# Evaluation of Concern Worldwide Infant Feeding Response in Haiti: one year after the 2010 earthquake

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**Executive Summary**

***Introduction***

More than 200,000 Haitians were killed, 300,000 were injured and over a million were left homeless after the devastating earthquake which struck Haiti on January 12, 2010. With the epicenter near Haiti's capital, Port au Prince, it paralyzed the country's already weak backbone. To respond to the Infant and Young Child Feeding (IYCF) needs in Port au Prince, created by the difficult living circumstances in camps, Concern Worldwide mounted 15 babytents, which are called Points de Conseils en Nutrition pour Bébés (PCNBs) in Haiti. This report describes the evaluation of Concern's IYCF approach.

***The Scope of the Evaluation***

The evaluation was undertaken 12 months after the first babytent saw its daylight. Haiti is one of the first emergencies where the babytent approach has been implemented on a large scale. The purpose is to assess the relevance, acceptability, effectiveness and sustainability of Concern's infant and young child feeding response, and to make recommendations for a) improved practice in future emergencies, b) updates/revision/development of existing policy guidance and tools and c) the direction of the current programming.

***The Evaluation Report***

This report starts with a description of the methodology and a provision of the country and IYCF context. The second part of the report discusses findings and recommendations based on observations in PCNBs. The last section works through each of the evaluation criteria, providing insights and recommendations. Concluding comments are made at the end of the document.

***Findings and Recommendations from the evaluation of the Haiti IYCF Project***

*Relevance*

By co-developing and implementing the PCNB approach, Concern has correctly addressed the IYCF needs in post-earthquake Port-au-Prince. The project was flexible enough to adapt to changing environments like the cholera outbreak, hurricane Thomas and the irregularities surrounding election.

- ✓ Although PCNB activities were sufficient and appropriate to accomplish the specific objective, the objectives should be formulated to make sure they are specific, measurable, appropriate, realistic and time-bound.
- ✓ Food security and livelihoods approaches should be added as a component to the project, in order for the beneficiaries to be able to sustain the improved practices.
- ✓ Offering of services like vaccination, deworming and micronutrients would add relevance to the project.
- ✓ Even though Concern offers services for severely malnourished children with (USN) and without complications (OTP), the link between the two should be improved. Also referral to organisations outside Concern should be improved.

*Effectiveness*

Concern has been effective in rapidly answering to the IYCF needs by quickly mounting PCNBs in selected camps. All nutrition targets were exceeded and Concern was able to open more PCNBs than originally planned. Psychosocial targets have not been reached because of staffing problems. Project outcomes like exclusive breastfeeding rates, diarrhoea, malnutrition and even mortality are very encouraging and all data suggest that behaviour change has taken place and will even benefit the future generations. Besides this, Concern has also been effective in building the capacity of its staff and the Ministry of Health (MSPP) through trainings and their many contributions to the development of the national PCNB guidelines. To decrease the default rate, Concern has recently implemented the "model mother" strategy in order to encourage women to come for pre- and postnatal counselling and keep them

longer in the program. Although no coverage assessment has been done, available data indicate that the coverage in camps was good.

- ✓ Psychosocial support outcomes would need to be investigated deeper as the participation rate to this component, as well as the prevalence of depression and PTSD found, seem low.
- ✓ The community members like camp leaders or even the caretakers themselves have not sufficiently been involved in the implementation of the program. Concern should take measures on how to improve this.

*Efficiency*

Considering the positive outcomes and given the context of the camps and the densely populated urban camps, the PCNB approach was a very efficient way to reach and engage women around the issues of IYCF and child interaction. Also the handling and distribution of large quantities of artificial milk has gone efficiently.

- ✓ To improve the impact on individual caretakers, it is important to integrate the psychosocial support and IYCF activities more.
- ✓ Even though supervision is very important in a project like this, two supervisors instead of three might be a way to make it more cost-effective, as it will save in staffing and fuel costs.
- ✓ Start-up trainings were sufficient to efficiently start the PCNBs. This is the time to improve in quality, especially in individual counselling using visual materials and extra lactation counselling skills.
- ✓ The communication with other cluster members was an efficient way to avoid duplication, but the communication with camp committees should be improved, especially in those camps where Concern is not doing camp management. It is necessary to investigate how the communication between staff members on the field could be improved. The same is true for supplies management, which is still too slow to efficiently support the PCNB activities.

*Coherence, alignment and integration*

Concern's PCNB implementation was very coherent, aligned and integrated with all national and international guidelines.

*Sustainability, Phasing Out and Exit Strategy*

Unlike other emergency interventions, the PNCB approach seems to be sustainable for two reasons. All data suggest that behaviour change on IYCF and other care-giving practices have occurred, in a way that will benefit future generations. Also, the approach has been supported by the MSPP from its inception, it is very likely that it will continue to exist.

- ✓ Since there is no exit-strategy yet formulated, it should be seen as the right opportunity to propose transferring PCNBs to existing health centres, as discussed within the nutrition cluster. Sound planning combined with a good exit strategy are essential to contribute to sustainable recovery and further development of the Haitian society.
- ✓ It is important to ensure that the practices shown in PCNBs become a sustainable behaviour by offering home-based support. It is observed that the health centre based staff does not have time for home visits, highlighting the need to develop another strategy on community-based breastfeeding support.

*Impact*

It is believed that the intervention ultimately affected psychomotor development positively, and reduced morbidity and mortality. However, the most important impact found in this evaluation is linked to behaviour change as this suggests that the impact is sustainable. The evaluator thinks that the introduction of RIUF has not impaired the Haitian market negatively, and did not cause any negative effects on breastfeeding rates.

