrangements: currently 97% of women live with family against 90% of men. More men now live alone (8% against 5% before the EQ) and the opposite for women (3% against 4%). No one currently lives with non-family members. When an OP requires personal assistance, 80% is done by children, 7% by a partner and the remainder by other family and friends.

m) Caring for children: 42% of men have a form of responsibility for children (4.6 on average) vs. 56% of women (2.7 on average). The majority (51 to 71%) profess to be responsible for the children, not just 'child minding'. *However, the level of responsibility is not clearly established and would need greater study. For example, it could be that the men feel responsible for paying for food and schooling while the women actively take care of children on a daily basis. From casual observation, it seems that many women engaged in home-based petty trading while minding children.*

n) For leisure activities, 82% of women and 90% of men listen to a radio daily. 14% of women and 18% of men profess not to socialise, partly due to indebtedness. Social activities include: 'chatting' (83% women and 68% men), singing and dancing (30%) and playing games (18% men, 3% women) and to do so with friends (60%), family (32% men and 13% women) and children (28% women, 12% men).

o) Feedback/complaint mechanism: none of the beneficiaries knew how to make a grievance directly to HelpAge. 85% would do it through the OPA committee.

p) OPA participation: altogether, 95% of OPs have regular and frequent contact with the OPA. Furthermore, 25% have participated in the ADA activities, in hygiene and DRR trainings (22% women, 13% men), outings (8% men, 4% women) and 5% in socio-cultural activities.

q) OPA appeal: respondents feel the OPA is important for improving 'advocacy'/respect (80%), helping with health services access (70%) with livelihood support (64%-33%), with socio-cultural activities (30%) and follow-up from HBCs and committee members (25%).

r) Protection: only 20% do not have a standard ID. Of those, 1/3 never had any, more men had lost it before the EQ and more women have lost it during or since.

s) Insecurity: 79% of men and 72% of women profess not to feel insecure or unsafe. 9% of women feel insecure due to flooding, 11% due to having a damaged house, and 3% for theft. This is very likely not representative of all camps.

t) NGO assistance: 75% of men and 55% of women have received assistance from other NGOs. The large majority of the assistance came through various Red Crosses with smaller

amounts through NGOs. Women received more food, kits (hygiene, kitchen), water & water treatment items and the men received more tarps and tents. 8% received a shelter.

u) The enumerator were tasked with making specific observations:
   a) 83% of the ToughStuff kits distributed to men were still functioning against 70% for women's.
   b) 72-76% had received a Voilá mobile phone. 87% distributed to men were still functioning against 69% for women's.
   c) 32% of women and 25% of men had a noticeable handicap (teeth, hearing, vision or physical).

4. Quality, appropriateness, timeliness, effectiveness and impact

0. Did the response achieve what it set out to do?

Very much so globally, especially for Phase 1 though some activities and their contextual grounding in Phase 2 needed a more thorough analysis for consolidation, best impact and easier transition to better sustainability.

Quality

Due to the previous experience in emergencies, HQ support and staff competence and motivation, the implementation of project activities has been of high quality. Due to ongoing monitoring, gaps in quality were promptly noticed and corrected. The main quality gap is in connecting the activities for best impact.

Appropriateness

The activities have addressed the more critical needs of post-earthquake OPs (shelter solutions, income support, and access to health services, more respect and self-respect) though the likely impact of some activities, such as the club media and the job centres remains unclear.

Effectiveness

The assessment and targeting of OPs was well executed, ensuring that the benefits were spread out to as many as possible with little opportunity for individual benefit accumulation.

Impact

It is too early to be able to assess a global impact as most activities are still underway. However, the impact on the individual beneficiaries has been clear and positive although it has also reinforced a high level of dependency such as the second distribution of ToughStuff kits in October/November 2011 and the continued payment of HBCs.

1. Phase 2 - Specific Objective 1: *within 1 year, 10,000 older person will experience increased protection and are empowered to advocate for their rights and most pressing needs*

The creation and active support of 12 communal OPAs and 93 initial camp based OPAs covering more than 11,000 OPs directly and the constant networking at cluster and bilateral NGO level has been essential to increase the level of protection and assistance to OPs, both inside and outside of HelpAge activities.

However, the advocacy and empowerment of the OPs through the OPAs are not yet demonstrated and are still in the early stages. A very deliberate effort (and also with staff) will need to be made on both fronts during Phase 2.2 as the OPAs have up to now been heavily dependent on and led by HelpAge. The cases of effective positive actions or redress for OPs have been primarily through HelpAge's doing, though there also been a few insufficiently documented cases of OPA initiatives.

2. Phase 2 - Specific Objective 2: *within 1 year, 10,000 older people will have improved their livelihoods through a social pension or an active economic role*

HelpAge has employed several methods to improve the life of OPs through economic and material support.

a) an outright $50 grant in Phase 1
b) short time grants (5 months of income transfers of $17, sometimes referred to as a 'pension') to those aged over 65
b) a onetime cash transfer of $50 through CfW, primarily for child-minding as OPs could not easily find access to the more traditional CfW activities used by other NGOs.
d) micro-credit activities (also known as conditional grants) for those could demonstrate a modicum of business acumen
e) HBCs are benefitting from a monthly CfW payment of $50 from HelpAge
f) creation of job centres and the registering of OPs

g) distribution of ToughStuff solar powered kits (complete sets or just for phone charging) to save money on phone charging, lighting and batteries (for radios primarily) and possibly to earn money by charging other people's phones (reported during the activity monitoring but not during the IBS a few months later)

The short time grants (5 months of income transfers of $17, sometimes referred to as a 'pension', or the onetime cash transfer of $50 through CfW in Phase 2.1 and the $50 grant in Phase 1) are too limited to be considered "improved livelihood", though they are of selective usefulness, depending on the intent(s) of the activity (i.e.: economic, social, learning and advocacy, or a combination thereof).

Current micro-credit activities (conditional grants) are likely to have only a small impact as they only cover 1,384 beneficiaries, do not involve much money ($100 as credit and $51 as grant) and do not seek to be sustainable (no interest charged and low social pressure to repay). Perhaps they are more of a social experiment to encourage the OPAs to be self-managing, but this is not clearly expressed and might constitute a barrier to real economic sustainability later (there is a natural tendency to see the working capital as HelpAge replenishable funding, especially if part of the transfer is a grant and part is a loan).

As for other active economic roles, only the HBCs are benefitting from a monthly CfW payment of $50 from HelpAge (and thus not sustainable) and the newly established job centres have not yet demonstrated their usefulness and will likely struggle to so considering the very high and chronic un- and under-employment rate for all adults and the generally low skill and education level of OPs.

3. Phase 2 - Specific Objective 3: *within 1 year, 10,000 older people receive appropriate healthcare including mental health support*

More than 11,000 OPs have had access to better healthcare through HelpAge activities, primarily through the HBCs, access to free NGO provided treatment (at mobile clinics or health posts), through the contracted health service providers (7 public and private hospitals and clinics) and a primary health care insurance system (DASH) in 4 communes. This healthcare ranged from sensibilisations on hygiene and small physical and psycho-social assistance from the HBCs for most OPs, out-patient and in-patient services, ophthalmic consultations and glasses, Trauma Resiliency (TRM) therapy sessions and field trips as part of psycho-social care.

Perhaps, a differentiation should be made between 'mental health' and 'psycho-social' support as the former is more clinical and there are few facilities in Haiti for the former while the latter is being addressed to some extent by HelpAge and other NGOs. The primarily activity of the PS support have been to train the HBCs to assist OPs in a general way and only a more in-depth study could inform on its effectiveness. From the FGD discussions, it can be sensed that perhaps the best PS support has been the small but constant social activities involving OPs, building up their self-respect and improving their social interactions rather than the small amount of specific TRM training and therapy (203 OPs) without active monitoring.

While providing access to health services to OPs in EQ zones during the first 6 months is part of the emergency response, the purpose of paying for such an unsustainable service for non-emergency purposes for a continuing 12 months as not been made clear. However, this access to healthcare has been well coordinated and closely monitored.

HelpAge was very well prepared for the response to the unplanned cholera epidemic by mobilising its medical team, HBCs and OPAs to particularly cover the needs of OPs as per Ministry of Health directives. Very few OPs within HelpAge's activity zones contracted cholera and there is an ongoing study with MSF to determine the impact of the cholera epidemic on OPs generally.

4. Were humanitarian principles observed and standards met (Red Cross Code of Conduct, Sphere, and HAP)?

Discussions with staff, beneficiaries and partners indicate that humanitarian principles and standards were met (respect, impartiality, participation,...). SPHERE standards are not particularly relevant for the current HelpAge activities in Haiti. Staff have been only briefly informed of the different codes and standards and a few have received specialised SPHERE training, but there has not been a determined effort to ensure understanding and compliance.

5. What has been the impact of the project for the direct beneficiaries, indirect beneficiaries and the wider communities?

