**Summary of responses to request on lessons learned for the Haiti IYCF-E response**

**August 24, 2021**

Below is a summary of responses received as a result of a request to IFE Core Group members to share lessons learned related to IYCF-E in Haiti. Table 1 presents previous programme documents, guidance, joint statements etc. that were shared. Table 2 includes articles written documenting the experience in 2010 and lessons learned. What follows is also a list of individual observations and lessons learned from IFE Core Group members.

**Table 1: Previous guidance and programme documents**

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| **Title of document** | **Nature of document** | **Description** |
| **Points de Conseil en Nutrition pour Bébé**  **Directives Nationales**  **National guidelines for infant nutrition** | **National guidelines** | This document outlines the standards related to responding to the needs of infants and young children during emergencies including the establishment of baby tents and provision of artificial feeding support |
| **Terms of Reference for Save the Children’s role in ready to use infant formula as a last resort in Haiti.** | **ToRs** | The document outlines the roles and responsibilities of Save the Children in temporarily assisting UNICEF to control supply of RUIF and cups to the nutrition cluster partners requiring it for their emergency nutrition response, while UNICEF positions itself to take on this role. |
| **Call for support for appropriate infant and young child feeding in Haiti** | **Joint Statement** | IYCF-E Joint statement |
| **Breast milk best for babies in Haiti, especially after earthquake** | **Press release** | Press release accompanying Joint Statement |
| **Technical Note on HIV and infant feeding** | **Technical note** | Provides a summary of the WHO recommendations on HIV and infant feeding and their application to the 2010 emergency in Haiti. Needs update? |
| **National Cholera training manual** <https://www.cdc.gov/cholera/pdf/haiticholera_trainingmanual_en.pdf> | **Training manual** | Full Course for Healthcare Providers on Cholera treatment. Needs update? |