*Monitoring*

As this was an emergency project, the monitoring system was simple, only collecting data for process indicators. Therefore some information is also missing to be able to calculate higher-level outcome and impact indicators. Project tools are pretty straightforward and staff gave the impression of being able to utilize them. That is without taking into account the "UNICEF reporting format" developed by the cluster, which still confuses the personnel.

- ✓ Concern, in conjunction with the MSPP and other stakeholders, should come up with higher-level outcome and impact indicators, making sure they get integrated into the existing monitoring system.
- ✓ There is no easy way to investigate the impact of the psychological support on the actual breastfeeding practices or on the nutritional status of the child. Therefore the IYCF and PSS registers should be linked to try to better understand this relationship.

*Concern Worldwide policies and guidelines*

Concern is currently including IYCF indicators in the new Results Framework for their global health program strategy. The evaluator thinks that those two tools, combined with the translated PCNB national guidelines (adapted to a more international context), are a good start to guide a well-established babytent approach in future emergencies. Gender and HIV issues were mainstreamed in the PCNB project, protection issues however could be better addressed to make sure every beneficiary gets the same chances.

### *The Direction of Current Programming*

Babytents in camps have been a valuable intervention measure during the acute phase of an emergency where a population is displaced and most families are dislocated from normal support structures and lack a comfortable home situation to care for their children. Now the acute emergency period is over, government services outside the camps are functioning again and the community has (re-)established some level of support structures. In that environment, breastfeeding support is best implemented as part of existing health structures, preferably complemented with a community-based approach. Concern and the MSPP have started discussions on how to integrate the PCNBs into perinatal ward to prepare the mother to breastfeed starting from pregnancy, and to offer breastfeeding support until the baby is 6 months old. Eventually this should lead to the development of a national or a Concern-specific PCNB exit-strategy for the camps.

### *Policy guidance and tools*

If PCNBs will be integrated into health centres, the workload will be higher and it will be necessary to rethink some of its activities and to develop new national guidelines. Some recommendations on how to do this are the following:

- ✓ Revisit the definition of defaulter, as clients live far from the health centre
- ✓ Revise admission criteria (e.g. only allowing babies 0-12 months)
- ✓ Discuss minimum space and personnel
- ✓ Reconsider growth monitoring, as weekly weighing is too frequent if PCNBs also want to keep-up with the quality of individual counselling
- ✓ Develop a strategy to maintain community-based breastfeeding support, like the use of successful mothers or youth volunteers
- ✓ Revise PCNB indicators and the monitoring system.

### *Future emergencies*

In the future, Concern should think about how reach more fathers and other behaviour influencers like grandmothers, as well as how to involve the community more in babytent activities. The international IFE guidelines, the Haiti PCNB guidelines and the Concern Results Framework are a good basis for

implementing the babytent approach in future emergencies. Everyone involved was aware of the need for strong monitoring and reporting in order to document successes and mistakes, but the reality has shown that this has not happened enough. Ultimately the international community would want the international standards to be completely developed, with standardised indicators, trainings as well as assessment, monitoring and reporting tools, such as the ones developed for OTP and CMAM. Although one has to be careful not to make it too complicated, as this is still an emergency approach during which data are more difficult to be collected. All findings/recommendations in this evaluation are quite applicable for similar emergencies in the future.

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**Acronyms**

ACF: Action Contre la Faim

CDC: Centers for Disease Control

CGI: Clinical Global Impression

CMAM: Community Management of Acute Malnutrition

DHS: Demographic and Health Survey

ECHO: European Commission Directorate-General for Humanitarian Aid

FGD: Focus Group Discussion

HIV: Human Immunodeficiency Virus

IDP: Internally Displaced People

IFE: Infant Feeding in Emergencies

IOM: International Organisation of Migration

IYCF: Infant and Young Child Feeding

LANPE: Lait Artificiel pour Nourrisson Prêt à l'Emploi

MINUSTAH: United Nations Stabilization Mission in Haiti

MSH: Management Sciences for Health

MSPP: Ministère de la Santé et de la Population

MUAC: Mid Upper Arm Circumference

NGO: Non-Governmental Organisation

NSU: Nutrition Stabilisation Unit

OFDA: Office for Disaster Assistance

ORS: Oral Rehydration Solution

OTP: Outpatient Therapeutic Care

PCNB: Point de Conseils en Nutrition pour Bébés

PPS: PsychoSocial Support

PTSD: Post Traumatic Stress Disorder

RUIF: Ready-to-Use Infant Formula

RUTF: Ready to Use Therapeutic Food

STD: Sexual Transmittable Disease

ToR: Terms of Reference

UNICEF: United Nations Children's Fund

WFP: World Food Program

WHO: World Health Organisation

## 1. Introduction

Concern has been present in Haiti since 1994, when Hurricane Gordon hit the country. Since then it has been implementing development programmes in health and HIV, education and livelihoods. It has three areas of operation: the island of La Gonave, the commune of Saut d'Eau in the Central Plateau and five slum areas of Port-au-Prince. In the capital, the organisation has been particularly active in terms of community health promotion, support to health centres providing care to children suffering from acute malnutrition and in supporting peace-building efforts.

