Fonkoze's CLM Ultra Poverty Programme:
Understanding and improving child development
and child wellbeing

Baseline report

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Table of Contents

# Table of Tables

Table of Figures

Acknowledgements

1. Introduction

This report represents baseline findings from a quantitative evaluation assessing the impact of Fonkoze's Chemen Lavi Miyò (CLM) programme, or "the pathway to a better life" programme, on child wellbeing in Haiti. The CLM programme is a so-called 'graduation programme', aiming to set people on a sustainable pathway out of poverty. Arguably, such graduation out of poverty is only truly sustainable if it is intergenerational (Roelen, 2015), requiring programmes to have a positive impact on household wellbeing at large and children in specific. While the evidence base regarding the impact of graduation programmes on households and adult members is steadily growing, little information is available about its impact on children and child development. This evaluation aims to contribute to this important knowledge base.

Graduation programmes are based on the notion that extremely poor households require a big push towards a positively reinforcing cycle of income generation and asset accumulation (Carter and Barrett, 2007). This requires a comprehensive sequenced package support that often includes consumption transfers, asset transfers, access to savings and credit, training and coaching (Hashemi and Umaira, 2011). Training and coaching are mostly focused on income generating activities but often also include messaging regarding health, sanitation and feeding practices. Rigorous evaluations of graduation programmes showcase positive impacts on consumption, assets and food security (Banerjee et al. 2015). However, evidence with respect to whether and how economic strengthening through comprehensive livelihoods programming translates into positive outcomes for children is relatively thin (Britto et al. 2013; Ellis and Chaffin 2015; Ssewamala et al. 2014).

Childhood development can be defined as a development process: 'a gradual unfolding of cognitive-language, social emotional and sensory–motor capacities' (WHO 2013, 4). A range of risk factors may impede child development, including poverty, socio-cultural factors, biological risk factors and psychosocial risk factors (see Figure 1) Poverty is considered a key risk factor underpinning biological and psychosocial risk factors, and being influenced by socio-cultural risk factors. Socio-cultural risk factors include gender inequality, low maternal education and reduced access to services. Biological risk factors include undernutrition, diseases and environmental exposures. Psychosocial risk factors include maternal depression, lack of cognitive stimulation, poor caregiver-child relationships and violence (Engle et al. 2007; Walker et al. 2007, 2011).

Figure 1 Risk factors for child development
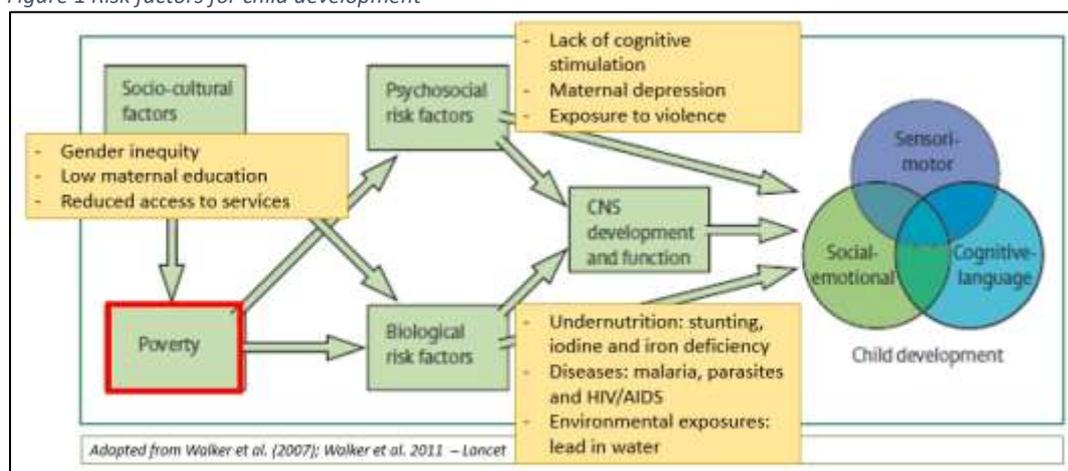
Participation in graduation programmes may link to risk factors in child development in two positive ways and through one potentially negative pathway (based on Barrientos et al. 2014; Roelen, 2015; Roelen et al. 2017:

1. Greater availability of cash, both as a result of cash stipends and through income earned as a result of business activities, can directly reduce poverty, and subsequently positive affect biological and psychosocial risk factors, including nutrition, maternal wellbeing, caregiver-child relationships and children's cognitive stimulation; and

2. The training and coaching around health, sanitation and nutrition may alter parenting and care practices, directly addressing psychosocial and biological risk factors.

Participation in such programmes may also reinforce risk factors:

3. The creation of business activities for and with women beneficiaries may lead to a gendered increase in the combined burden of paid and unpaid work. The drudgery of unpaid (care) work and the struggle for women to manage their many responsibilities is widely documented (ActionAid 2013; Chopra and Zambelli, 2018). Coping with associated physical and mental stress and strategies towards balancing paid and unpaid (care) work may undermine their quality of care and parent-child relationships (see Roelen et al. 2017). The additional work requirements may also require children to get involved in productive activities (Roelen et al. 2015); this could have both positive and negative effects.

Finally, the overall absence of services present structural barriers that prevent child development despite economic strengthening. Graduation programmes often have limited means to address such structural constraints.

Against this backdrop, this quantitative evaluation aims to gain insight into the impact of one graduation programme – namely the CLM programme in Haiti – on areas of wellbeing that reflect risk factors towards childhood development and on the interaction between work and care.

This baseline report provides an overview of the CLM programme and its activities, particularly considering how they may impact children's outcomes. It sets out the overall methodology and sampling strategy underpinning the baseline survey and evaluation overall. It discusses the situation at baseline for the areas of wellbeing, particularly considering differences between programme beneficiaries and control group members.