**Table 2: List of articles and main conclusions/lessons learned**

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| **Title of document** | **Nature of document** | **Main conclusions** |
| **Challenges to the Programmatic Implementation of Ready to Use Infant Formula in the Post-Earthquake Response, Haiti, 2010: A Program Review**  <https://pubmed.ncbi.nlm.nih.gov/24391877/> | **Peer review article** | Administering artificial feeding support - RUIF - should be based on **a clear protocol** which should contain:   * admission and discharge criteria, * standardized infant records forms and guidance on monitoring infant growth, * minimal program monitoring and evaluation package, * training package, * appropriate numbers of staff, * logistics components which address procurement, warehous- ing, transport and waste disposal issues.   Importance of **not losing sight of the overall support for breastfeeding mothers given the added complexity and demands of the BMS component**. Programs should still focus on the broader aspects of IYCF: support for breastfeeding mothers and appropriate complementary feeding of older infants. |
| **The Haiti Earthquake - Country and Global level Cluster Coordination Experiences and Lessons Learnt**  <https://www.ennonline.net/fex/39/haiti> | **Field Exchange article** | The article emphasized the importance of securing capacity for the IYCF-E response including both at cluster level and in terms of programming.  Two important points:   * The inadequacies of the **general food ration** were a major concern, to the degree that staff found it difficult to counsel on optimal infant and young child feeding practices when mothers were reporting their ongoing lack of food. * **Supplies:** the biggest weakness was on **coordination of the logistics chain** and subsequently UNICEF was unable to move supplies from well stocked warehouses to the field in a timely manner at the beginning. |
| **Disasters and women's health: reflections from the 2010 earthquake in Haiti (2013)** <https://pubmed.ncbi.nlm.nih.gov/23290319/> | **Peer reviewed article** | **Language and culture sensitivity:** most of the hospital was staffed by ***foreign physicians and nurses***, with only limited numbers of contributing Haitian staff. This impacts their ability to communicate well with patients and to decrease one of the many barriers patients have to accessing care under already challenging circumstances. **Making use of local personnel allows for an increased sense of patient trust and for improved understanding of culturally-sensitive topics.**  At General Hospital, the almost uniformly **young adult male translator** staff may have presented **a barrier to accurate history-taking and created uncomfortable or embarrassing situations for female patients.**  // Ideally, all agencies providing health care have a plan that includes the minimum basic supplies and services, and have trained their providers in the importance of screening for women-specific issues such as **domestic violence and sexually transmitted infections.**  **Anticipatory counselling:** Women specific complaints included vaginal infections, breast pain or masses, and pregnancy-related concerns or complications. Women were also targets of gender-based violence. // Humanitarian workers must also use caution when interviewing female patients so as not to assume that a man who accompanies the woman is her husband or that he speaks on her behalf //  **Mode/location:** Camp geography should foster both **patient privacy and security during sensitive examinations.** This could  have been improved upon by geographically separating men’s and women’s treatment areas and using a barrier screen to generate a more private examination environment. |
| **‘It is me who eats, to nourish him’: a mixed‐method study of breastfeeding in post‐earthquake Haiti (2013)**  <https://pubmed.ncbi.nlm.nih.gov/22784020/> | **Peer reviewed article** | * The main findings emphasize how it is important to **understand the local nuances** - especially in relation to women’s concerns over the quality of breastmilk and how it is perceived to be affected by diet. * The paper also emphasizes how the elder community members, **grandmothers, traditional midwives and herbalists are an important resource of knowledge.** They should be consulted and engaged during counselling and education to ensure behavior change. |
| **Protecting and improving breastfeeding practices during a major emergency: lessons learnt from the baby tents in Haiti. (2013)**  <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3738309/> | **Peer reviewed article** | The paper describes the baby tents programm, how it was implemented including the different components (please refer to paper for details, and footnote 1 below includes key points). The paper highlights challenges and provides lessons learned including:   * The need for **clear and easily adaptable infant feeding guidelines** for emergencies that include a set of minimum implementation and reporting standards and monitoring tools for use at the individual and project levels. * Ensuring the **involvement of community leaders and caregiver**s in the design and implementation of baby tent programmes to ensure community awareness, participation and follow-up. * **Better evaluation methods** and comprehensive guidance on the implementation and monitoring of baby tents * Ensuring a post-emergency baby tent **exit strategy** in which “model mothers” continue to receive support in their role as counsellors on infant feeding practices in each community and in which the population is informed about the reintegration of baby tent activities into existing health and community structures (**sustainability).** |
| **Tech RRT IYCF-E/CMAM adviser: experiences from Niger, Haiti and Nigeria**  <https://www.ennonline.net/fex/56/techrrtnigerhaitiandnigeria> | **Field Exchange article** | * There was **no IYCF technical working group** or platform to discuss technical issues at departmental level. * IYCF needs were identified in the assessments and a response plan developed, but **responsibility to take this forward and the best modalities to deliver on activities could not be identified** in the absence of engagement by the MSPP. At the time of Tech RRT deployment, national nutrition coordination was just evolving; a nutrition working group was set up at Port au Prince and UNICEF was recruiting to increase nutrition programme capacity. Finally, the TOR included IYCF-E and response plan trainings, however **participants were not available for training within the deployment’s short timeframe**. After the Tech RRT deployment ended the nutrition working group followed up on outstanding TOR objectives. |
| **Save the Children’s IYCF programme and linkages to Protection, Food Security and Livelihoods in Haiti**  <https://www.ennonline.net/fex/41/save> | **Field Exchange article** | This is a comprehensive review of the IYCF programme in Haiti implemented by Save the Children. It provides a thorough description and evaluation of the programme including suggestions for programme design for future emergency response:   * Meeting basic needs of pregnant and lactating mothers * Addressing the nutritional needs of separated children and children in residential care * Improve the organisational capacity to promote cross-sectoral integration   Other recommendations:   * The importance of pursuing **integrated programming from the very beginning of the relief operation** should become a key strategic principle, not only for organisations working in multiple sectors such as SC, but also for the whole cluster system to ensure coordinated and effective response. * The importance of **a prompt and systematic exchange of information** and collaboration between the Separated Children Working Group (**Child Protectio**n sub-cluster) and IYCF Working Group (**Nutrition cluster**) to set-up effective referral mechanisms, especially for children under 24 months of age among all partners. * It is important to ensure that **information on Family Tracing and Reunification (FTR) services** (such as the call centre for separated children) is **disseminated at the nutrition cluster** level and that **information on IYCF services** (including artificial feeding management cases) is **disseminated to child-protection sub-cluster actors**. * FSL interventions should have a clear nutrition objective to support IYCF interventions * Interventions in **residential care centres** to manage artificial feeding and to support adequate complementary feeding need a specific well planned strategy |

**Observations from IFE Core Group members:**

* **Capacity building:** Ensuring local organizations are empowered to provide response is critically important. Here’s a list of local organizations that come recommended by the March 4 Black Lives - they may not all be doing IYCF-E but may be potential critical partners: <https://docs.google.com/document/d/1w6INzfKCQ6nSunZHZSEMfVz2DOBqmlpLKjR4M-4s2lM/edit> (Aunchalee)
* Setting up a **HELPLINE** was really fruitful, both for directing people to services or providing advice as well as keeping a record on what issues were raised to get an idea about the good and bad practice coping mechanisms (Mija)
* Not lessons learned, but **Save the Children’s IYCF-E toolkit** also contains a number of tools from previous Haiti responses including example of BMS Donation questionnaire; BMS Donations Mapping Report; Example of RUIF exit strategy; Infant Feeding Songs. (Isabelle)
* **Donor human milk:** while we were revising the OG-IFE, experiences shared around helicopters loaded with donated breastmilk that could not be used circling above Haiti was what led to our OG-IFE recommendation regarding donor human milk and milk banks. (Isabelle)
* **Integration:** as part of a Save the Children review on integrated programming, the following best practices were identified:
  + Essential heath care services were provided through mobile teams
  + Health systems strengthening included capacity building for district trainers on topics such as IMCI and CMAM
  + IYCF\_E counsellors were included in mobile clinic teams and health workers were trained on IYCF-E.
  + Support for breastfeeding within Cholera Treatment Units were identified as an activity as well as dissemination of messaging on IYCF and Cholera.
  + Mother Baby Friendly Spaces were established.