However since the earthquake of 12 January 2010, Concern has developed an emergency response to support survivors in their recovery. Building on its existing strengths and expertise as well as its networks of local contacts, Concern has prioritised the following areas of intervention:

1. Prevention and treatment of acute malnutrition, including infant feeding (IYCF) and psycho-social support
2. Access to clean water and sanitation
3. Transitional shelter, emergency shelter and non-food items
4. Cash transfers to facilitate recovery and cash for work
5. Camp management and protection
6. Peace Building program
7. Primary education provision (in settlements/camps)

Concern Worldwide has committed itself to follow the Operational Guidance on Infant and Young Child Feeding in Emergencies (Ops Guidance) when doing Infant and Young Child Feeding (IYCF) interventions. Therefore it was logical for them to be involved in the development of the babytent approach in Haiti, a process conducted by the nutrition cluster but closely followed by the nutrition world. Due to Concern's involvement a consultant was hired to evaluate this relative new IYCF approach. ACF has already conducted a similar evaluation but the report was not yet out at the time of this evaluation.

This report describes the evaluation of Concern's IYCF approach, more specifically the babytents, which are called Points de Conseils en Nutrition pour Bébés (PCNBs) in Haiti. Concern's PCNBs have been operating in 15 camps since the earthquake, although some have been closed, merged or relocated since then, making a total of 12 functioning PCNBs at the moment of the evaluation.

## 2. The scope of the evaluation

### 2.1 Rationale of the evaluation

Haiti is one of the first emergencies where the babytent approach, that includes both skilled breastfeeding support and artificial feeding support (the latter including distribution of ready-to-use-infant-formula), has been implemented on a large scale. Babytents have now been running for 12 months, hence this evaluation. The purpose is to assess the relevance, acceptability, effectiveness and sustainability of Concern's infant and young child feeding response, in particular the babytent model, for earthquake-affected communities in Port au Prince/Haiti, and make recommendations for a) improved practice in future emergencies, b) updates/revision/development of existing policy guidance and tools and c) the direction of the current programming.

### 2.2 Methodology

The Terms of Reference (ToR) included a summary of the evaluation criteria and key questions. They were circulated to key staff members, cluster members and members of the international nutrition community for review, prior to the evaluation. The ToR is included in annex 1. The consultant was hired upon approval of the suggested research methods for each one of the research questions. The schedule of her fieldwork is included in annex 2.

Concern has 12 PCNBs running: 9 in IDP camps and 3 in existing health structures. The consultant decided to sample 3 out of 12 PCNBs for certain methodologies of the evaluation, while other questions were investigated for each of the PCNBs. The sampled babytents and the rationale behind their selection can be consulted in table 1 below.

| Selected PCNBs | Rationale[1] |
|---|---|
| Mais Gaté | The best performing PCNB |
| Parc Colofe | The least performing PCNB |
| Diquini | A PCNB integrated in a hospital |

**Table 1: sampled PCNBs and sampling rationale**

Interview and focus group discussion (FGD) guides can be found in annex 8. The methods used for this evaluation were:

1. Literature review of relevant existing reports and documents (annex 3)
2. Email with key people implicated in the development and the implementation PCNB approach
3. Interview with the head of the Nutrition Bureau within the Haitian Ministry of Health, the Ministère de la Santé et de la Population (MSPP) who is also nutrition cluster lead
4. One-day long observations in each one of the three sampled PCNBs
5. Focus group discussions with lactating mothers in each one of the three sampled PCNBs
6. Focus group discussions with caretakers having received Ready-to-Use Infant Formula (RUIF) in two of the three sampled PCNBs
7. Individual interviews with 18 beneficiaries who received individual psychosocial support, 6 in each one of the three sampled PCNBs
8. Focus group discussions with key PCNB field personnel: with 12 PCNB in-charges, with 10 social workers, with 6 psychologists and with 2 out of 3 PCNB supervisors
9. Interview with two camp committees: one where Concern is not involved in camp management (Parc Colofe) and another where Concern is responsible for the good functioning of the camp (Dahomey)
10. Key Informant Interviews with Concern Haiti field office staff, more specifically managers of: child survival, Outpatient Therapeutic Care (OTP), Nutrition Stabilisation Units (NSU), psychosocial support (PPS), camp management, protection, PCNBs, health, finance and systems and logistics (annex 3)
11. Meeting with key cluster members who are also implementing the PCNB approach in the country (annex 3)
12. Meeting with UNICEF's PCNB manager, who also used to be Concern's PCNB program manager from April until September 2010 (annex 3)
13. Data analysis of electronically available PCNB data[2].

A single consultant conducted the evaluation, although she was assisted by a MSPP member for all of the observations and focus group discussions as well as most of the interviews. Her insights were highly valued by the evaluator. One of the PCNB supervisors was assigned by Concern to organise the activities and assist where needed during the whole period of the fieldwork.

### 2.3 Limitations

Because of the emergency context, no baseline study has been done so there is no possibility to compare information before and after the intervention. Where possible the consultant has tried to use existing data from before the earthquake. The number of days assigned to the evaluation did not allow for a larger sample than three out of twelve babytents. This will not influence the results of the evaluation because the responses from respondents in the three sampled PCNBs were not significantly different. There was also not sufficient time to go through all the hard copies with information collected in the babytents, only electronically available data was considered for this evaluation (see "5.7 Monitoring"). The evaluator is a nutritionist specialised in public health, with no experience in the field of psychosocial support (PSS). It is recommended that a more specialised and in-depth study is carried out if need be. Ideally a PCNB evaluation would include a comparison with PCNBs implemented by other NGOs. This has not been done though some information provided by Save the Children during the cluster member meeting has been mentioned where useful.