2. CLM programme

The CLM programme targets women who are able to work from extremely poor households with dependents, helping them onto a 'pathway to a better life'. It supports them over 18 months through a carefully tailored and sequenced package of cash and asset transfers, skills development, coaching and service provision. In the words of prospective programme beneficiaries, they were selected because *"… they were taking the people that were soaked, not only wet"* and receive support to *"get a path to a better life"* and *"start some small commerce"* [group discussion with prospective beneficiaries, Mableux, 22 May 2017].

The programme can be broken down as follows:

1) **Beneficiary selection:** Selection is an elaborate four-step process including social mapping, participatory wealth ranking, preliminary selection and final verification. Social mapping and participatory wealth ranking exercises aim to categorise a group of 50-100 community members across five wealth categories; those members in the bottom two categories are deemed eligible for the programme. Case managers undertake preliminary selection by surveying the eligible community members as well as looking out for community members that may not have been mentioned during the social mapping. Final verification is undertaken by case managers and programme management team;

2) **Enterprise selection:** Selected beneficiaries are officially invited into the programme during a visit by the case manager. During this visit, the case manager will also introduce the programme and lay out the option in terms of income-generating activities that the programme can support. The women beneficiaries choose their preferred activities in conversation with the case managers;

3) **Orientation and launch**: The orientation includes a six-day training on activities that women have chosen, mostly rearing goats and pigs. The training is undertaken by supervisors and case managers at community level. In order to ensure that the community as a whole is informed about the programme, the training is preceded by a community meeting that is open to all community members. The official start of the programme is marked by a launch ceremony, which is both a celebration as well as a formal occasion with women beneficiaries signing a contract with the CLM programme.

4) **Asset transfer**: Beneficiaries receive their asset transfer in the first few weeks after the launch ceremony. Depending on the selected business activities, this transfer will consist of livestock such as poultry, goats and pigs or other materials.

5) **Cash transfers:** During the first six months of the programme, women receive a weekly stipend of 300 gourds (roughly $4). This stipend is paid by the case managers at the end of each visit.

6) **Savings account:** All women beneficiaries will have a savings account set up for them at Fonkoze. They are also encouraged to save in a *sól*, which is a traditional community savings group whereby members contribute regularly with one member receiving the whole pot at every contribution. Women are encouraged to save money from their weekly stipend in the first six weeks of programme implementation, and from their earnings afterwards.

7) **Weekly home-visits:** Case managers visit the beneficiary at home to observe her living conditions, discuss progress towards the business goals and discuss health and hygiene messages. Topics include sanitation, clean drinking water, nutrition, family planning and vaccinations, among others. During each home visit, case managers will discuss two of 12 messages, which they rotate and then repeat again after a full rotation of six weeks. The visit will be completed with a conversation about plans for the coming week and longer future.

8) **In-kind support**: Beneficiaries may also receive tailored in-kind support such as support with construction of a pit latrine or materials to improve housing conditions. It also include emergency subsidies, such as in the case of funeral or large health expenses. Such support is decided on an individual basis based on the assessments by the case managers.

9) **Village Assistance Committees**: Fonkoze establishes community committees at village level with volunteers – usually village leaders having previously taken a leading role in assisting the most vulnerable in their community – to offer supervision and support in absence of case managers and to manage any tensions between beneficiaries and community members who are not part of the programme.

Case managers are mainly responsible for supporting the women that participate in the programme. Case managers usually support 50 women. During the week the case managers live in the area that they cover, and they use motorbikes to get around. Each case manager has their own motorbike.

Monitoring assessments are carried out throughout the programme period. A first assessment is undertaken immediately after the launch ceremony in order to catalogue the beneficiary's assets. The second assessment takes place after six months to assess progress in towards their business plans. The third and fourth assessments is based on a 10-question survey that will establish the beneficiaries' progress towards graduation. The third assessment is undertaken at 12 months to select which beneficiaries may be able to graduate; the fourth assessment is done at 17 months to establish whether beneficiaries have graduated or not. A graduation ceremony celebrates the progress made and marks the end of programme participation. Graduates are linked to Fonkoze's credit scheme.

Previous studies have demonstrated that the CLM programme leads to positive results for beneficiaries (Huda and Simanowitz, 2009; Pain et al, 2015). For example, 93 percent of beneficiaries having participated in the first pilot met the graduation criteria at the end of the 18-month programme period with 92 percent of beneficiaries operating at least two income generating activities. (Huda and Simanowitz, 2009). Whilst the intra-distributional allocation of increased income can be expected to benefit children at least proportionately, more evidence is needed. For example, severe malnutrition among children appeared to be eradicated among all beneficiary households participating in the first pilot of the CLM programme (Huda and Simanowitz, 2009).
No information is available regarding the interaction between participation in the programme and repercussions for child care or child work.

A conversation with prospective beneficiaries during the setup of fieldwork in May 2017 suggested that women mostly expected the programme to have a positive effect on child wellbeing through its direct income effect. The issue most frequently mentioned was high cost of schooling and how this prevents them from sending their children to school:

> *"The programme will help us by teaching us how to make sacrifices so that the children can go to school. They will teach us how to do commerce and how to sell young goats well so that we have enough money." […] "Some of our children were in school but had to drop throughout the year because of lack of money. Other children have not been in school at all."*
>
> [group discussion with prospective CLM members, Mableux, 22 May 2017]

It should be noted that women were interviewed during the time of the orientation training during which they are especially sensitised to the business element of the programme and opportunities for earning an income.

3. Research design

The evaluation is based on a semi-experimental design. The sample for the treatment group was pre-determined by programming considerations and includes all women that were included in the Kellogg cohort of the CLM programme. Sampling of the control group was undertaken in such a way to maximize explanatory power and limit spillover effects.

3.1. Sampling

Control group respondents were identified in two-step process: (i) identification of neighbourhoods that are similar to those where the treatment group/ programme beneficiaries are located; and (ii) identification of women respondents with similar living conditions and situation as the programme beneficiaries. The first step was undertaken by the Fonkoze team based on their longstanding experience and deep knowledge of the Central Region of Haiti and its locations. The second step involved participatory wealth rankings at village level. This process mirrors the targeting process for the CLM programme, thereby ensuring that the control group includes women that are extremely poor and fit the targeting criteria. A total of more than 160 participatory wealth rankings were undertaken to select the full number of respondents.