Best practice: the nutrition backstop reviewed the health component of the strategy and provided feedback including 1) to apply the new WHO recommendations on ANC including provision of maternal nutrition and breastfeeding counselling, and 2) provide private breastfeeding spaces in CTUs.

Visit <https://ta.nutritioncluster.net/> to request support on nutrition in emergencies.

Visit [www.en-net.org](http://www.en-net.org) to request peer support on nutrition in emergencies including IYCF-E.

Footnote 1 (more details from the paper: Protecting and improving breastfeeding practices during a major emergency: lessons learnt from the baby tents in Haiti. (2013) - From Isabelle

* + - **Intended population:** They were attended by 180 499 infant–mother pairs and 52 503 pregnant women over a period of 29 months. Of the 180 499 infants enrolled, 54% (97 469) were less than 6 months old // They also paid home visits, sometimes assisted by the psychologist. Home visits were conducted to encourage absentee mothers or caretakers to return to the tents; to counsel mothers experiencing breastfeeding difficulties; to see if the caretakers of infants who could not be breastfed were using ready-to-use infant formula and to investigate why some infants were losing weight. The displacement of large numbers of people and the lack of social cohesion made it difficult to ensure community participation in baby tent programmes and to follow up some of those mothers and infants who participated. // Equally challenging was setting criteria for determining when an infant could never be breastfed; procuring enough infant formula . // community leaders and caregivers became involved in baby tent programme activities and were empowered from the beginning and throughout
    - **Referrals:** Children with acute malnutrition were transferred to the closest government-run or NGO-run nutrition programme, as appropriate; those with other severe medical conditions, such as dehydration or pneumonia, were transferred to the closest health centre.
    - **Capacity Building:** Training materials for workers and programme monitoring tools on optimal infant feeding practices appropriate for the Haitian context, particularly on the use of ready-to-use infant formula, did not exist. Following the earthquake, the health ministry was severely weakened and there arose an urgent need for trained health workers who could provide counselling and for qualified psychologists, which were very few.// Counsellors and health professionals were trained in counselling techniques and in infant and young child feeding practices; national guidelines, monitoring tools and training materials and job aids on infant and young child feeding were developed in Haitian Creole
    - **Anticipatory counselling:** Urban mothers often worked or had to procure food outside their home and had to leave their children with others.
    - **Mode / location:** infant feeding had to be facilitated through the creation of spaces where mothers could receive antenatal and postnatal counselling and safely breastfeed their infants, and where infants who could not be breastfed (e.g. orphans and infants separated from their mothers) could be given ready-to-use infant formula. This led to the establishment of the baby tent programme. // Baby tents were relaxed, friendly and stimulating spaces where mothers could breastfeed comfortably and be supported by a trained counsellor and their own peers. The tents were spacious, light, clean, attractive and, in places with electric power, equipped with fans. Safe drinking water was available and there were mats and mattresses for sitting and relaxing. The tents were often decorated with child feeding balloons and posters and children’s songs were played in some of them between other activities. // Maintaining confidentiality while integrating infant and young child feeding practices and providing psychosocial support to mothers was also very difficult. // Confidential space for psychosocial support can be created.
    - **Operational challenges:** Before the earthquake breastfeeding practices and guidelines were generally poor. programme monitoring tools on optimal infant feeding practices appropriate for the Haitian context, particularly on the use of ready-to-use infant formula, did not exist. Because of space constraints, ready-to-use infant formula was distributed in the same tents where breastfeeding counselling was conducted and this may discourage mothers who could breastfeed. To overcome these challenges, optimal infant and young child feeding practices were intensely promoted within baby tents and in the community using culturally appropriate messages and materials. and a central database was established
    - **Lessons learned:** It is important to promote optimal infant and young child feeding practices through people with effective counselling skills during times of normality, before disaster strikes.• There is a need for clear and easily adaptable infant feeding guidelines for emergencies that include a set of minimum implementation and reporting standards and monitoring tools for use at the individual and project levels.• Involvement of community leaders and caregivers in the design and implementation of baby tent programmes are essential to ensure community awareness, participation and follow-up.

ensure a post-emergency baby tent exit strategy in which “model mothers” continue to receive support in their role as counsellors on infant feeding practices in each community and in which the population is informed about the reintegration of baby tent activities into existing health and community structures.