[1] Based on data and the experience of the PCNB supervisors, the PCNB manager and the health and nutrition coordinator
[2] Monthly reports for IYCF and PPS

## 3. The context of the evaluation

### 3.1 The country context

Haiti, the first independent black republic, has had a troubled history marked by consecutive periods of unrest combined with natural disasters. Rates of child malnutrition in Haiti are among the highest in Latin America. Almost one-quarter (24%) of children less than five years of age are stunted - an indicator of chronic malnutrition associated with long-term insufficient dietary intake and recurrent illness measured by height for age - according to the 2005-2006 Demographic and Health Survey (DHS). Nine percent of Haitian children are wasted – an indicator of acute weight loss measured by weight for height. Furthermore, since early 2008, rising prises for fuel and basic commodities, combined with Haiti's very high dependency of imported food and poor infrastructure, have led to catastrophic rises in food prices and consequent food riots. This situation has been made worse by a series of devastating hurricanes in late August-early September 2008, which created widespread flooding and has further aggravated the already very serious food insecurity problem.

At approximately 4.45 pm on 12 January 2010 an earthquake estimated at 7 on the Richter scale, with an epicentre close to Haiti's capital, Port-au-Prince, caused serious destruction and loss of life. Up to 1,000,000 are thought to have been made homeless. Extensive damage was also reported in the towns of Jacmel, Leogane and Cabaret. Public buildings and houses have been destroyed or damaged beyond repair, trapping tens of thousands of people under the debris. Government ministries, UN buildings, churches, an international hotel and dozens of schools have collapsed. Concern staff members are among those who have lost children and had their homes destroyed.

Port-au-Prince, a hilly city of close to 3 million people, was already home to a generally poor population with very limited access to basic services. This situation became significantly more acute following the widespread destruction. Economic activity was seriously restricted, with further unemployment and major impediments preventing rural producers selling their goods on the urban markets. International assistance was mobilised and two organised official camps –Corail and Tabarre Issa the latter managed by Concern were established. Now, almost one year after the earthquake, it is imperative that IDPs move out of camps and spontaneous settlements and back in to neighbourhoods. However the emergencies that have continued to ravage Haiti: the Cholera outbreak in October, Hurricane Tomas in November, and Presidential election chaos in November/December have not only continued to compound the on-going crisis but slowed plans for return and resettlement.

### 3.2 The infant and young child feeding practice context

Before the earthquake

Breastfeeding has always been considered 'natural' among Haitian women, as shown by the 2005-2006 Demographic Health Survey, which found that the median duration of breastfeeding in Haiti was 17.7 months (the ideal duration would be 24 months). Infant and young child feeding (IYCF) practices in Haiti were generally sub-optimal prior to the earthquake as exemplified by a national exclusive breastfeeding rate between 33-41% among infants <6 months of age and 23% bottle feeding in infants of the same age[3]. A survey conducted by ACF for the MSPP in 2009 found an exclusive breastfeeding rate of 21.7% for Port-au-Prince, the lowest in the country[4]. The economical situation of many mothers does not allow them to practice the ideal behaviours and many local beliefs surround IYCF in Haiti, especially around delivery and breastfeeding (see Haiti IYCF practices summary table in annex 9). For example, there is the belief that a newly delivered woman should take care not to be in contact with air. That is why she stays at home for 1 up to 3 months after birth or if she has to leave she should make sure to "plug" all their openings (e.g. mouth, ears, vagina) for air not to enter. This substantially complicates the provision of postnatal care and breastfeeding support. Another belief is that breast milk can get sour when a woman was out in the hot sun[5][6]. The same studies describe the introduction of complementary foods, in particular watery porridges, as early as a few days after birth, often under pressure from grandmothers, and sometimes fathers. In general, mothers reported that they did not use formula milk, or at least not regularly as

[3] Demographic Health Survey, 2005-2006.

[4] Ministère de la Santé Publique et de la Population/ACF/UNICEF/Commission Européenne, Enquête Nutritionnelle Anthropometrique Enfants 6-59 mois, République d'Haiti, Mars 2009.

[5] Concern Worldwide, Knowledge, Practices and Attitused on Nutrition: La Gonav, Sodo and Sen Maten, 2001.

[6] Save the Children, Améliorer l'Alimentation et l'Hygiène des Enfants de 0 à 36 mois en Haiti, Développement d'une Stratégie de Changement de Comportement, 2005.

they were too expensive[7]. The most striking barrier to exclusive breastfeeding in Haiti however is that mothers do not carry their babies on their backs out of fear for the "evil eye". This especially creates problems in urban areas, where mother are often obliged to work far from home. Other risk factors to malnutrition include a relatively high low birth weight rate of 25% likely related to the suboptimal diet of pregnant women and a high diarrhoea prevalence of 22% in infants less than 6 months and 38-41% in the age group 6-23 months. An HIV prevalence rate of 3.8%, though relatively low globally, is the highest in the region[8].

After the earthquake

There is no baseline or endline data available to show that the earthquake negatively impacted breastfeeding behaviours, but it was generally expected that the earthquake would worsen the already weak IYCF practices. Several sources (field personnel, MSPP resource people) affirmed this. Due to several cultural beliefs, some women tended to stop breastfeeding for a while (e.g. strong emotions –like trauma- spoil the breast milk which makes it unsuitable for the baby) and other stopped completely (e.g. a mother who does not eat properly cannot produce enough/quality breast milk). Moreover, most caretakers lost everything making it very difficult to prepare complementary foods adapted to the child's needs. The emergency response was an effort to redress the IYCF practices lost due to the earthquake, to prevent further deterioration but also to correct poor pre-earthquake IYCF practices.

The nutrition cluster estimated that 10% of babies in Port au Prince would need infant formula because of being orphaned or separated by their mothers.