A full overview of the baseline sample can be found in Table 1. The three neighbourhoods where the programme is implemented each have their specific characteristics. La Chappelle is located along and close to the main road westwards from Mirebalais. Marche Kana lies off the main road from Mirebalais to Lascahobas in a valley along the river. Mableux is the most remote location in the hills past Marcha Kana at an altitude of around 1,200 metres. Control group respondents are selected from two locations; Desarmes is located along and close the main road westwards from Mirebalais past La Chapelle. Savanette is in the south-east corner of the central plateau.

Table 1 Overview of baseline sample

Department, Arrondissement	Commune	Neighbourhood	# respondents	# children <18
Treatment group				
Artibonite, Saint-Marc	La Chappelle	La Chappelle	300	862
Centre, Mirebalais	Mirebalais	Mableux	222	683
		Marche Kana	109	307
Total #N treatment			*631*	*1,892*
Control group				
Artibonite, Saint-Marc	Verrettes	Desarmes	398	917
Lascahobas	Savanette	Savanette	352	1,041
Total #N control			*750*	*1,985*
Total #N			***1,381***	***3,884***

Data for the treatment group was collected in June and July 2017 during which women beneficiaries received orientation training. Data for the control group was collected from August to December 2017. Data was collected using digital devices with the survey questionnaire pre-programmed on those devices.

A note about differences between the treatment and control group is warranted. The selection of control group members was undertaken in areas that are generally wealthier than where the CLM programme is implemented. In addition – for practical and logistical reasons – the selection process of control group members involved fewer steps than the selection of CLM programme members. Both processes are premised on participatory wealth ranking (PWR) exercises involving a group of community members that maps all households in a cluster of 50-80 households and ranks them in five wealth categories. Follow-up questions are then asked for households with women in the bottom two categories as a means of verification. While the selection of CLM beneficiaries also includes home visits by case managers and verification by supervisors, this step was not part of the selection of control group members.

As a result of both factors – geographical differences and differences in the selection process – we find the control group to be better off in many areas. This is good news for the programme; it means that programme operates in the poorest areas and includes the poorest households. The differences between treatment and control groups complicate the impact evaluation as both groups are not directly comparable. However, the control group was oversampled for this reason and matching techniques may be applied to overcome this issue.

3.2. Survey questionnaire

The questionnaire was administered to the CLM programme member (main woman in the household) in the treatment group and to the main woman in the household in the control group. She was asked for information about herself, other household members (with certain questions specifically referring to children) and the household at large.

The questionnaire was built up around 6 modules, namely:

(1) Household roster with information about individual household members, including education, and health-seeking behaviour for all, work for those aged 6 or older, and child stimulation activities with children fort those aged 3-5

(2) Living conditions

(3) Food and diet

(4) Maternal stress and depression

(5) Child protection attitudes

(6) Balance between work and care

4. Findings

The discussion of findings is structured around the main risk factors for child development, namely socio-cultural factors (including demographics), poverty, biological factors and psychosocial factors.

4.1. Socio-cultural factors

We consider overall characteristics of the household and maternal education.

The majority of CLM members are women aged 18 to 49 (Figure 2), with an average of three children per household and at least one child aged under 5. Most women live with a partner or spouse, mostly in traditional or informal arrangements (Figure 3). With an average of five household members, the dependency ratio is 1.5.[1] Households in the treatment group are significantly larger and have a higher number of children and dependents compared to those in the control group.

Figure 2 Age distribution of respondents
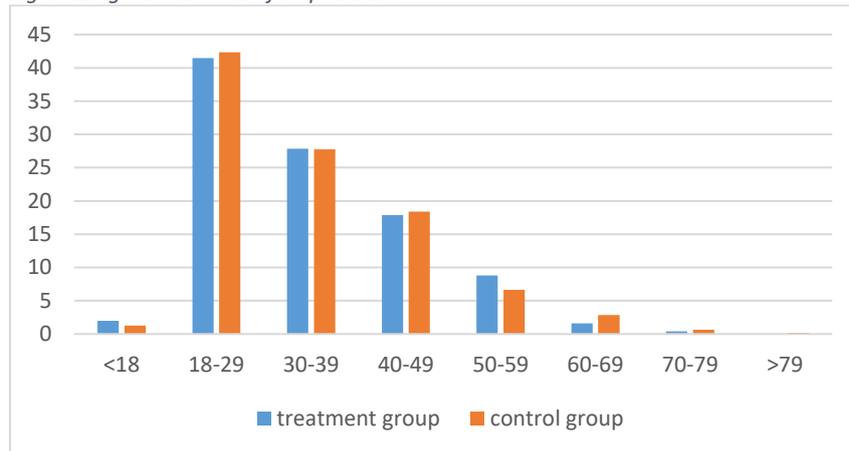
Figure 3 Marital status of respondents
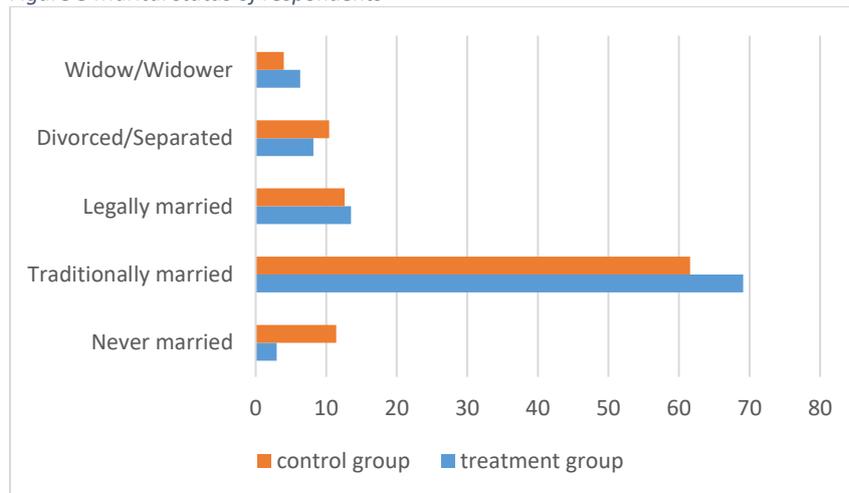
Table 2 Demographic characteristics of households

	Treatment	Control	Difference
	mean	mean	b
household size	5.3	4.9	-0.40***
# children <5	1.1	0.9	-0.18***
# children <18	2.9	2.6	-0.32***
dependency ratio	1.6	1.4	-0.13*
Observations	631	750	1381

[1] Calculated as the number of dependents – children under 18 and adults above age 65 – divided by the number of adults aged 18-65.