1) Direct beneficiaries:
a) OPs: very positive (FGD, IBS) without exception in all sectors of activity but with high expectations for HelpAge to keep on providing products and payments.

b) OPAs: positive but with high expectations and dependency (organisational and economic) and currently unclear sustainability. Phase 2.2 is critical to establish an appropriate level of sustainability. Some examples of the level of dependency created when visiting OPA offices: 1) the meeting rooms are set up with all the chairs facing a head table, classroom style instead of being more convivial and inclusive, 2) all the OPA's work plans and other written information are done on a computer and printer by HelpAge staff rather than handwritten by OPA members.

c) HBCs: very positive impact but also with unclear sustainability (paid monthly $50 by HelpAge).

2) Indirect beneficiaries:
a) Non-project OPs: positive in that the profile of OPs has been raised, both nationally and in HelpAge's IDP camps and implementation zones and there have been a few positive outcomes from advocacy activities but the future depends on the sustainability and level of advocacy activities at all levels.

b) OP service providers (health facilities, local NGOs, nursing homes, etc.): positive and undetermined but likely short term and on a case-by-case basis thus far. The future depends on the longer term strategy.

c) Non OPs: small impact thus far (and unquantified) and mostly through mainstream media (radio and television programmes) and the ADA activities.

3) Wider communities
a) Neighbourhoods: only on an ad-hoc basis where previously camp based OPAs have continued operating once the camps have been closed. There is no clear indication of how the former camp based OPAs have continued once relocated in their neighbourhoods.

c) Communal level: OPAs are too new to yet have had an impact at this level and it will depend on OPAs and HelpAge to determine the level of impact at this level.

d) Supporting agencies (INGOs, LNGOS, RC-RC and UN systems): limited impact thus far due to a lack of systematic coordination (mostly done on a case by case basis) but there has been progress, particularly in influencing and information sharing through the cluster system, though demographic data analysis still does not disaggregate on an age basis for OPs. It is also the case that there is a high turnover of staff in all agencies and the cluster system which is also unstable due to chronic funding issues. The future impact will depend primarily on HelpAge and its advocacy partners at the international/national/regional level with support from OPAs at the communal/local level. The impact will be able to be measured during the response to the next disaster to affect Haiti.

e) National and local authorities: primarily through the DPCs at local levels which have received manuals for dealing with OPs in emergencies and questionnaires which include OPs. Some OPA members have been able to join local emergency committees. There is a system to send SMS to OPs when the DPC declares an emergency and to broadcast OP specific radio messages. There is a start of discussions with the Ministry of Social Affairs to raise awareness of the issues affecting OPs. The future impact will depend primarily on HelpAge and its advocacy partners with support from OPAs.

f) Public media: HelpAge has had a positive presence in public media, public and private, but the current impact is difficult to assess and future impact will depend primarily on how HelpAge and its advocacy partners use public media for information sharing, awareness raising, influencing or advocacy.

6a) Was the programme relevant to the particular needs of older people?

The programme has been very relevant to the expressed needs of older people. The sectors of protection, health services access and livelihood support are essential. The only specific need that was not addressed directly by the project was for shelter, but this is a very difficult issue in Haiti and the fact that more than 1,000 OPs have been accommodated through other agencies is an excellent result and needs on-going effort in the longer term.

6b) Did it target and reach them effectively and appropriately?

Yes, as nearly all the OPs living in the camps covered by HelpAge have been assessed and registered. The use of HBCs is instrumental in reaching OPs effectively and appropriately, especially the more vulnerable ones who are harder to find and assist. HBCs have also had the support of OPA committee members and HelpAge staff, particularly the Community Agents and the Nurses.

6c) Did it target the most vulnerable older people?

Yes, for social, health access and livelihood support activities. All registered OPs above 65 received a cash transfer worth $85 over 5 months. Furthermore OPA committee members and HBCs assisted in selecting particularly vulnerable OPs to benefit from specific distributions for which they did not otherwise qualify (since the criteria were based either age or child-minding). The HBCs have the best way into communities of OPs. FGD with general OPA members agreed that the process for the selection of the most vulnerable were fair and transparent.

6d) Did it impact women and men differently?

Not generally, but slightly in some specific cases where there was a decision on increasing access for women, such as in CfW and micro loans, but it is also the case that there naturally are more women living into older age. Gender based lifestyle differences seem smaller in OP populations, save for more women the taking care of small children (usually grandchildren). All FGD indicate that women have at least the same access to services and to decision making than men. It is also the case that about two thirds of the HBCs are men (even though about two thirds of OPs are women), but this seem to work well and not raise any particular issues, though this should be monitored regularly.

7) Were DRR measures integrated in the programme (e.g. preparedness for hurricanes).

Yes, DRR was one of the main motives for HelpAge to work in Haiti before the earthquake. DRR measures were integrated both at the individual level and camp/neighbourhood with OPAs and HBCs and at the communal level through the communal DPC who have been briefed and trained on including OPs in their response. There is a DRR focal point in each OPA and some

members are also part of the local emergency response committee. The result from the IBS indicate that this topic needs to be an ongoing effort.

5. Accountability

8) Participation – What was the level of involvement of and accountability to beneficiaries?

As HelpAge has achieved much in a short time (reaching to more than 10,000 OPs and launch more than 100 OPAs), without starting with trained staff or with a community base during an extreme emergency, beneficiary participation has been adequate and there are now ongoing efforts to improve beneficiary participation.

Looking at the different levels of participation:

Information: activity based information has been good, mostly orally, though project-wide information has not been well disseminated, partly because of the lack of an overall framework.

Consultation: due to the ambitious project plans, short time-frame and newness of relationships for trust building and project understanding, opportunities for consultation started small but have been increasing. Though the great majority of beneficiaries for money or material distributions were selected primarily on age criteria using the HelpAge database, OPA committees were asked to select other particularly vulnerable and deserving OPs who did not meet the age criteria. Increased consultation can only occur after a level of mutual understanding has been achieved (through information sharing backed by practice) and in Phase 2.2, there is an increasing level of participation, especially at communal OPA level, such as for activity planning, resource management and use of funds.

Involvement *(deciding together)*: up to the end of Phase 2.1, involvement has been limited and determined primarily to satisfy project objectives and there are more opportunities underway in Phase 2.2, particularly for increasing the self-sufficiency of the OPAs.

Collaboration *(acting together) and Empowerment (supporting others)*: these are starting in Phase 2.2 and the future will depend on the HelpAge and partner strategies.

Accountability toward beneficiaries has been good but largely activity based (such as a complaint mechanism, close monitoring with feedback, group discussions). Although there is an accountability framework, its implementation with both staff and beneficiaries has been sporadic and activity based rather than mainstreamed (ongoing and project-wide).

9) Complaint Handling - to what extent was the cash transfer complaints mechanism used by beneficiaries?

This was well set up as part of the monitoring and it was used during the few months of the activity with less than 100 complaints registered (approximately 2% of total), mostly for issues of non-payment (either due to technical problems or with weaknesses of the service provider, Voilà, who was also in the rollout phase and used the activity to develop its own capacity) and individual remedial action was taken on a case-by-case basis. This agrees well with the IBS rate of 2% having had problems.

However, the complaint mechanism system has not been used since the activity ended and is now ineffectual. The IBS suggests that OPs do not know how to make a complaint to HelpAge, none have the phone number (though 3,000 pamphlets had been distributed at the time of the cash transfer), nor is it advertised on the communal OPA office walls.

10a) Monitoring, learning and evaluation.

Monitoring: activity monitoring is generally well set up, with administrative and financial checks and regular field visits. The health sector could use more systematic monitoring of whether patients are correctly diagnosed and receive the appropriate treatment (primarily lab tests and medication, as HelpAge pays for these). The potential for the mis-handling of drugs is well known and has to be closely monitored. For example, the team knows that patients receive tablets (receipt provided and patient confirms receiving tablets), but they do not know if those tablets are the real medicine and if they are what is needed for the patient's treatment.

Learning: there is much learning by doing with creative solutions found to resolve issues. However, the learning is not systematically analysed, contextualised and disseminated (if something works or not: why is it so, what are the enabling features, what makes it exceptional or capable of replication elsewhere, how does it fit within the HelpAge discourse, what are the costs/benefits, does the result/impact fit with the intention and hypotheses, etc…).

Evaluation: the only other evaluation was internal at the end of Phase 1 and this external one against the project objectives for Phase 1 and 2.1. There have been only two small internal impact activity specific evaluations (cash transfers during emergencies and the use of community networks in vulnerability assessment and response).

10b) Was the programme informed by lessons and experience from previous emergency programmes?