### 3.3 The camp context

Of the 1.9 million people who are thought to have been made homeless by the earthquake, it is estimated that as many as 680,000 people are still living in camps[9]. Camps are a difficult place to raise and feed children: they are very crowded, unsafe, unsanitary and under the plastic sheets the heat is often unbearable.

### 3.4 The (inter)national IYCF context

Experiences in other emergencies had taught the international nutrition community that massive imports of infant formula as a part of the emergency relief should be avoided by all means[10]. This to avoid that certain mothers would decide to give up breastfeeding to become eligible for the formula, but also to avoid excess death due to diarrhoea caused by bottle feeding in unhygienic circumstances. On the other hand, it was estimated that many breastfeeding children had lost their mother and would need artificial milk. Hence the idea grew of a space where mothers could safely breastfeed and where caretakers who needed it could also access safe infant formula.

Babytents were grafted on the experience of 'breastfeeding corners' (e.g. North Western Tanzania) and babytents were experimented in a few countries. But post-earthquake Haiti is the first experience ever of such a large, coordinated babytent response in an emergency context, including the controlled distribution of artificial milk.

Since the early days after the earthquake, nutrition cluster members were working on the national guidelines for PCNBs: Points de Conseil en Nutrition pour Bébés, Directives Nationales. This document has not yet been finalized but can be obtained from UNICEF and implementing partners (attached in annex 10). As mentioned earlier, this programme was established to protect, support and promote breastfeeding of babies until 12 months. During the creation of the national guidelines, the promotion of optimal complementary feeding was added as an objective, amongst others (see below). In the course of the implementation it was also decided to monitor children 12-23 months in the PCNBs too.

According to the national guidelines, the general objective of the PCNBs is "to promote and sustain adapted feeding for children less than one year old in all health structures as well as in PCNBs, while reducing the risks associated with the non accompanied use of artificial infant formula".

The specific objectives of the PCNBs are stated as follows:

- To provide a supportive environment for breastfeeding mothers living in difficult circumstances, enabling them to continue breastfeeding

[7] Table with key IYCF issues, IYCN, 2010.
[8] Demographic Health Survey 2005.
[9] Survey by the International Organization for Migration (IOM), March 2011.
[10] Indonesia 2005/ Lebanon 2006

- To promote optimal breastfeeding practices with technical support for breastfeeding mothers, from an educational and emotional point of view
- To promote optimal complementary feeding practices
- To educate pregnant women about the many benefits of exclusive breastfeeding in the first 6 months in order to stimulate the development of optimal breastfeeding
- To focus on the relationship caretaker-child through play activities, baby massage sessions and other activities, especially as this relationship may be disturbed by the post-emergency situation
- To assess the nutritional needs of infants under one year who lack access to breastfeeding and meet their needs. Caretakers receiving artificial milk will be followed by the teams to ensure safe preparation through nutrition and health education, until the child is at least 6 months but preferably 1 year
- To identify the caretaker-child couples in need of psychological or psycho-social support and refer them to appropriate centres.

**4. Observation of Concern Worldwide's PCNBs: Descriptions, Discussions and Recommendations**

Activities at the PCNB

*The consultant has been able to observe three PCNBs, each one for a full day, and found that Concern implements the national guidelines in the following way:*

- *Opening the tent at 8 am*, which has been cleaned by the night guard, and installing the mattresses and the toys.
- *Hand-washing* with water and soap of caretakers, usually mothers, and their babies before entering the PCNB.
- *Screening and registration of new arrivals - infants:* Nutritional status is determined with the help of weight, height and Mid Upper Arm Circumference (MUAC), severely malnourished babies are referred to OTP or NSU and sick children are referred for health care. The caretaker is interviewed about the baby's feeding habits and is asked simple questions to determine whether it would be necessary and/or desired to participate in a counselling session with the psychologist. If possible, a breastfeed is observed, if this is not possible, it is done at a later time. All this information is gathered in the baby's register, which will also contain the information from all following visits.
- *Screening, registration and referral of new arrivals - pregnant women.* MUAC is used to determine the nutritional status. Women are taken through simple checklists to decide whether they need antenatal care and/or psychosocial support. Weight gain is used to monitor progress.
- *Determining eligibility of non-breastfed children for Ready to Use Infant Formula (RUIF)* (see annex 4 for criteria). Eligible caretakers are given an appointment for counselling on how to administer the RUIF.
- *Individual nutrition counselling of caretakers and/or pregnant women*, the subject depending on the problem encountered during screening. Children with non-life threatening diarrhoea were given Zinc and ORS, purchased by Concern.
- *Group education on a health topic*, sometimes even two to three times a day depending on how busy the PCNB is. In one PCNB also a group education session undertaken by the psychologist was observed.
- *Individual assistance to breastfeeding women*: this happens all day long, during breastfeeding sessions.
- *Distribution of BP5 biscuits, twice a day*. These are officially meant for the lactating women, although complementary fed children also benefit from it. There is no systematic hand-washing before eating the biscuits.
- *Potential income-generating leisure activities*. The afternoon activities observed were embroidery and crochet, but this could have been something else, depending on the skills of personnel and caretakers. During the afternoon it tends to be very hot in the tent, and caretakers and babies use this time for relaxing activities.
- *The PCNB typically* ends at 4 pm.

The order in which these activities take place is not always the same in each PCNB, but all activities have been observed in all three sampled PCNBs. When it is not the first visit of a baby in the PCNB, the initial screening does not take place. Only the weight is taken on a weekly basis, followed by a counselling session by the nurse, the other anthropometric measures are recorded every month.