CLM members have generally low levels of education. Only one third of all members have ever attended school; 63 percent of those having attended school have completed primary school. Roughly 70 percent do not know how to read or write. Respondents in the control group have higher levels of literacy and educational attainment.

Table 3 Educational attainment and literacy of respondents

	Treatment	Control
Ever attended school?		
Yes	35.0	40.8
Highest level of education		
None	3.7	2.6
Pre-primary	20.5	17.4
Primary	62.6	54.8
Junior/Lower Secondary	9.6	18
Higher Secondary	1.4	5.6
University/College	0.5	0
I don't know	1.8	1.6
Know how to read and write?		
No	70.8	64.7
Only knows how to write name	15.0	14.6
Can read but not write	0.8	1.3
Yes, can read and write	13.4	18.9
I don't know	0.0	0.5

4.2. Poverty

CLM members in the Kellogg cohort prove to be among the poorest households in Haiti, and to be significantly poorer than those in the control group. The Progress out of Poverty Index (PPI) score indicates that CLM members are very likely to be categorised as poor using the national poverty line; the average score across the treatment group points towards 87 percent likelihood of being poor according to the national poverty line (Table 4). This compares to 79 percent for the control group.

The PPI score is based on indicators such as housing materials, availability of clean drinking water, households having a stove or radio and the availability of labour in the household[2]. Indeed very few CLM members have access to a safe main source of drinking water or healthy source of energy for cooking[3] in their households, and their situation is significantly poorer compared to the control group.

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[2] For a full description of the PPI and its methodology, see Schreiner, M. (2016) Haiti 2012 Progress out of Poverty Index (PPI): Design Memo and PPI for Haiti. progressoutofpoverty.org.
[3] Safe sources of drinking water include well, private faucet/DINEPA, or treated water; spring, surface water, rain, untreated water are considered unsafe. Good energy sources for cooking include charcoal, solar power, propane, electricity or kerosene; wood, straw and other sources are considered unsafe.

Table 4 Progress out of Poverty score and living standards

	Treatment	Control	Difference
	mean	mean	b
PPI score	26.92	31.15	4.23***
Likelihood to be poor - national poverty line	87%	79%	-7.60***
safe main source of drinking water	0.08	0.21	0.13***
good main source of energy for cooking	0.02	0.07	0.05***
household has stove	0.21	0.33	0.11***
household has radio	0.08	0.09	0.01
Observations	631	750	1381

4.3. Biological risk factors

The biological risk factors considered as part of this evaluation mostly pertain to nutrition, including the numbers of meals consumed per day, the numbers of days and months of hunger and the dietary diversity index, and health-seeking behaviour.

Nutrition

CLM members and their children suffer from limited meals and poor dietary diversity. More than half of all adults and children in CLM member households eat only one meal per day, which is significantly lower than for children in the control group areas (Figure 4).

Figure 4 Number of meals eaten by household members yesterday
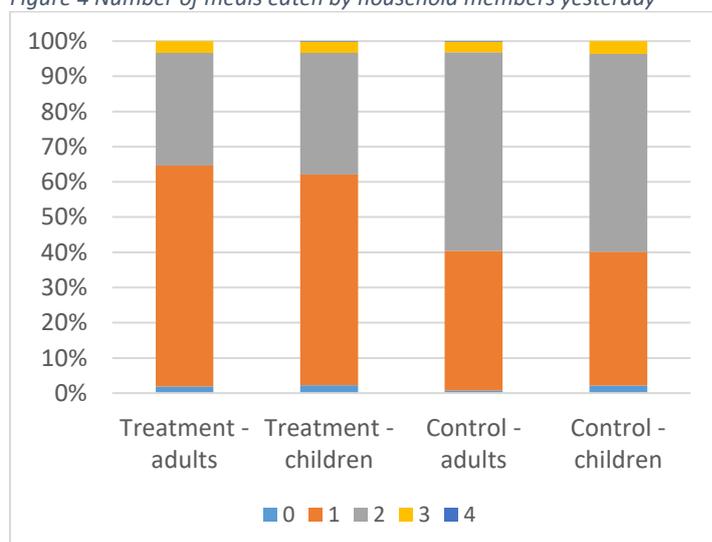
Table 5 provides information about experiences of hunger and dietary diversity. Results indicate that households in the treatment group experienced more hunger in the past month compared to the control group, but that household diets were relatively more diverse compared to the control group. On average, CLM member households experienced hunger during 11 days in the past months, compared to an average of 9 days for control group members. The Household Dietary Diversity Score (HDDS) index – reflecting the diversity of food groups consumed (out of 12) – is low at an average

below 4[4] for both treatment and control groups. Children's dietary diversity measured using the Children's Dietary Diversity Score (CDDS) index for children aged 3-5 and Young Children Feeding Practice (IYCFP) index for children aged 6-14 month also point towards limited dietary diversity with average CDDS index scores of below 3 (out of 8 food groups)[5] and IYCFP scores of below 2 (out of 7 food groups)[6]. There are no significant differences in the number of months that households experienced hunger in the past year and with respect to dietary diversity for children.