Clearly yes, with the focus on Protection (with camp based OPAs and HBCs), Health, Livelihoods, DRR and shelter (though indirectly) which addresses well the expressed needs of the beneficiaries as indicated in the IBS and FGD. However, what has been missing until the beginning of Phase 2 has been a closer coordination with local actors for a multiplier effect (save for shelter and health service access and only on a case-by-case basis), such as with Handicap International and the RC-RC movement, especially the British Red Cross, also a DEC member. Another factor is that the programme does not fit into a longer term country strategy and thus appears as a group of activities, each worthwhile in its own right, but without interconnectedness and a longer term outlook (impact and sustainability).

11) Transparency – Did the organisation provide information and consult with stakeholders to ensure the understanding of the Organisation's commitments and programme activities.

Yes, to all major stakeholders, such as OCHA, UN clusters, NGOs and government ministries. However, HelpAge – Haiti could not communicate on its commitment to Haiti beyond the immediate programme activities.

12) Human Resource Practice – Did HelpAge staff and partners behave in a manner that respected older people and enhanced HelpAge's reputation?

Personal discussions, the IBS and the FGD revealed a very high appreciation for HelpAge's work, practices and staff performance. While the consultant has not had extensive interaction with HelpAge's partners, FGD and KII
indicate respectful relationships with OPs, except for the occasional contracted health partner challenging contractual project obligations and this was quickly remedied by the health team.

6. Efficiency

13) Did the project provide the best possible value for money?

This is an appreciation and remains subjective without using detailed auditing measures and beyond the scope of this project evaluation. Considering the level of activities, of coverage in the time frame and in the difficult environment, the consultant is satisfied that HelpAge has thus far provided good value for money. This is helped by reasonably low expatriate staff content (ratio of less than 1 in 10) and low staff turn-over, as compared to other NGOs in Haiti since the earthquake.

However, this statement needs clarification. Firstly, as the project is not finished with Phase 2.2 running until July 2012 it is not yet possible to tell whether certain activities will reach the intended level of impact and whether the cost/benefit is acceptable. These include the sustainability of OPAs, the sustainability and function/use of the Club Media and the sustainability and function/use of the job centres, the impact of group and individual IGAs and advocacy results.

Some examples of best value for money is the use of mobile phone cash transfers, where the economy of scale reduces the transaction cost to about 2%, the use of the DASH health system wherever possible which reduces the health cost per patient to $6 monthly, the use and support of existing health services providers rather than direct service provision.

Some examples of results where the value for money is unclear and could be investigated for learning are the actual impact of the TRM training on OPs (if only 203 out of 11,000 have received treatment); the transfer of $85 in 5 instalments rather than in one (reducing the amount of staff involvement with the process over several months) and the distribution of the two kinds of ToughStuff kits (cost/benefit of each after a few months' use from HelpAge and beneficiary standpoints).

The two aspects which could have most likely led to better value for money, but which are now being addressed, are the incomplete multiplier effect through linkages with other obvious International Partners (Handicap International, BRC, etc.) and a country strategy which helps to define 'value' in terms of intentions and impact rather than just outputs and outcomes.

However, there is a large but intangible value in creating the OPAs, giving OPs respect and self-respect and raising the profile of OPs locally and nationally and HelpAge has much experience in establishing OPAs around the world with results to show that OPAs can be sustainable and very effective in the longer term.

14a) Did the organisation ensure processes were in place at the appropriate level governing the use and management of funds?

HelpAge has used experienced expatriate finance managers and used internal manuals and procedures since 2007. This also covers procurement and logistics. Additionally, there is an internal annual financial country audit. There is a monthly monitoring of all financial contracts with partners.

14b) Did the programme design and procurement processes maximise value for money - balancing quality, cost and timeliness?

Yes, as best possible within the context. HelpAge has a manual and procedures for procurement but the situation in Haiti after the earthquake was particularly difficult to manage as the newly recruited staff initially did not have the capacity to implement procurement effectively and the few suppliers had little incentive to negotiate and perform well (for example requiring up-front payment). One example of continuous improvement has been the move from contracting a single public hospital for performing OP patient care in Phase 1 to the Phase

2 contracting a local primary health service provider (DASH) on a monthly patient insurance basis ($6/person-month) in 4 communes and contracting a mixture of 6 other Ministry registered public and private facilities to deliver OP health services (at an all-included cost of approximately $17/person-visit).

7. Sustainability

15a) Is there a continuing need for the activities and services provided by the project?

Yes, but in a modified form, particularly to devolve more authority to OPAs (and train them to find other sources of support) and to build the capacity and work more through local partners.

Now that the emergency phase is over, HelpAge should become less of a direct implementer (except perhaps as a lead for advocacy and media activities), reach out and represent all OPs, not just those affected by the earthquake and become more of a catalyst and seek synergies with others. However, priorities will need to be established to capitalise on HelpAge's greatest added value and ensure that it does not foster dependency or substitute for services that should be provided by either the public or private sector.

15b) Have plans been made and measures taken to ensure the continuation of the programme after DEC funding ceases?

For a year before the end of the DEC project, proposals have been developed and submitted to institutional donors to seek other funding sources and increase coordination and cooperation with others stakeholders. A 5 year country strategy is currently being defined.

16) How can the benefits of the project be most appropriately and effectively continued or extended for the target population?

HelpAge has made an excellent start with the 12 communal OPAs and their role needs to be consolidated and linked to other local and international partners. A distinct possibility is to extend the communal OPA model to other areas of Haiti. Similarly, the benefits of advocacy can be extended throughout the country, in depth and breadth, especially as Haiti is poised to suffer further disasters, particularly hurricanes and flooding.

Are the nice OPA offices with generators, printer/photocopiers and multi-media equipment provided by HelpAge appropriate and sustainable?

Is this OPA office reachable only by this steep staircase appropriate?

8. Partnership

17) Did the project work appropriately and effectively with partner agencies (international and local)?

There has been good cooperation with partners such as with IPESI, OCHA and at the UN cluster level, though the nature of the involvement has to be long term to see a measure of effectiveness. There have also been many examples of appropriate and effective cooperation in the field, usually on a case-by-case basis, such as with MSF for access to mobile clinics and other agencies for access to shelters. During Phase 1, Haitian partners were also victims of the disaster and save for IPESI, not resourceful enough to assist significantly but HelpAge was able to mobilise the strong assistance of ALA, a Dominican Republic partner.

However, more could have been done with partners and international potential partners during Phase 2.1 and this is being remedied in Phase 2.2, both on a bilateral basis (projects, activities and trainings) and with the creation of an OP platform with a few partners for policy, advocacy, etc... This weakness in cooperation with international partner agencies was due primarily to the heavy work load but a better effort could have been made with the major and most likely partners, such as Handicap International and the Red Crosses.

18) Did the capacity building and training done by IPESI, a key partner, improve the quality of services provided for older people?

It is clear that the collaboration and the trainings delivered by IPESI to nurses and medical personnel, middle level project staff and at community level (HBCs, OPA committees and OPs) has been very professional, appropriate, well received and appreciated.

19) Would it be appropriate to continue any or all of the partnerships in order to ensure continuing assistance to the target population? If so, how?

It is essential to develop the current partnerships for best effect based on strengths and complementarities. Partners are very different and each partnership has to be evaluated for its current status, what it wants to accomplish and determine the steps needed. The most important current issue for partnership is for advocacy, both with international and national actors and both for emergencies and longer term development. While there are only two local partners with a remit to assist OPs, there are others whose issues and objectives overlap, such as groups for the blind (SHAA, who is the third HelpAge Affiliate along with CARPA and IPESI) and the handicapped (HI and its local partners).

9. Learning

20) Did the programme develop any particularly effective and/or innovative approaches that could improve humanitarian assistance for older people in future?

Effective

1) The creation of 12 communal OPAs has been effective in giving OPs hope, self-respect and also respect from others. They are also a good link between the more local OPAs (camps and neighbourhoods) and the communal, regional and national level (HelpAge and eventually others). However, there are two questions on the effectiveness of the approach; 1) their general sustainability (social and economic) and 2) their adaptability, i.e.: how have the former camp based OPAs continued once relocated in their neighbourhoods?

2) The use of contracted national health service providers (public and private hospitals and clinics) and primary health insurance (DASH) is both cost effective and supports local structures.

Innovative

3) HelpAge Haiti has been a pioneer in using mobile phone technology to transfer cash to its beneficiaries. While there have been some delays and implementation issues with a new system still under construction, it was a complete success and with long term low transaction costs (about 2%). Furthermore, issuing mobile phones with solar chargers to beneficiaries also gives them access to communication, a small torch and to receive emergency SMS.

4) The creation and support of the HBCs is an excellent initiative as they disseminate information and assist the beneficiaries directly and also relay information to the OPAs and HelpAge. They are in fact the "hands and ears" of each towards the others.

5) ToughStuff solar kits as they have the potential to give OPs long lasting and free access to: phone charging, battery charging for radio listening and an LED light for home lighting, all very important.

21) Have these been documented and shared internally and/or externally?

There have been three specific documents produced thus far, but none are dated and authored and it is unclear how they have or will be used:

1) A review of the purpose, delivery and impact of the Cash Transfer in Phase 1 through UniTransfer (but the article does not state the amount of the transfer to each beneficiary).