Community mobilisation and home visits

Every morning and sometimes in early afternoons, community mobilisation and home visits are undertaken by one of the nutrition staff, who is said to be sometimes assisted by the psychologist. Community mobilisation is done with the use of a megaphone. Home visits are conducted to encourage absentees to return or to find out what is happening in the homes of babies who are losing weight.

Staffing and opening hours

Each PCNB has four staff members: a nurse in-charge, a "social worker" -who is mostly a(n) (auxiliary) nurse or social worker-, a psychologist (one for 2-3 tents) and a guard, who is also responsible to keep the tents clean. The job description of the in-charge and the social worker are very similar, with the only difference that the in-charge is the overall responsible of the tent, has to do the nutritional and health assessment and makes sure her reports are written and correct. Three supervisors are responsible for supervising the 12 PCNBs. Until December 2010, babytents operated 7 days a week, with 3 technical nutrition staff instead of the actual 2. Also the number of psychologists has decreased from 1 per tent to 1 for every 2-3 PCNB. Now the IYCF activities operate 6 days a week, from 8 am until 4 pm and each tent chooses which day they close.

Attendance

Women come and go with their children throughout the day, men sometimes attend briefly when they bring/pick up their partner and baby. There has been no in-depth evaluation to know how much time a caretaker typically stays in the PCNB, or how many sessions they typically attend per month. Observation revealed that some of the tents had quite a lot of breastfeeding women returning daily and some did not. This seemed to be more connected to the motivation, enthusiasm, and encouragement of individual tent staff rather than specific services provided. Most caretakers appeared to stay for at least four hours (those who stayed less than 4 hours were the ones coming late). This is different in Diquini where mothers would typically come once a week for growth monitoring.

Men are allowed to participate in the babytents, but observation suggests that attendance is very low. Until recently, they were not encouraged to come because babytents were meant as a safe space for breastfeeding. With the integrated approach, their participation will become more important as the accent will be less on the "safe space" aspect of the PCNBs but on the provision of a growth monitoring and IYCF service within the hospital. This will accommodate the suggestion made by field staff complaining about men being a barrier to behaviour change.

In Mais Gaté, there were less PCNB participants in the morning than in the afternoon because women were doing food for work activities implemented by another NGO than Concern. The work they were doing was to clean the gutters around the camp, full of black sticky slash. Knowing that there was a cholera epidemic going on, and that these women had to go home in regular intervals to breastfeed their infants, this seemed unacceptable. Another example of where the project could advocate to change policies was that of a handicapped woman with a few-weeks-old baby who was employed by the MINUSTAH[11] and discontinued to come to the PCNB for much needed breastfeeding support (see recommendations).

[11] United Nations Stabilization Mission in Haiti

**Picture 1: PCNB beneficiary doing cash for work activities in the morning and attending the babytent in the afternoon**

Set-up of the camp-based PCNB

PCNBs are relaxed environments where women can feel comfortable. To that end, the tents are spacious, light, clean and attractive. They have fans where electricity is available, although they tend to become very hot in the afternoon. Drinking water is available as well as mats and mattresses for sitting and relaxing. They are decorated with balloons, posters, coloured cloths, and other decorations. Some PCNBs also played children songs when no education was going on.

Especially the children more than one year old play with the toys available, but there was no "organised play" going on in the PCNBs, other than on days that this was organised by the psychologist (not observed). Some toys were hung at the ceiling (since the cholera epidemic, see "5.1 Relevance").

**Picture 2: Babytent in Colofe camp**

Individual IYCF counselling

As described under "Activities at the PCNB" above, not only the baby's anthropometric data are collected but also information on the IYCF situation. Two different screening tools are used for this purpose, one on breastfeeding (breastfeeding observation form) and one on drinking and feeding behaviour (nutrition screening tool). Both tools take about 10 minutes to administer -the breastfeeding observation might take place at a later time when the baby does not want to feed- and they serve as a reference during future counselling sessions. At the bottom of each page there is space provided to note down problems, advice given and progress.

Women with lactation problems, or women who show a lack of confidence in breastfeeding, are supported through counselling and encouragement. Women with children under 6 months who are not exclusively breastfed are encouraged to return (or start) exclusively breastfeeding. Caretakers with babies with diarrhoea are counselled about hygiene. Also counselling on age-appropriate feeding is offered. Caretakers requiring psychosocial counselling are referred to the psychologist on days s/he is present or given an appointment on the other days. Nutrition counselling takes place at a table away from the other caretakers.

Ideally a counsellor would first try to understand a caretaker's current behaviour, and based on this information, try to find a feasible change together with the caretaker. The few counselling sessions observed revealed that counselling didoes not always start from the knowledge the caretaker already had. For example, when it was discovered that a baby had suffered from diarrhoea, the nurse gave advice on hygiene, without trying to understand what could have caused the diarrhoea. Another example was a baby that had not eaten vegetables yet, the nurse advised to give vegetables without trying to understand how the food is currently prepared and how vegetables could be added to this diet. This is a missed chance as the in-charges really take their time for counselling. The PCNB staff does not have visual aids to assist in counselling. The MSPP has just released a new IYCF counselling tool, which can be used with 2 take-home brochures. A training guide has been developed to teach the counsellor how to use this set of counselling cards. It is very practical containing lots of role-plays.

It was also observed that breastfeeding counselling mainly focuses on positioning in the "Madonna" position, while other positions and especially attachment to the breast are not given attention.