Table 5 Hunger and dietary diversity

	Treatment	Control	difference
	mean	mean	b
How many months was the household hungry in the past year?	4.46	4.45	-0.01
How many days was the household hungry during the last month?	10.87	8.95	-1.93***
Household Dietary Diversity Score index	3.95	3.74	-0.21**
Children's Dietary Diversity Score index (3-5 years)	2.91	2.89	-0.02
IYCFP score (6-24 months)	1.84	1.84	0

Health-seeking behaviour

Findings with respect to illness and health-seeking behaviour is presented in Table 6. Approximately half of all respondents and their household members in the treatment group were ill or injured in the past year. This compares to one thirds of all household members in the control group. In both groups, for roughly 20 percent of household members – both adults and children – healthcare was sought. For the large majority of treatment group household members, lack of money was the main constraint in terms of seeking healthcare. Self treatment constituted the main reason for a substantial proportion of the control group; for 32 percent of adult household members and 24 percent of children who had fallen ill but did not seek healthcare.

Table 6 Illness and health-seeking behaviour

	Adults aged 18 and over				**Children aged under 18**		
	Treatment	Control	Difference		Treatment	Control	Difference
	mean	mean	b		mean	mean	b
In the last year, has household member been ill/injured?	0.52	0.33	-0.19***		0.48	0.3	-0.18***
Sought no healthcare when ill/ injured	0.22	0.17	-0.05*		0.22	0.18	-0.04
Lack of money was main reason for no health care	0.91	0.6	-0.30***		0.9	0.73	-0.17***
Self treatment was main reason for no healthcare	0.08	0.32	0.23***		0.07	0.24	0.16***

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[4] For a full description of the HDDS and its methodology, see FAO (2013) Guidelines for measuring household and individual dietary diversity. Rome: FAO. URL: http://www.fao.org/docrep/014/i1983e/i1983e00.pdf
[5] For a full description of the CDDS and its methodology, see Swindale, A. and P. Bilinsky (2006) Household Dietary Diversity Score (HDDS) for Measurement of Household Food Access: Indicator Guide (v.2). Washington, D.C.: FHI 360/FANTA. URL: https://www.fantaproject.org/sites/default/files/resources/HDDS_v2_Sep06_0.pdf
[6] For a full description of the IYCFP and its methodology, see WHO (2010) Indicators for assessing infant and young child feeding practices Part 2 Measurement. Geneva: WHO. URL: http://apps.who.int/iris/bitstream/10665/44306/1/9789241599290_eng.pdf?ua=1

4.4. Psychosocial risk factors

The psychosocial elements that may constitute risk factors or important enabling components of child development that are included in this evaluation are maternal depression, child stimulation, education, and safety and security.

Maternal depression

Maternal depression represents an important risk factor for child development. This research includes the K6 scale and Rosenberg Self-Esteem Scale as indicators for maternal stress and depression; both widely used across the world.

The K6 scale of mental illness developed by Kessler et al. (2003) assesses mental health. The survey module asked how often in the past 30 days the respondent felt any of these six symptoms: nervous, hopeless, restless, so depressed that nothing could cheer them up, that everything was an effort, and worthless. The more frequently someone indicated to experience any of these feelings, the higher the score[7]. A K6 score exceeding 13 is considered to be an indicator for respondents suffering from serious mental illness (Kessler et al., 2010).

For the Rosenberg Self-Esteem Scale (RSES), respondents react to 10 statements on a four-point scale - from strongly agree to strongly disagree. Statements include positive phrases such as "On the whole, I am satisfied with myself" and "I take a positive attitude towards myself" as well as negative affirmations including "At times, I think I am no good at all" and "I feel that I do not have much to be proud of". The higher the score, the higher the self-esteem.[8] The scale ranges from 0-30; scores below 15 suggest low self-esteem.

Results for both the K6 and Rosenberg Self-Esteem Scale are presented in Table 7. It can be observed that mental health and self-esteem are a concern among the women that were interviewed. Average K6 scores range from 10.6 for the treatment group to 11.4 for the control group, and one in three of all women can be considered to experience serious mental health issues. The average scores on the RSES scale are below 15, suggesting fairly low self-esteem. The control group appears to suffer significantly more from mental health issues and low self-esteem, although differences are fairly small.

Table 7 Maternal stress and depression

	Treatment	Control	Difference
	mean	mean	b
K6 score	10.6	11.4	0.80***
K6 - serious mental illness	0.33	0.36	0.03
RSES	14.7	14.1	-0.57***

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[7] Answer categories for each feeling include: 'all the time', 'most of time', 'some of the time', 'a little of the time' and 'none of the time'. These responses are scored according to the frequency of the symptom, e.g. a respondent answering 'all the time' to all six items would receive a maximum K6 score of 24 (6*4).
[8] See full instruction on http://www.yorku.ca/rokada/psyctest/rosenbrg.pdf.

Child stimulation

Child stimulation is a crucial psychosocial element for early development. This study considers the number of activities undertaken with children – either by the main woman in the household or any other adult in the household, and finds that the extent of such activities is limited (see Table 8). Out of five activities including singing songs, telling stories and playing, CLM members engaged in only two of these activities with their children aged 3-5. The average number of stimulating activities does not increase much when also considering undertaking activities with another adult in the household; on average, CLM members' children aged 3-5 participated in four activities with either the respondent or adult, while this amounted to three activities for children aged 3-5 in the control group. Represented as an index, children in the treatment group participate in 40 percent of all activities with respondent or another household compared to 30 percent for children in the control group. It is interesting to note that children in the treatment group are significantly better off with respect to stimulating activities compared to their peers in the control group.

Table 8 Activities undertaken with children aged 3-5 in last 3 days, with respondent and other adult in household

Activities with children aged 3-5 in last 3 days			
	Treatment	Control	Difference
	mean	mean	b
# activities with adults (out of 10)	3.8	2.7	-1.19***
# activities with respondent (out of 5)	2.2	1.5	-0.68***
index of activities as share of possible activities	0.4	0.3	-0.15***
Observations	394	375	769

When considering engagements of respondents with their children across types of activities (Figure 5), playing with children occurred most frequently. Eighty one percent of CLM members indicated to have played with their children aged 3-5 in the preceding 3 days, compared 73 percent of the control group members. This is followed by singing songs and telling stories, although these take place much less frequently at 41 percent and 36 percent for CLM members respectively.