2) A review of the Roles of Community Networks in Vulnerability Assessment and Response which explains the rationale for the use of VFCs, HBCs and Community Agents. However, the report does not address the issue of gender in HBCs and the possible conflict of interests or confusion when an HBC is also a member of the OPA committee or its president.

3) The strategy for using mobile phone cash transfers. However, an evaluation of the activity has not yet been completed. The analysis should also address the benefits of transfers in small lump sums instead of very small instalments, the additional benefits of the mobile phone, what is the threshold of credit/grant and other key factors which allows an OP to invest in productive rather than consumptive activities (level of child care activities, age, gender, location, family support, etc.).

Other lessons learnt could be documented, beyond what is in monthly reports and in emails, such as:

4) The payment for the provision of health services, especially when they are supposed to be free or at least cost controlled and not related to the emergency (i.e.: in Phase 2.1)

5) The purpose, method, results and replicability of various advocacy initiatives (successful or not)

6) The rationale and effectiveness of the ToughStuff solar kits has yet to be studied (economic, social and technical) but current limited information suggest that the problems encountered could be easily overcome and this merits further consideration.

7) An analysis of the intention, hypotheses, progress and results of activities which start during the emergency phase and continue into longer term development, such as OPAs, HBCs, advocacy, livelihood and health activity support.

8) The cost effectiveness of each of the psycho-social support activities. For example, taking a few hundreds of OPs to the beach or the mountains has been expensive and appreciated, but would a wider dissemination of the TRM tools have had more sustainable impact?

5) Conclusions and Recommendations

The general conclusion is that this programme has been very successful, especially in Phase 1 with some creative solutions and but it needs to be consolidated into a longer term strategy. HelpAge Haiti is doing itself a disservice by not documenting well enough its activities and successes.

There have been a few implementation delays, due mostly to the difficult post-earthquake environment, but all activities are on track to be finished by the end of Phase 2.2. It has been fortuitous to be able to divide the intervention into the 3 approximate phases of 'prime emergency, recovery and development' where each builds on the strengths of the previous one.

Some of the following recommendations are already being implemented but are still included for completeness. They are separated into immediate ones for Haiti and more general ones for future interventions where HelpAge knows from the start that it will transition from an acute emergency response to one of longer term development and they occasionally overlap.

GLOBAL

WWE and HQ

a) HQ to improve technical packages and guidance for different sectors on how to manage specific emergency responses (from instant onset like earthquakes and tsunamis through to slow onset like famines) with pre-defined priorities and planning for exit strategies and ongoing development, depending on whether the response is only for a few months ('Phase 1'), 1 to 3 years ('Phase 2 – recovery') or more than 3 years ('development'). This would alter implementation approaches such as which activities to engage and how to minimise the dangers of the high dependency effect of emergency activities (such as paying people to accomplish family or community activities or focusing on a limited number of people or the level of passive and active advocacy). Also to define what constitute the thresholds on the continuum from the acute emergency response to the long term development (rather than think of different separate phases, which might fit a form of institutional reality but does not readily apply to beneficiary and ground reality).

b) If advocacy is a core function of HelpAge, even in emergencies, then HQ should also send advocacy support at the start of the acute phase of the emergency and to set up a tailored pro-active advocacy program (for NGOs, service providers, local, communal, regional and national authorities, media, etc.). Staff on the ground are too busy with the day-to-day activities to take on the additional role of advocacy as an activity in itself, except on a passive, field based case-by-case basis. Strong advocacy support from the beginning is one of the recommendations from the ALNAP Responding to Earthquakes study 2008.

c) Healthcare is a vast subject and the demand will always outstrip the supply. HelpAge needs to consider its position and develop a strategy for this sector in the context of providing services (directly and indirectly) from the first few weeks and months of the acute phase of a disaster response when savings lives and alleviating the additional suffering is paramount, to the provision of health care for the usual non-disaster ailments probably starting no later than 6 months after the disaster. One special case of health services to be taken into account throughout the first 24 months at least, is that of psycho-social support, where problems also have a delayed and subtle onset. It may be more cost effective to be more of a catalyst and enabler than to provide direct or indirect health services after the emergency response. Such enabling activities can include training (health providers, health policy makers, OPAs, partners, etc., advocacy, studies, information gathering and sharing, etc.) One small successful example from Haiti has been supporting the delivery of specific modules on taking care of OPs to a few medical and support staff working with OPs (this was successfully done through IPESI) but it could also be made more systematic with the delivery of modules on geriatrics/gerontology (and including Post Traumatic Stress Disorder) to medical establishments, nursing/health staff, contract health service providers and even NGO staff.

d) Prior to an emergency response, HelpAge should coordinate on projects and approaches with key international partners (HI, BRC, Merlin, etc.) in order to maximise impact and optimise resource use.

HAITI

a) Decide on a longer term strategy for Haiti (with a SWOT analysis of potential activity sectors and partners) and how/who to respond to ALL the needs/expectations raised, focusing on specific concerns of OP as against adults in general.

b) Ensure to give people choices rather than a one size fits all approach. Just because people have reached a certain age does not imply that they face the same issues or have the same hopes and interests. Age is only a proxy for 'vulnerability' and is different from a noticeable vulnerability, such as blindness, deafness or other physical or mental disability.

c) Consider moving the office from its current location in a residential area, about an hour's drive to most locations of interest, to a location closer to other NGOs, partners and development actors. This would largely facilitate networking and transport.

Programme objectives

1. Specific Objective 1: *within 1 year, 10,000 older person will experience increased protection and are empowered to advocate for their rights and most pressing needs*

a) Encourage more organisational and financial autonomy of OPAs before July 2012. Ensure that each has its own strategy tailored to its context and its membership choices while reducing HelpAge's material, financial and organisational inputs.

b) Consider the creation and support a Federation of OPAs (by itself or as part of another federation) to be supervised by a local group as currently HelpAge assumes the function of the 'federation'. Common agenda items for a Federation could include such items as: DRR issues, access to health services and shelter solutions at all levels, advocacy within government structures, provide economies of scale with service and product providers (reduced insurance prices with DASH, lower transfer costs with mobile phone companies, etc.).

c) Create an advocacy policy for Haiti with clear goals and principles for HelpAge, its partners and the OPAs and provide specific training on advocacy to staff, partners and OPAs. Perhaps there is a need to differentiate between passive 'awareness raising' and active 'advocacy'.

d) Encourage the communal OPAs to develop and disseminate their own information and accountability material, especially in their offices and meetings, such as: accountability processes, organisation and activity information (who, what, where, when, how much, etc.), photos with narrative highlights of local and all OP successes, definitions with graphics of rights/roles and responsibilities, etc. Capitalise on local and other OPA successes and make it visually interesting (see Annex 5).

e) Develop ideas to encourage motivation/participation without resorting to outright payment, especially for community or family level activities: 1) use matching funds to encourage finding other funding, 2) use a reward system (such as some form of media exposure, a special trip or other non-financial incentive) with friendly competition for various activities, whether at OPA or member level: game tournaments, advocacy and livelihood successes, alternate funding sources, artistic productions, storytelling, creative solutions, etc.

2. Specific Objective 2: *within 1 year, 10,000 older people will have improved their livelihoods through a social pension or active role*

a) Include more and better micro-projects and micro-credit for both OPAs and OPs (include business & management training and plans) from the beginning of Phase 2 as real livelihood

improvements rather than limited one-time economic injections. This is also a recommendation from the ALNAP Responding to Earthquakes study 2008.

b) Encourage Income Generating Activities which do not directly compete with other main-street activities and are suited to OPs (OPA office room rental, solar charging business, chicken/rabbit raising, special foods or food supplements (no cook, easy digest, vitamins, high micro-nutrients (sprouts), etc.), etc.).

c) Assist OPAs who wish to do so, to systemise a funeral fund and/or a caisse communautaire (perhaps on a form of matching fund basis), as some already do this but on an ad-hoc basis but the need has been voiced both in FGD and in the IBS.

3. Specific Objective 3:*. Within 1 year, 10,000 older people receive appropriate healthcare including mental health support*

a) The recommendation is the same as in the global section, in that the details are in the definition of "appropriate". Generally appropriate health care for OPs (in which case, how does that fit within HelpAge's global and country goals?) or disaster response appropriate OP health care? (which becomes more difficult to define 6 months after a disaster, except for psycho-social support and mental health, a distinction to be defined within cultural and medical contexts)

4. Were humanitarian principles observed and standards met (Red Cross Code of Conduct, Sphere, HAP)?

a) There is a need for more staff training (with pre/post testing), mainstreaming (in project design and implementation) and regular monitoring (project activities and staff performance appraisals).

b) The accountability framework and its implementation with both staff and beneficiaries has to be mainstreamed with information boards, suggestion and complaint boxes and phone numbers, regular feedback meetings with beneficiaries and staff, etc.. This effort is currently in progress in Phase 2.2 and needs to be consolidated in Haiti.