Health, nutrition and psychosocial group education in PCNBs

Two to three times a day, the in-charge, the social worker or the psychologist leads an education session for all PCNB participants. Staff plans the sessions for each day at the beginning of the week and each subject is repeated 2-3 times a week, depending on the target group. Observation showed that the morning session is always health or nutrition related, while the other(s) could be about health, nutrition, caretaker-child relation, childcare or about an income generating activity. In Diquini there was time for only one session a day and the day of the observation it was about malaria. This means that these mothers, only coming once a week, were not subjected to IYCF education other than during individual counselling. The sessions observed were using the question and answer method as well as songs. On one occasion visual aids were used for education on hygiene. Although the cards were too small for a group, the PCNB staff solved this by sitting amongst the women on the floor (see picture 3 below). Other available tools for IYCF group education were posters which were hung in the tent, and which showed proper attachment and positioning as well as breast problems. PCNB education methods are outlined in annex 5 but the PCNB manager admitted that other methods than education and songs are rarely used because they require more preparation. The education topics can also be consulted in annex 5.

Observation revealed that PCNB staff knows the theory on health topics well but that health education mostly happens in the "teacher-pupil" way and that mothers were not congratulated enough for their input. The new national counselling cards and brochures recommended above for individual counselling would also benefit the group education sessions, as visual aids and health/ nutrition education materials were very limited and the session on complementary feeding was too general (see below).

The "3 food groups" topic has been observed at two different occasions in two different PCNBs. It is handled too theoretically, with little or no examples of recipes linked to the topic (the consultant did not observe a session on complementary feeding). The existing MSPP brochure with recipes mentioned above has been produced to guide animators of mother's club/babytent/etc. to lead sessions on complementary foods and to conduct cooking sessions. Some PCNBs have already prepared babyfood recipes as a group, but never using cooked food out of fear for fire. In other countries (e.g. Care in Zimbabwe) they have asked caretakers to bring previously boiled foods, which are then "finalized" (e.g. mashing, adding oil) together. The babytent in-charge could have access to

a small budget and buy missing ingredients. A lesson could be learned from Save the Children, which already prepares complementary foods in "complementary feeding groups" formed from PCNB beneficiaries.

The psychosocial support group sessions started when psychologists became aware that there was little interaction between mothers and babies and a support programme was developed for mothers in order to help them provide more attention, stimulation and affection to their babies. Every week, psychologists' propose specific sessions for mothers and babies focused on games and interaction. In some PCNBs the psychologist have formed clubs, examples being a club for pregnant women to discuss foetal development and a baby club to discuss the needs of babies.

Only one PSS group education session was observed in the three observation days, on how a caretaker can show love towards her/his baby. The psychologist had a good interaction with the caretakers and took his time to listen to all the mothers' input. He did however fail to get across the "right answers" (like cuddling, kissing, smiling, playing) to the beneficiaries' input (which were feeding, bathing, cutting fingernails etc.) and the French on the flipchart seemed out of place.

**Picture 3: Health education in Mais Gaté camp**

Access to Ready to Use Infant Formula (RUIF)

The International Operational Guidance on Infant Feeding in Emergencies (IFE)[12] states that an appropriate breast milk substitutes (BMS) should be provided to assessed and targeted infants that meet the established criteria. The earthquake created a need for infant formula but the environment did not lend itself to the safe preparation of a powdered version. The use of wet nurses was not accepted by the MSPP because of HIV, and the import of breast milk was also not an option because of the lack of electricity. Hence the decision that Ready to Use Infant Formula ('Lait Artificiel pour Nourrisson Prêt à l'Emploi'- LANPE in Haiti) needed to be imported. This was in accordance with the Joint Statement on infant and young child feeding in Haiti issued by WHO, WFP, UNICEF and the MSPP[13].

RUIF was procured by the US Office for Disaster Assistance (OFDA) on behalf of the nutrition cluster and in collaboration with the MSPP, the first batch still with label while waiting for the ones with a generic label in Creole. For approximately the first 6 months the RUIF stocks were being managed by Save the Children at the request of the cluster, after which UNICEF took over. The RUIF has been supplied to and distributed by nutrition cluster partners following the compulsory training of NGO staff members, including NGO project coordinators and technical staff as well as the nutrition workers and counsellors who would be working in the PCNB sites.

[12] IFE Core Group. Operational Guidance on infant and young child feeding in emergencies. Version 2.1, February 2007.
[13] MSPP, WHO , WFP and UNICEF Joint Statement on Infant and Young Child Feeding in Haiti, available on the One Response link for the Nutrition Cluster Haiti: http://oneresponse.info/Disasters/Haiti/Nutrition/Pages/default.aspx

A RUIF 'impact' study, implemented by UNICEF/MSPP and designed and analysed by CDC, is still in the data cleaning stage and will be available soon. The draft of the qualitative part of the study[14] is already available and did not bring about different findings than this evaluation. Another reason why this evaluation does not go in-depth into the RUIF-side of the intervention is that it was conducted after the stricter criteria for RUIF had already been applied and only 16 children were still receiving RUIF in March.

But interviews and observations did reveal the following Concern-specific information. Non-breastfeeding mothers who claimed to be HIV-positive were confidentially asked to come with test-results in order to have access to RUIF. All other mother-baby couples that could not breastfeed were asked to put the baby on the breast several times during the day, and consequent days if deemed necessary. When a female caretaker claimed not to be the mother of a baby and that the baby was orphaned, PCNB staff were gently asked to put the baby on the breast to confirm that the caretaker was indeed not the birth mother. . Surprise home visits were also carried out to ensure that the caretaker did indeed fall into the RUIF admission criteria. Where relactation was not possible, and where the caretaker fell into the criteria shown in annex 4, the caretaker was explained how to properly feed the baby with RUIF.