Figure 5 Activities undertaken by respondents with children aged 3-5 in last 3 days

15
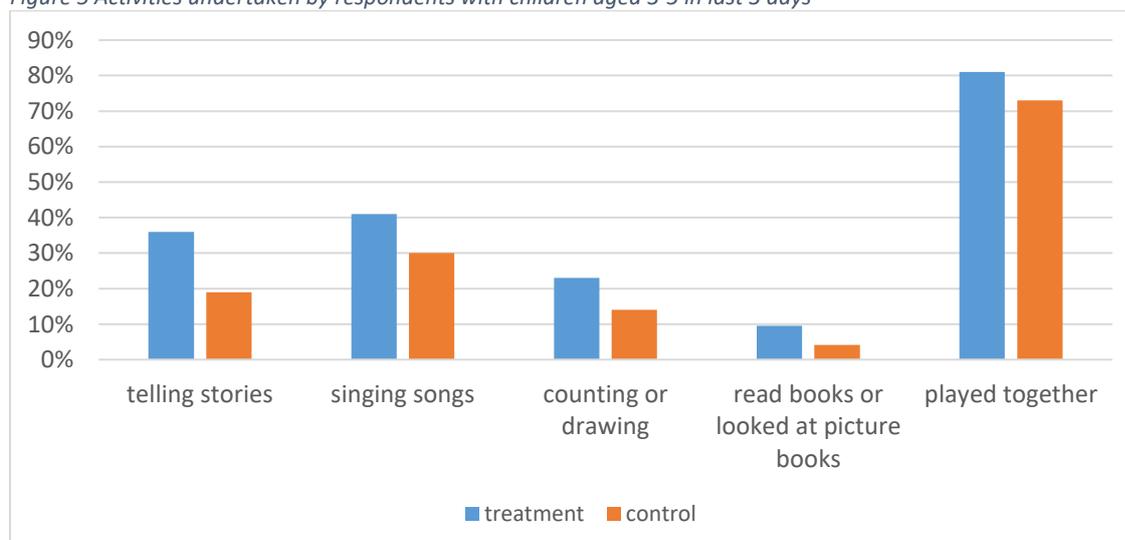
Education

For children aged 5 and older, school is an important component of development. As shown in Table 9, reported school attendance is fairly high; roughly two out three children of CLM members aged 6-17 are reported to be attending school. This compares to 82 percent of children in the control group. School absenteeism is substantial however. Two thirds of children of CLM members in the age groups 5-12 and 13-17 missed at least one day of school in the past month, and 10 days on average. The most frequently cited reason for missing school is lack of money for fees, supplies and transport, suggesting a considerable risk for drop-out. Illness is another important reason for missing school.

*Table 9 School attendance and absenteeism for children aged 6-12 and 13-17*

Children aged 6-12	Treatment	Control	Difference
	mean	mean	b
currently attending school	0.68	0.82	0.13***
missed any days of school in last month	0.65	0.44	-0.20***
# days missed school in last month	9.45	8.89	-0.56
illness is main reason for missing school	0.26	0.26	0
lack of money for fees/transport/supplies is main reason for missing school	0.48	0.57	0.1
Children aged 13-17	Treatment	Control	Difference
	mean	mean	b
currently attending school	0.62	0.7	0.07
missed any days of school in last month	0.67	0.4	-0.28***
# days missed school in last month	9.35	9.64	0.29
illness is main reason for missing school	0.26	0.18	-0.08
lack of money for fees/transport/supplies is main reason for missing school	0.38	0.6	0.22**

Safety and security

Violence – both in the household and community – is deemed a key risk factor, with safety and security being crucial for securing child development. Respondents were asked a range of questions with respect to how often certain practices were happening in their community. This includes observations or personal experiences of physical violence at home, in school or in the community generally; threats, neglect and humiliation of children; forced marriage; children selling sex for clothes, food or money; sending children to work as domestic servants; and giving children away in exchange for money.