5. What has been the impact of the project for the direct beneficiaries, indirect beneficiaries and the wider communities?

Generally to include regular impact studies (they can be small) as part of the M&E activities, perhaps within a month of an activity and again 6 months later. This would be useful both for accountability and learning.

1) Direct beneficiaries:
a) HBCs have such an important function that they will have to be encouraged without the need for a monthly payment. Possibilities for other forms of reward other than financial have to be tested. A different kind of economic incentive can be a special HBC roll-over loan (with interest) of significant size but related to job performance. In the near future, the HBCs should be made accountable directly to the OPAs with occasional support from HelpAge (trainings, information sharing, etc.).

2) Indirect beneficiaries:
a) Perform a small study to assess impact on the indirect beneficiaries (first need to define who they are, what are the likely effects and also search for perverse effects – do no harm). For example measure the impact on health service providers or the DPC such as activity & result snapshots before, during and after the project and absolute and relative numbers of OPs on the total work load; the effect of camp based OPAs on other nearby camps; etc...

b) Depending on the strategy, to make links for inter-generational dialogue and activities, for example with the Boy/Girl scouts and other Youth Clubs.

4) Wider communities

a) As above, to perform occasional mini-impact evaluations on specific 'wider community' segments and not just the measurement of outputs as done in monitoring.

b) Continue the parallel approach of coordination and cooperation with key international partners at HQ and national levels to ensure that OPs are taken into account in all policies and operations and include a regular feedback and reflection mechanism, perhaps at 3 months intervals following a specific response.

c) Consider also working with the Haitian red Cross specifically, though it is, in theory, co-operating with the DPC in emergencies but the field reality is often different.

d) Continue with national and local level media campaigns but within a strategic framework, to reinforce the advocacy with awareness raising is its essential first part.

7) Were DRR measures integrated in the programme (e.g. preparedness for hurricanes).

a) There needs to be an ongoing effort to sensitise, advocate and train all disaster response agencies at regional and national level on the specific considerations of OP in emergencies. There is already some activity at the cluster level.

b) OPAs need to be fully trained and briefed on their responsibilities to ensure appropriate DRR measures, both within their members but also within their sphere of influence (DPC, CRH and others).

c) Perhaps develop a special OP emergency kit with: solar panel+radio+light; waterproof pocket for documents (with an HelpAge sticker with emergency phone numbers and HelpAge accountability number), soft medicine, etc.; emergency food; aquatabs; blanket; warm hat; basic hygiene items; list of emergency phone numbers, etc..

10a) Monitoring, learning and evaluation.

a) To develop a clear and systematic monitoring plan (of what, when and how), and also broader than just in response to activities (inputs, outputs and outcomes).

b) To develop a clear and systematic internal plan for evaluation of results, direct and indirect outcomes and impact, but at the three levels of activity/project, sector/programme and strategic.

c) To develop a clear and systematic learning plan (why/why not, how, testing of hypotheses, what risks and assumptions, the lessons learned and validated, the level of information required, the decision making processes, etc.), both at the national and international level, internally and externally.

d) Perhaps to set aside one day per quarter to review all the accountability, monitoring, learning and evaluation activities and to document them in a systematic format for easy dissemination. Document each activity with short summary using a mini log frame stating hypotheses, risks, assumptions, logical progress from inputs to outputs, outcomes and expected impact, which HelpAge and donor indicators, etc...

e) Creating a specific position for Quality, Accountability, Monitoring, Evaluation and Learning. This person would supervise all these cross-cutting issues, which often are incomplete and only activity based. This person would be responsible for gathering all the evidence, all the documentation and disseminating Good Practice and Lessons Learned.

f) to assist with learning and good practice, HelpAge should develop a more systematic information management system with internal HelpAge indicators, beyond what is required for donor indicators. This includes a HelpAge standard form of beneficiary database (easy to manipulate by non-specialists) to be able to easily produce standard reports on a regular basis and the monitoring, evaluation and learning plans mentioned above.

11) Transparency – Did the organisation provide information and consult with stakeholders to ensure the understanding of the Organisation's commitments and programme activities.

It would be useful to document relations with all stakeholders using a standardised form to cover such items as: organisational structure, capacity assessment, information sharing (what, when and how), relationship/partnership issues, what are the commonalities, joint decisions taken, brief summary of important meetings, etc..

12) Human Resource Practice – Did HelpAge staff and partners behave in a manner that respected older people and enhanced HelpAge's reputation?

a) While the staff has behaved well with the beneficiaries, they have not received much training and it could be useful to provide them with more training and support on a few specific issue such as: a) how to best work with OPs and deal with difficult situations, b) a better understanding of their work such as programme/project information generally, concept and practice of quality and accountability, how to reduce dependency, etc.. c) advocacy and how to do it well.

14a) Did the organisation ensure processes were in place at the appropriate level governing the use and management of funds?

a) As public and private health institutions in developing countries are highly susceptible to mismanagement, HelpAge should also put in place close monitoring of expenses in such facilities. While the administrative monitoring is already taking place, there also needs to be monitoring of appropriate diagnosis and treatment through a trail of evidence at the individual patient level.

14b) Did the programme design and procurement processes maximise value for money - balancing quality, cost and timeliness?

a) Procurement/logistics is often not taken seriously enough under consideration during emergencies and usually needs external support for a few months (within HelpAge or on consultancy basis) to set up systems, train new staff and speed things up from previous experience. HelpAge did provide an expat logistics manager until the end of 2010 to assist with very difficult issues of logistics/procurement in Haiti.

15b) Have plans been made and measures taken to ensure the continuation of the programme after DEC funding ceases?

Sustainability should always be considered from the start and re-evaluated throughout the project, even in emergencies. One key method is to have a country strategy and to regularly question its validity and update it. There are several kinds of sustainability: social, material/technical and financial and each has to be considered both independently and in combination.

Partnership

17) Did the project work appropriately and effectively with partner agencies (international and local)?

This has two components:
1) At HQ level, there is already a level of discussion and engagement among key international agencies (UN, RC-RCs, NGOs and others). However, the inclusion of OP issues in internal policies and operationally takes time and needs regular urging at all levels of the hierarchy down to national and field level. This level of coordination and cooperation also needs to take place at the very early stages of a disaster response. This should not only encompass project issues (assessments, target zones, timing, activities, beneficiary and local partner selection, etc.) but also programme support such as possibilities for resource sharing (especially information, transport and maintenance, office and staff housing, warehousing, staff recruitment, procurement/logistics, national regulations, etc.).

2) In country, similarly with local partners to operationalise agreements made at higher levels.

3) Continue and strengthen the relationship with IPESI and ensure that pre- and post- testing is used to measure the performance of both the knowledge dispensers and knowledge acquirers in all situations. This partnership is likely to be limited only to trainings due to IPESI's mandate.

4) A SWOT analysis of each partner should be performed, with an accompanying work plan and strategy for each and should be jointly reviewed regularly.

Learning

1) Document internally and publish externally the advocacy successes (in Annex 5) and the innovative and effective approaches, including the alternative choices and why they were successful in the context. This would very useful for accountability, learning and advocacy.

6) Key Lessons learned and Way Forward

Key lessons

1) At least 4 key management positions need to be filled at the beginning of any emergency (most likely with experienced expats): 1) the Emergency Coordinator (project/activity focused), 2) the Country Representative (for advocacy, networking, donor relations, etc.), 3) the Quality, Accountability and Learning Coordinator which includes M&E, 4) the Support Services Coordinator (sometimes as the Financial Coordinator but with at least procurement, logistics and contract oversight/ management and possibly H.R. and administration).

2) Better documentation: first document the purpose, hypotheses, risk and assumptions, timeframe, indicators, (etc.), for each activity and how it fits with other activities and within a strategy. Secondly document the implementation, monitoring, problems and solutions (lessons learned), results and if possible, impact.

3) Regularly reflect and learn together (where is the best value added, the best opportunities, the lessons learned, what are the real risks and assumptions, etc.).

Way Forward

Organisation

4) Develop a country strategy starting with core goals and approaches. Some questions to answer: should the next 5 years focus on consolidating the current work in the EQ zones or should there be an outreach to other areas of Haiti, if so which and why? Are the activities and the three sectors of protection, health access and livelihood still the most relevant and represent the best value adding of HelpAge, if so how? International help will continue decreasing, what and when are the best opportunities for a multiplier effect?

Protection

5) Pursue coordination with the relevant agencies to keep finding shelter solutions for OPs while the shelter issue is still being worked upon (this will diminish over time).

6) Pursue the implementation of an advocacy plan with partners, with media work as a support.

Health

7) Consider the best ways of supporting OPs to gain access to reasonable health services, other than direct implementation (even through contractors).

Livelihoods

8) Pursue more sustainable livelihood and livelihood support solutions.