Findings in Figure 6 suggest widespread occurrence of harmful or threatening situations across the treatment and control groups. Children being sent away as domestic workers, witnessing violence at school in the community or at home, receiving harsh corporal punishment and selling sex were most frequently reported to happen either often or sometimes to children in the community. Many respondents did also indicate to be unsure about the answer. Children in treatment areas are reported to experience significantly more violence than children in control communities, with the exception of children being sold for money. This observation goes in hand with expectations about the relationship between poverty and interpersonal violence. The difference between children selling sex across the treatment and control areas is not significant in a statistical sense.
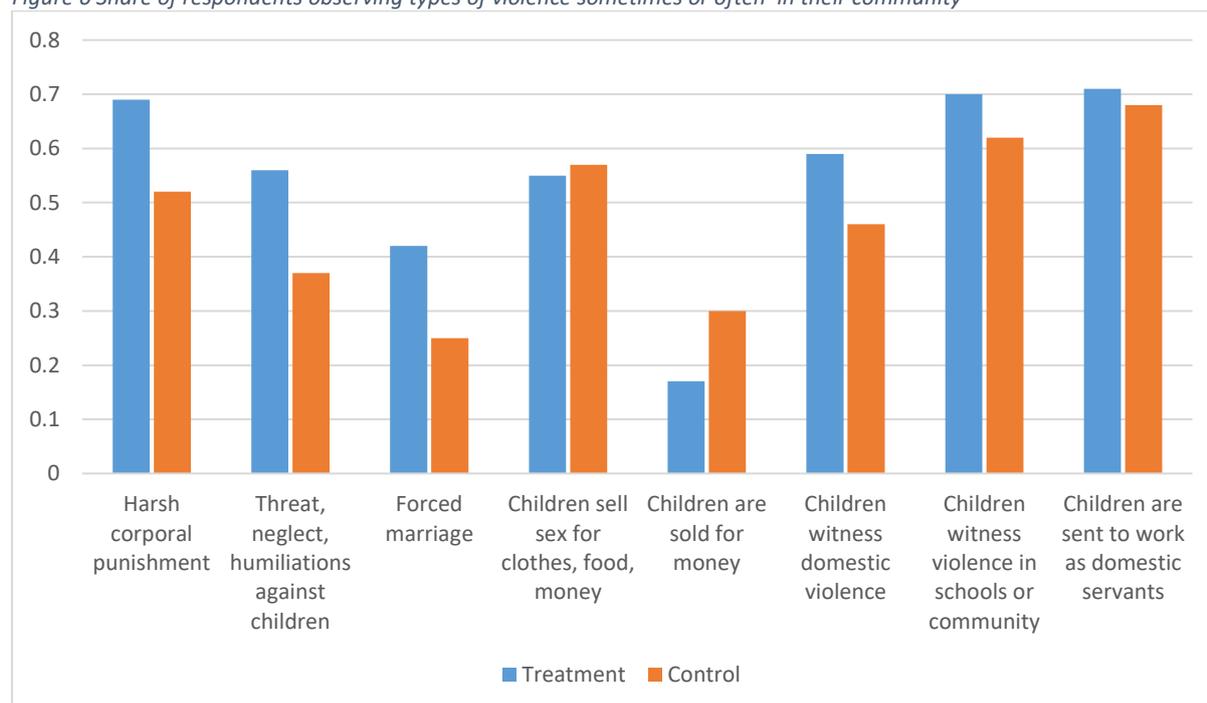
4.5. Work and care

The role of paid work and rise in productive activities deserve special consideration in relation to child development and childe wellbeing. Paid work and income generating activities are important for reducing – a main risk factor for child development and child wellbeing – but may also at a cost in terms of care for children in terms of increased time burden and drudgery for women.

The survey questionnaire included questions regarding the amount of time spent on paid work, care work and fetching fuel and collecting firewood. Table 10 provides an overview of time spent by the main woman in the household. Strikingly 37 percent of CLM members and 42 percent of the control group respondents spent no time on paid work on a typical day in the past week. Only one out of four women spent either half or a full day on paid work. The majority of women spent less than half a day on care work, with women in the control group spending relatively less time compared to women in the treatment group. Most women do spend at least a few hours on fetching water or collecting firewood.

Table 10 Time spent on paid work, care work and fetching fuel and firewood for main women in household

On a typical day, how many hours do you spend doing all forms of paid work in the past week?	Treatment	Control
	%	%
No time (0 hours)	37.2	42.2
Little time (0-2 hours)	7.2	5.1
Less than half a day (2-4 hours)	13.6	12.9
Roughly half a day (4-5 hours)	15.4	20.9
Almost the whole day (5-7 hours)	19.0	14.4
The whole day (more than 7 hours)	7.6	4.4

On a typical day, how many hours do you spend doing all forms of care work in the past week?	Treatment	Control
	%	%
No time (0 hours)	1.9	8.7
Little time (0-2 hours)	34.2	51.1
Less than half a day (2-4 hours)	37.2	28.9
Roughly half a day (4-5 hours)	11.7	8.4
Almost the whole day (5-7 hours)	9.3	2.5
The whole day (more than 7 hours)	5.8	0.4
On a typical day, how many hours do you spend on fetching water or collect firewood in the past week?	Treatment	Control
	%	%
No time (0 hours)	6.2	4.0
Little time (0-2 hours)	54.8	76.9
Less than half a day (2-4 hours)	30.2	17.8
Roughly half a day (4-5 hours)	5.0	1.1
Almost the whole day (5-7 hours)	2.1	0.3
The whole day (more than 7 hours)	1.8	0.0

When asked about the sufficiency of time to undertake all work and chores (see Table 11), approximately half of the CLM members indicated to have always or mostly enough time. The other half of women experienced insufficient time occasionally or more frequently. Women in the treatment group are more likely to experience time constraints compared to women in the control group.

Table 11 Sufficiency of time and money

Do you feel that you have enough time to undertake all your chores and work?	treatment	control
	%	%
Always enough	43.7	52.4
Mostly enough	11.4	15.1
Sometimes enough and sometimes insufficient	20.9	13.5
Mostly insufficient	15.2	15.5
Always insufficient	8.7	3.6
Do you feel that you have enough money to provide for your children?	treatment	control
	%	%
Always enough	3.2	0.8
Mostly enough	0.2	1.2
Sometimes enough and sometimes insufficient	9.2	9.7
Mostly insufficient	25.8	38.9
Always insufficient	61.6	49.3

In order to cope with lack of money to care for children, women prioritise certain items and forego others. Figure 7 below shows which items get prioritised and which ones dropped in times of need. The large majority of women prioritise food expenditures, with smaller groups indicating to prioritise school fees and clothing. Expenditures on clothing are the first to be dropped in case of limited financial means, followed by housing materials.

Overall, both treatment and control groups make very similar decisions as to which items they prioritise. However, larger differences exist between the groups with regards to decisions regarding

business expenditure, which are much more likely to be prioritised in control areas, and fodder for livestock, which less frequently gets dropped in treatment areas.