7) Annexes

Annex 1 – Detailed results from the 171 beneficiary survey

Key results from the beneficiary survey (141 visited out of 11,845 in the database, or 1.44% of total)
Based on the questions in the beneficiary questionnaire. See the full questionnaire in Annex 2. Respondents were able to make free comments on most questions. They were later coded. The data has been analysed only on the basis of sex differentiation. But other analyses could be done based also on age ranges and locations (PaP and Léogâne).

This survey only covered 4 camps out of many, the information presented is not globally representative but suggests trends or where better information should be sought (*marked in italics)*. The information is based only on a gender disaggregated basis. No attempt has been made to disaggregate further by age group or location as the sample is neither large nor representative enough. The sample covers 100 women and 41 men aged over 55.

Q5) More women have moved a smaller distance (77% against 64% within the same neighbourhood) and more men have moved a medium distance (36% against 19% from within the same commune). 4% of women and no men have moved from other communes.

Q6) The current greatest needs expressed are very similar and in priority order: livelihoods (89%), shelter (79%), health services (women 55%, men 40%), food (41%), health insurance (30%), funeral insurance (women 3%, men 10%). It has been expressed that funeral costs can reach $700.

Q10) HelpAge provided health services have benefitted 59% of women and 67% of men, primarily for outpatient services (34%) in a private facility (27%) and in mobile clinics (33% men and 24% women). 43% of men receive OPA/HBC help for health matters vs. 30% of women. 7% have received some form of health equipment (glasses, mobility aid, etc.).

Q11) Health facility visit in past 6 months: 13% have not gone. 8% have gone once. 28% of men visit 2 times vs. 13% of women. 5% of men visit 3 times vs. 28% of women. 10% visit 4 times. 16% visit 5 times. 23% of men visit 6 times vs. 10% of women.

These results (b, c & d) merit further investigation in that it seems that men have greater use of health services and women expressed a greater need. Could it related to the fact that 2/3ds of HBCs are men?

Q7) Food intake in the previous week (the norm in Haiti is to eat 2 meals/day):
- Women: 46% spent at least one day without eating (average 1.8 d/w) and 97% spent at least one day eating only one meal (average 5.9 d/w). Only 14% had at least one day with 2 meals (average 3.2 d/w).
- Men: 48% spent at least one day without eating (average 1.9 d/w) and 100% spent at least one day eating only one meal (average 6.1 d/w). The data gathering was incomplete for the case of eating twice a day.

# of days/week with no meal	1	2	3	# of days/week with 1 meal	1	2	3	4	# of days/week with 2 meals	1	2	3	7
% Men	32	42	26		13	20	15	53		N/A	N/A	N/A	N/A
% Women	41	39	20		**46**	17	20	45		21	21	36	21

Q8) Normal portion of protein intake in the previous week (eggs, meat or fish): 75 % had none, 15% had one, 8% had 2, 2% had more than 2 portions/week.

Although there are small differences between the sexes which could be further investigated, it is clear that both the quantity and quality of food intake in the elderly is inadequate. However,

when asked if the elderly suffered from a food apportionment discrimination inside the family, the answer was that the whole family was food poor and all shared equally what was available. A nutritional survey among the OPs would be instructive but need to be considered with care so as not to unduly raise expectations and with a view of the possible responses to the findings.

Q11) 80% of respondents claimed to need medication regularly.

Q12) 100% received visits from HBCs. On a monthly basis, 65% of women received 1-3 visits vs. 48% of men. 10% of women received 4 visits vs. 29% for men and 23% of both received more than 4 visits.

Q13&30) The purpose of the HBC visits was very similar for both: 82% for information sharing, 13% for assistance to get to a health facility, 7% for socialising and the rest for health advice/follow up and 'other'. Nearly 100% received information on hygiene and cholera and about 70% had received information on cyclone DRR.

Q14&15) Where as 100% claim to have had a livelihood in the past, only 12% of men and 23% of women do so now. 86% of women were formerly traders and only 21% are now as against 23% and 8% respectively for men. 60% of men formerly had manual skill jobs, only 5% do so now as against 14% and 2% respectively for women. 10% of men formerly had more professional jobs, 0% do so now as against 0% and 0% respectively for women.

Q16&17) Indebtedness: 64% of women and 72% of men have debts. There are other significant differences: a) whereas the % of women with debt decreases smoothly with increasing amounts (from 34% for <$50 to 2% for >$500), it is very uneven for men with a peak of 34% in the $50-$125 range, another of 24% in the 275-$500 range and 7% for >$500. In both cases 59% of loans were from friends, family (13% women, 3% men), money lender (14% men, 5% women), trader (14% women, 10% men), microcredit institution (7%) and the rest from various sources but including schools and funeral providers.

Q17&18) ToughStuff solar kits: the results are quantitatively unclear in that there had been 2 distributions of 2 different kinds of kits and the second distribution was incomplete but a qualitative interpretation can still be made. What can be discerned: 66% had received it. 38% of men were using it as against 20% of women, 6% of women claimed it was broken against 0% of men and 8% of women claimed it was lost or stolen against 5% of men. Only 5% of women mention using it for home lighting. 100% claim that it saves them money (primarily for phone charging) and 100% claim not to earn any money from it. *When considering that the enumerators observed that there was a 15% difference between men's and women's phone still working, it seems that women may have more difficulty in using these technologies.*

Q19, 20 & 21) Cash transfers:
a) Phase 1 $50 grant: 10% men and 7% women received it
b) Phase 2 $50 CfW: 10% men and 17% women received it
In both cases, the majority was used for food: 57% women and 50% men, for trading (31%), to repay debts (17% men and 5% women) and only 5% of women spent it on health.

c) The 5 monthly instalments of $17: 55% of women and 65% of men have received it and only 2% profess to have had problems receiving the transfer. In both cases the majority was used for food: 72% men and 65% women, for trading (18% women, 10% men), to repay debts (16% women, 7% men), for health (7% men and 2% women).

d) the conditional loan of $100: 12% of women and 2% of men have received it and nearly all used it for trading (it was tied to an economic activity and women are more engaged in trading than men) and one used it for health.

Q22&23) 2% of women admitted to begging a few times a month to help feed themselves against 0% for men. The enumerators felt that the people responded without hesitating or trying to minimise it.

Q24,25&29) Currently 97% of women live with family against 90% of men. More men now live alone (8% against 5% before the EQ) and the opposite for women (3% against 4%). No one currently lives with non-family members. When an OP requires personal assistance, 80% is done by children, 7% by a partner and the remainder by other family and friends.

Q26) 42% of men have a form of responsibility for children (4.6 on average) vs. 56% of women (2.7 on average). The majority (51 to 71%) profess to be responsible for the children, not just 'child minding'. *However, the level of responsibility is not clearly established and would need greater study. For example, it could be that the men feel responsible for paying for food and schooling while the women actively take care of children on a daily basis. From casual observation, it seems that many women engaged in home-based petty trading while minding children.*

Q27&28) For distraction from the daily routine, 82% of women and 90% of men listen to a radio daily with 8% of women having very little access to a radio. 14% of women and 18% of men profess not to socialise, partly due to indebtedness. The social activities include: 'chatting' (83% women and 68% men), singing and dancing (30%) and playing games (18% men, 3% women) and to do so with friends (60%), family (32% men and 13% women) and children (28% women, 12% men).

Q31) Nearly 100% have received information on hygiene and cholera prevention and about 70% for hurricane preparedness. When asked about the 3 most important things to do for hurricane preparedness, the responses were: to find a safe place (84% women, 72% men), to secure essential documents (84%), to prepare food and water (41% men, 31% women) and to pray (15% men and 10% women).

Q32) 85% would try to feedback to HelpAge through the OPA committee and none would attempt direct contact, partly because most do not have the HelpAge phone number (it was distributed a few months before along with an activity but the beneficiaries do not perceive it as a long term way to feedback to HelpAge). 63% of women would talk to the committee in person against 49% or men, the others would phone.

Q33, 34&35) 98% of men and 89% of women participate in OPA meetings, a few times/week: 55% for men and 43% for women and a few times/month: 43% and 50% respectively. Altogether, 95% of OPs have regular and frequent contact with the OPA. Furthermore, 25% have participated in the ADA activities, in hygiene and DRR trainings (22% women, 13% men), outings (8% men, 4% women) and 5% in socio-cultural activities.

Respondents feel the OPA is important for improving 'advocacy'/respect (85% men, 76% women), helping with health services access (74% men, 66% women), with livelihood support (64% men, 33% women), with socio-cultural activities (39% women, 26% men) and follow-up from HBCs and committee members (25%).

Q36) Only 20% do not have the standard ID. Of those, 1/3 never had any, more men had lost it before the EQ (+13%) and more women have lost it during or since (+28%, partly due to the difference of carrying it in one's pocket instead of a purse or bag).