Figure 7 Proportion of respondents prioritising or dropping expenditures when financial means are lacking
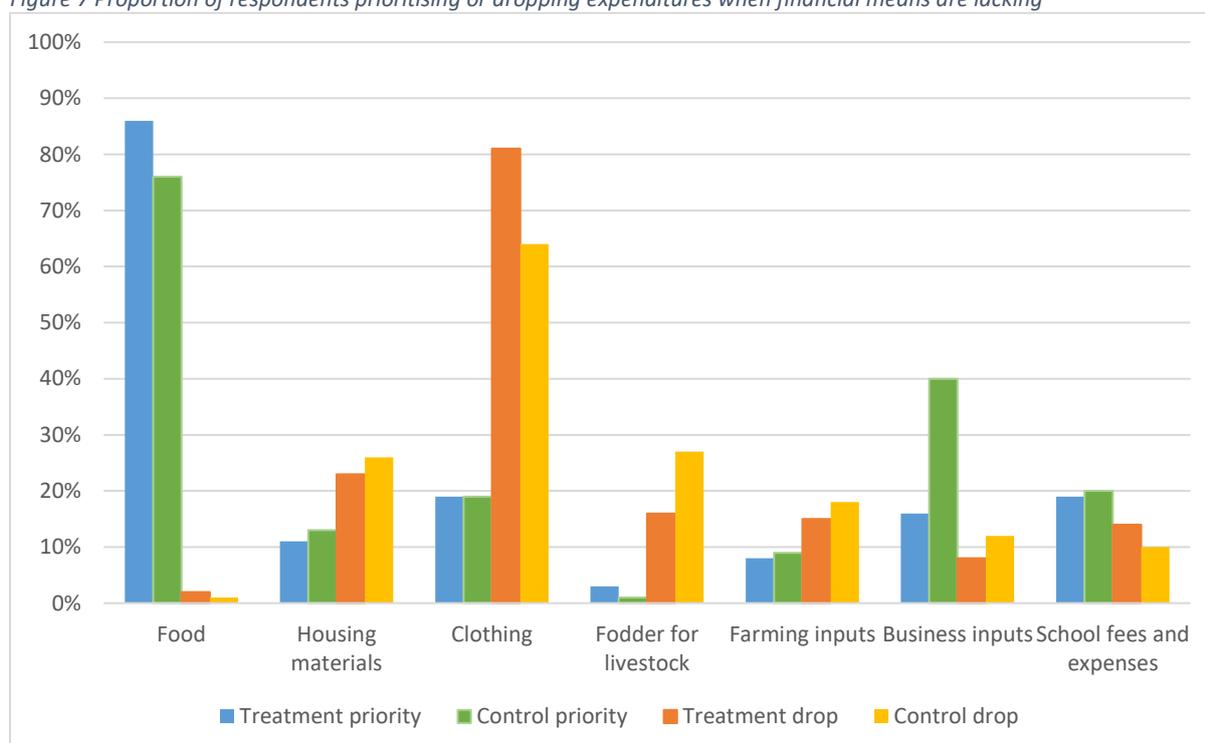
Children may support adult household members with both paid and unpaid work activities. Table 12 below shows that children aged 10-14 in treatment and control groups are much more likely to carry out unpaid care work or household tasks, such as fetching water, than paid work. It also shows that children in CLM households are more likely to engage in paid work, which is possibly explained by greater household poverty that necessitates children to generate income.

Table 12 Share of children aged 10-14 who participate in care work, fetching water or paid work

	Treatment	Control	Difference
	mean	mean	b
Care work	0.61	0.67	0.06
Fetching water or firewood	0.86	0.86	0
Paid work	0.09	0.03	-0.06***

Considering the average numbers of hours engaged in work activities in the week preceding data collection, children in both control and treatment groups spent an average of 4-5 hours on paid work (excluding those who did not do any paid work). While engagement in care work and fetching water and firewood is more widespread, the average amount of time spent on such activities is much shorter, with the majority of children spending up to 2 hours. Children from CLM households are more likely to spend more time on unpaid activities compared to children in the control group.

5. Conclusion

This report provides findings from the baseline survey on the impact of the CLM programme on child development and child wellbeing. The overall evaluation aims to understand the extent to which so-called graduation programmes can break the intergenerational transmission of poverty, and lead to 'intergenerational graduation'. In doing so, we focus on factors that are widely understood to be important for child development and wellbeing, including poverty, nutrition, maternal mental health, child stimulation, education and safety and security. We also consider the balance between paid work and unpaid care, considering the potential tension that may arise for primary caregivers between providing quality care for their children while engaging in income generating activities at the same time.

Overall we find that children in both CLM member households and in the control group face considerable obstacles to healthy child development and wellbeing. Poverty is widespread, as measured by an index of living conditions and other proxies for poverty. Biological risks include relatively undiversified diets and frequent experiences of hunger. The majority of individuals do seek health care when ill or injured but a lack of money presents the main obstacle towards doing so for those not seeking healthcare. Psychosocial risks include poor maternal mental health, with many respondents suffering from serious mental health concerns and low self-esteem. Engagement of adults in stimulating activities with young children is mostly confined to playing together but rarely includes singing songs, telling stories or counting or drawing together. The majority of children up to age 18 are enrolled and attend school. Absenteeism is relatively high at least half of all children having missed school in the preceding month, often due to lack of money for transport or school supplies. Exposure to threatening and harmful situations is widespread with children being sent away to work as domestic servants, witnessing violence at school, in the community or at home and receiving harsh corporal punishment reportedly being observed in the communities under study.

Considering paid work and unpaid work patterns, we find that the majority of women spend less than half a day on paid work, and between 0-4 hours per day on care work and on fetching water and firewood respectively. The majority of women do not appear to experience difficulties juggling their paid and unpaid work activities in terms of their demands on time. Lack of financial resources does prevent most women from providing their children with all the care that they need. In lean times, coping strategies include foregoing expenditures on clothing and housing materials. Food expenditures are highly prioritised. Children engage in both paid and unpaid work activities. Engagement in paid work is less widespread but takes up more time when children do engage; engagement in care work and fetching water and firewood is common but takes up less than two hours on a typical day.

Despite efforts to find a control group that is comparable to CLM members, we find significant differences between the treatment and control group. Control group respondents, their households and children are faring better than those in the treatment group. This holds across many outcome areas, apart from child stimulation. This is good news from a programming point of view as it suggests that CLM indeed includes the poorest areas and households. From an evaluation perspective, these significant differences between both groups will need to be taken into account and controlled for when analysing impact using follow-up data, which is to be collected next year.

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