Q37) 79% of men and 72% of women profess not to feel insecure or unsafe but 9% of women feel insecure due to flooding, 11% due to having a damaged house, 3% for theft and a smaller percentage for threat of eviction. This is possibly not representative of all camps.

Q38) 75% of men and 55% of women have received assistance from other NGOs. However, it is not clear whether this is at the individual level or family level. The large majority of the assistance came through various Red Crosses with smaller amounts through NGOs (CRS for 14% and ACF for 5% of women – much less for men: 3% from CARE and ACF). Women received more food, kits (hygiene, kitchen), water & water treatment items and the men received more tarps and tents. 8% received a shelter.

Q39) The enumerator were tasked with making specific observations:
a) 83% of the ToughStuff kits distributed to men were still functioning against 70% for women's.
b) 72-76% had received a Voilá mobile phone. 87% distributed to men were still functioning against 69% for women's.
c) 32% of women and 25% of men had a noticeable handicap (teeth, hearing, vision or physical).

Annex 2 – Questionnaire used in the beneficiary survey

Section 1 - General

1. **Neighbourhood:** Tapis Rouge, Park Acra, St Rose, Boulos, Tabarre, other: … … … … … … … … … …

2. **Name of respondent: … … …** … … … … … … … … … …

3. **Age of respondent:** … … … … … … … ..

4. **Respondent gender:** M / F

5. **Where were you just before the EQ**: a) the same place, b) <100meters, c) same neighbourhood, d) same municipality, e) other municipality … … … … … … … … … … … … … … ….

6. **What are your three biggest needs**: a) Housing … … b) … food. c) livelihood … .. d) health services. … .. e) personal assistance … … f) drugs … … g) equipment (glasses, cane, etc.). … …. h) social activity …. i) funeral cover/insurance… …. j) Health Insurance … …. k) security / respect … … .. l) literacy …. ---- m) means of transport … …. z) other: … … … … … … … … … … … …

Section 2 - Health

7. **In the past week, how many days without eating?** … **Eat one meal? … two meals** ?.....

8. **In the past week, how many eggs or serving of meat or fish did you eat?** 0 - 1 - 2 - 3 - 4 -> 4

9. **Since April 2011, how often did you get treatment at a health facility?** 0 - 1 - 2 - 3 - 4 - 5 -> 5

10. **If you have received a health assistance through HelpAge:** a) none **Yes**, **with** b) HBC c) APA d) community worker e) at public centre f) at private centre) g) at NGO facility h) as outpatient i) as inpatient k) received health insurance cover (DASH), l) access to mobile clinic, m) received health equipment: . … … …. z) other:

11. **Do you regularly need medication:** no - **yes: What … … … … … … … …** .. … … … … … … …

12. **How many times a month do you receive a visit from an HBC?** 0 - 1 - 2 - 3 - 4 - 5> 6

13. **What do you do with the HBC**? a) health / first aid, b) help to go to a treatment centre c) social activity d) receive information / awareness, --- z) other: …. .

Section 3 - Livelihood

14. **What was your economic occupation before?** a) none b) trading c) manual labor (informal) d) work (formal)

15. **What are your economic activities today?** a) none b) trading c) manual labor (informal) d) work (formal)

16. **If you are in debt today:** a) amount (HG): … … … … … … **To whom:** b) family c) friends

d) money lender e) institution / microfinance f) informal lending group g) trader z) other: … … … … … … … ..

17. **Solar Panel Kit:** a) not received b) still in use c) broken … d) lost / stolen e) lent / sold z) other: ……..

18. **With the solar panel kit, was it possible to:** a) save money? .. b) make money?... …

19. **Have you received a gift of 2000gd from HelpAge?** None, a) Cash for Work (10 days in 2011) b) gift (early 2010), **Used the money for:** c) to buy food) to repay debts e) pay for health / drugs f) petty trading z) other:……

20. **Did you receive a transfer T-Cash** (700gd for 5 months)? a) No b) **problem?** no / **yes why:** … … … … .. , **Use the money for:** c) to buy food) to repay debts e) pay for health / drugs f) petty trading

21. **If you received a loan of HelpAge** (6000gd), **use the money for:** b) not received c) to buy food) to repay debts e) pay for health/ drugs f) petty trading g) to other economic activity … … …

22. **Do you sometimes beg?** (in the street, to strangers) a) never b) a few times a year c) a few times a month d) a few times /week e) almost every day z) other: … .

23. **Reason for begging:** a) to eat b) for health / medication c) to repay debts) to give to family e) give to someone else (not family) f) other personal expenses … … … … … … …. … … …. z) other: ……..

<u>Section 4a - Social Aspects family</u>

24. **How do you live now?** a) alone b) with family c) with friends z) other: … … … … … … … … …

25. **With whom did you live before the EQ?** a) alone b) with family c) with friends z) other: … … …

26. **Do you <u>mind</u> or <u>are responsible</u> for how many children on a regular basis?** a) none b) … … …

27. **Listen to the radio?** a) never b) once a month c) a few times /week d) almost every day z) other:…….

28. **Can you amuse yourself regularly?** N - **O how …. … … … … with whom… … … … … … … … … ..**

29. **When you need personal help, who helps**? A) no one b) partner/spouse c) children d) another family member e) friend f) HBC g) a member of the OPA z) other: … … … … … … … … …

<u>Section 4b - Social aspects OPA</u>

30. **What awareness or information you have you received from the OPA / HBC?** A) DRR / cyclone b) hygiene / cholera z) other … … … ..

31. **When a hurricane threatens, what are the three most important things you need to do:**
a) … … … … ……. b) … … … … … … … … … … . … .. c) … … … … … … … … … … … …. … … … . … …

32. **How and who can you contact at HelpAge if there is a serious problem or complaint:** (staff of HelpAge, an HBC, a member of the APA, etc.). **Who? … … … … … … … … … … … … How?** … … … … … … … … … …

33. **Which OPA activities have you participated in?** a) nothing b) regular meetings c) day trips d) information e) ADA day / Oct.1st f) socio-cultural (films, games, ...) z) other: ... ...

34. **Frequency of contact with the OPA?** A) none b) a few times/year c) a few times /month d) a few times/week e) almost every day z) other: ... ...

35. **Which are the three main benefits you get from the OPA?** a) more respect (advocacy) ... b) access to health services ... c) access to basic services ... d) help with livelihood .... e) solidarity / social activities ... f) follow-up visits from HBC and Committee ... z) other: ... ...

Section 5 - Protection

36. **Do you have a formal ID card?** Yes / No **If no, why:** a) never had b) lost but non-earthquake c) Lost in earthquake z) other: ... ...

37. **Do you feel in danger / insecurity?** No - **Yes, why?** ... ...

38. **Did you receive help from another NGO?** No **/ Yes: which one ... .** . ... **What ... ...**

Section 6

39. **Observations of the survey enumerators:**

a) Kit ToughStuff in working order: none received / Y / N	b) Have the phone No. for complaints: Y / N
c) Mobile Phone Voila works: none received / O / N	d) Is person: alone / with family
e) Does person present a visible handicap Y / N – kind:	

40. **Other comments from:** a) the respondent or b) the surveyor: ... ...

Annex 3 – OPA Focus Group Guidelines

General

1. As a OP, how are your needs different from other adults in your family (male / female)? Or from your peers in your neighborhood?

2. What/how is your relationship with your family? (Social, economic, etc.).

3. What are the rights of the elderly? How do you know?

4. Who has a CIN / NIF ID card? Did HelpAge help you get it?

5. What is the role of the OPA? What does it do? How do you participate?

6. What were the interventions of HelpAge? (Protection-respect/ ID, physical health care, mental health care (travel, activities), cash transfers / CfW, Toughstuff, shelter, DRR, advocacy, HBC, media campaigns (radio, TV), ……

7. How have you participated in these activities? What are the +ves and –ves of these activities?

8. Are there any OP who do not participate? Who, where and why?

9. How does HelpAge communicate with you? (Community workers, OPA committee,….)

10. If you have complaints or suggestions for HelpAge, how do you do it?

11. How have you benefited economically from HelpAge?

12. In the future, what are the expectations and responsibilities of the OPA?

13. In the future, what should be the role of HelpAge? How can they help the OPA to do better?

14. How do you envisage the future with a reduce role of HelpAge? (Money, support….

Committees

15. Describe your activities / responsibilities as a committee. What is the structure? Is it satisfactory? What can HelpAge do to better help you?

16. Who are your external stakeholders? What interventions/relationships do you have with them?

Livelihood

17. How have you used the money from HelpAge?

18. What IGA have you done or intend to do?

Annex 4 – Key Informant Questionnaire

1. How long have you worked with HelpAge?
0-1 months 2-3months 4-6 months 7-9 months > 10 months

2. What were your activities for this project (details and timetable):

3. What were the positive aspects of this project?

4. What were the aspects to improve?

5. What were the constraints for the success of the project (internal and external)?

6. How have they been overcome (or not, how / why)?

7. In hindsight, if the project had to be re-done (back to July 2010), what should be done differently?

8. Coordination / integration with other stakeholders - internal / external (who, what, how)?

9. Comments on the social aspects, internal / external (participation, information, accountability, gender)

10. Questions for staff: manuals, procedures, reports, planning, IEC materials, tools, info sharing internal support, etc…

11. Any other comments?

Annex 5 – Advocacy successes meriting further documentation

- In Croix des Bouquets, the OPA has successfully advocated for the integration of older people in a cash for work activity
- In Croix des Bouquets, OPA obtained the dismissal of a camp committee that was not working for the wellbeing of camp residents
- In Jacmel, one OPA has created cash box where members contribute. With the contributions, they are able to support a member facing some problems. For example they were able to cover funeral fees for one member
- In Petion-Ville, OPA members have started a literacy program for those of the association who cannot read
- In Petit-Goave, the local associations has taken the initiative of setting up an OPA at the communal section level.
- Older people in the RRS camp in Petion-Ville have replicated the training they have receive on hygiene promotion to prevent cholera
- In Petion-Ville, OP are more aware of their rights and are more demanding. For example one OPA requested better service at one health center.
- Two health centres: Eliazar Germain in Petion-Ville and Memphis Medical Mission in Croix des Bouquets have opened up special lines for older people, as a new good practice.
- In two camps (Marassa 14 and Theatre National) OPA members were allowed to join the camp committee.
- A video clip produced by HelpAge has allowed an older person placed in a nursing home to reunite with relatives who thought she was dead
- Older people are socializing more now.

Annex 6 – Full evaluation TORs

Evaluation Purpose and Objectives

a) To assess the extent to which the programme met its objectives as set out in the Phase 1 and Phase 2.1 proposals with particular emphasis on the appropriateness, timeliness, efficiency and effectiveness of the intervention.

b) To learn lessons from the experience in order to improve HelpAge's future emergency interventions and humanitarian assistance for older people more generally.

HelpAge's emergency strategy is to ensure that older people receive the humanitarian assistance they need by not only providing assistance directly but also by ensuring that other humanitarian actors address older people's needs in their responses in accordance with the principle of impartiality. The evaluation will therefore include an assessment of HelpAge's advocacy work with the cluster system and other actors and its impact on the inclusion of older people in the broader emergency response.

The evaluation will also need to consider the operating environment of the Haiti response and take into account its effect on the responses of HelpAge and other international agencies. The evaluation report will be published in accordance with the DEC evaluation policy.

Quality, appropriateness, timeliness, effectiveness and impact

- Did the response achieve what it set out to do?
- Were humanitarian principles observed and standards met (Red Cross Code of Conduct, Sphere, HAP)?
- What has been the impact of the project for the direct beneficiaries, indirect beneficiaries and the wider communities?
- Was the programme relevant to the particular needs of older people? Did it target and reach them effectively and appropriately? Did it target the most vulnerable older people? Did it impact women and men differently?
- Were DRR measures integrated in the programme (eg preparedness for hurricanes).

Accountability

Were the following elements of the HelpAge Accountability Framework followed:

- *Participation* – What was the level of involvement of and accountability to beneficiaries?
- *Complaint Handling* - To what extent was the cash transfer complaints mechanism used by beneficiaries?
- *Monitoring, learning and evaluation* – Was the programme informed by lessons and experience from previous emergency programmes?
- *Transparency* – Did the organisation provide information and consult with stakeholders to ensure the understanding of the Organisation's commitments and programme activities.
- *Human Resource Practice* – Did HelpAge staff and partners behave in a manner that respected older people and enhanced HelpAge's reputation?

Efficiency:

- Did the project provide the best possible value for money?
- Did the organisation ensure processes were in place at the appropriate level governing the use and management of funds? Did the programme design and procurement processes maximise value for money - balancing quality, cost and timeliness?

Sustainability:

- Is there a continuing need for the activities and services provided by the project? Have plans been made and measures taken to ensure the continuation of the programme after DEC funding ceases?
- How can the benefits of the project be most appropriately and effectively continued or extended for the target population?

Partnership

- Did the project work appropriately and effectively with partner agencies (international and local)?

- Did the capacity building and training of IPESI, a key partner, improve the quality of services provided for older people?
- Would it be appropriate to continue any or all of the partnerships in order to ensure continuing assistance to the target population? If so, how?

Learning

- Did the programme develop any particularly effective and/or innovative approaches that could improve humanitarian assistance for older people in future?
- Have these been documented and shared internally and/or externally?

Annex 7 – Evaluation plan / timeline of activities carried out

Day #	Date	Day	Activity
1	13-Oct	Thu	Travel Paris to London - KII with staff.
2	14-Oct	Fri	AM: KII with staff. PM travel London-USA
3	18-Oct	Tue	Fly to PAP. PM: meetings with Judith, Jude and Herby and Bertin
4	19-Oct	Wed	Prepare FGD, logistics, bank, DB review.
5	20-Oct	Thu	Field visit to CDB communal and Claircine camp OPAs with James.
6	21-Oct	Fri	Note taking, KII contacts, Herby KII, survey questionnaire preparation.
7	22-Oct	Sat	Field visit to LGN and Jacmel communal OPAs with James.
	23-Oct	Sun	return from Jacmel
8	24-Oct	Mon	survey draft, …
9	25-Oct	Tue	train and test surveyors at Camp des Victimes (Tabarre)
10	26-Oct	Wed	Field day with OPAs to the 2 Goaves and Léogâne. Survey in LGN at St Rose+Boulos.
11	27-Oct	Thu	data entry train, KII Claudel. Survey in Tapis Rouge.
12	28-Oct	Fri	OPA meeting - all day. Survey in Parc Acra (Delmas).
13	29-Oct	Sat	survey data analysis, note writing.
	30-Oct	Sun	Rest
14	31-Oct	Mon	KII at Asile Cacré Coeur, IPESI and Eliziard Germain hospital.
15	1-Nov	Tue	AM: debrief with surveyors. PM: Interview with Judith.
16	2-Nov	Wed	AM: interview with Gaetan. PM: Note taking and presentation preparation.
17	3-Nov	Thu	AM: Prepare presentation, final data entry and analysis for presentation. Phone interview with Protection Cluster. PM: presentation with discussion to management staff (Herby not present)
18	4-Nov	Fri	AM: Feedback and learning from Tefera, Gaetan and Bertin. PM Fly to US
19	9-Nov	Wed	Report writing
20	10-Nov	Thu	Report writing
21	11-Nov	Fri	Report writing
22	12-Nov	Sat	Report writing
	13-Nov	Sun	Fly to UK.
23	14-Nov	Mon	HelpAge office visit
24	15-Nov	Tue	HelpAge presentation
25	16-Nov	Wed	Report writing
26	17-Nov	Thu	Report writing
27	18-Nov	Fri	Report writing
28	19-Nov	Sat	Report writing

Annex 8 – Consultant Bio

International development professional with 15 years of experience in organisational and technical program management and evaluation in Asia, East & West Africa and Central America with more than 30 years of living and working in 13 different countries.

Immediately prior to Haiti in 2010, worked for BRAC in Liberia, Oxfam GB in Eastern Chad, Action Against Hunger in Southern Pakistan and with Catholic Relief Services in Senegal and West Africa.

Since April 2010, completed 8 separate missions in Haiti working for CARE as an M&E advisor for 6 months and then performing several evaluations: two transitional shelter projects evaluations and a housing beneficiary baseline survey for Habitat for Humanity, an ECHO shelter evaluation for CARE (written in French), a country strategy mid-term evaluation for LWF, the final evaluation for the third phase of the SPHERE project for World Vision, an ECHO multisectoral evaluation for the French Red Cross (written in French) and a DEC project evaluation for HelpAge International.

Completed 27 independent consultancies for 18 INGOs in the last six years in agriculture/food security, WASH, livelihoods, green energy, infrastructure, etc., providing evaluations, baseline surveys, project design and implementation, strategic planning and review, emergency staff replacement and market and marketing research. I have also served as Desk Officer, Program Manager and Country Director for NGOs and as Technical Advisor for a bilateral aid project.

Knowledge and skills for developing country relief and development cover a range of sectors such as: refugee and internally displaced camps; water, sanitation and hygiene (WASH); seed system management; food storage and processing; food security; sustainable livelihoods; green/renewable energy; infrastructure (transport, roads and buildings); rural markets; fair trade; markets and marketing; rural microfinance; avian influenza management; locust and caterpillar infestation mitigation; primary and MCH health and HIV/AIDS; cooperatives/associations; micro-enterprises; livelihoods and income generating activities; agriculture extension; community development; soil and water de-salinisation; saline (halophyte) agriculture; transitional shelter.

Fluent in French and English with an M.Sc. in Engineering for Rural Development from the University of Cranfield, UK and a B.Eng. in Mechanical/Civil Engineering from the University of Warwick, UK.