In the Concern sites there was insufficient space and personnel for two separate tents, one for breastfed children and one for children feeding on RUIF. The two groups of children were supported in the same space. In the Mais Gaté PCNB, the personnel decided to come one hour earlier (7 am) and to distribute the RUIF before the breastfeeding mothers arrived, latecomers had to wait until the evening. In other PCNBs, the distribution of RUIF as well as the practice for cup feeding took place in the psychosocial corner. Counselling of those caretakers happened during opening hours, and when a baby had to be cup-fed the caretaker was asked to do so behind the screen. The "RUIF caretakers and babies" were also invited to participate in other PCNB activities. During the first couple of weeks of being in the program, caretakers were asked to come on a daily basis, so that the baby and the feeding could be closely monitored. When the caretakers were skilled enough and the baby was doing fine, they came on a weekly basis for anthropometry and to get a new supply of RUIF.

Innovation to improve attendance of new mothers

As described under "3.2. The infant and young child feeding practice context", Haitian women tend to be secluded at home after delivery, often leaving the camp to deliver at their parents' in the countryside. Concern has implemented a new strategy to the PCNB approach to try to decrease the number of defaulters (see section "5.2 Outcomes" for details on the reasons for defaulting) and to have more impact on breastfeeding by motivating pregnant women to stay in Port au Prince and seeing the new mothers in the early days after giving birth.

Once every 2-3 months, women satisfying the criteria outlined below are celebrated as "model mothers" with a small party and presents. These criteria are:

1. As a pregnant mother they attend antenatal care and they commit to practice early initiation within an hour after birth and exclusive breastfeeding for 6 months
2. They come back to the PCNB within a few days after giving birth
3. They come lightly dressed (See cultural practice surrounding birth in "3.2. The infant and young child feeding practice context")
4. They assist the PCNB 2 hours per day

[14] Rapport étude LANPE Phase 2 - Draft 1

**Picture 4: Model mother showing their presents at a model mothers' celebration**

Psychosocial support

The psychosocial support (PSS) activities in PCNBs have only started in mid-June of 2010, especially concentrating on post-traumatic stress. Now the support has reoriented its focus on long-term problems and on postnatal depression, still with the objective to improve the caretaker-child relationship, on the born and unborn child. PSS is provided as individual counselling and during group sessions.

At the same time of IYCF assessment, the IYCF staff member screens every caretaker for psychosocial problems, especially looking for those at risk of depression and suffering from Post Traumatic Stress Disorder (PTSD). They only refer those caretakers requiring individual counselling. During the individual counselling, the psychologist uses anamneses[15] checklists and a form during the first visit and a follow-up form for the next ones. For women with new-borns there is also a questionnaire to detect postnatal depression.

When the psychologist is present in the PCNB, individual counselling starts as soon as clients arrives, for both those clients with an appointment, and those referred through screening. This is done in a corner separated by two screens allowing for a minimum of confidentiality. As the information is considered confidential, information collected by the psychologist goes into a file kept by them.

The two observed psychologists gave the impression they have yet to adapt themselves to the post-emergency situation. In the two PCNBs in camps, they often spent their time waiting, "babysitting" or doing embroidery. It is easy to imagine how everybody was very driven in the beginning to help all the victims. It is true that earthquake-related problems are now less important than in the past year and that the workload has decreased, but psychosocial support remains very important to address in the Haitian context. The focus group with the psychologists revealed that Haitian caretakers do not value affection and consider themselves good parents as soon as they provide food and a bath once in a while. Also, caretakers in distress (even non-earthquake related) are often having difficulties to breastfeed. The opposite problem occurred in Diquini where the PCNB attendance rate is much higher and the psychologist was overwhelmed with clients who ended up waiting for hours for their turn (mentioned as a complaint in two individual PSS interviews).

The evaluator cannot judge on the quality of individual counselling, as she is not a psychologist, although observation left a good impression. Individual interviews disclosed that beneficiaries appreciate the psychosocial support.

[15] Anamnesis – a recollection of events, especially from a supposed past experience.

Diquini, a PCNB within a hospital setting

In Diquini, the approach is a little different because of the non-camp setting, and the small room they are working in. While in the hospital waiting room, caretakers and their sick babies are invited to come to the PCNB. Group education starts once most caretakers have obtained their waiting number. After education, the purpose of the PCNB is explained and the caretakers are called one by one for anthropometry and screening. Also babies who come for follow-up are seen at the same time. Because of its attachment to the hospital, this PCNB sees more caretakers than the more typical "babytents" in the camps (6 times more new admissions than in Mais Gaté and Parc Colofe in January). The nurse explained that they also conduct home visits to defaulting caretakers, but that it is very difficult to trace the homes of people not living in camps. Addresses are often too vague, far away or house numbers do not make sense. She also said that the PCNB tends to be even more crowded on days that one of them is absent doing home visits. Because of the crowdedness of this specific PCNB, PSS counselling could hardly be called confidential. Systematic hand washing was not observed in Diquini, because mothers come to the PCNB directly from the waiting room, even though there was a hand-washing facility at the entrance of the clinic. This PCNB does not have mattresses because of lack of space (see picture 5 below).

**Picture 5: Diquini PCNB adjacent to the hospital's waiting room**

*Recommendations on set up and daily operation of PCNBs:*

- ✓ Provide training to PCNB field staff on how to receive and host PCNB beneficiaries. Strengthen the training by organising cross-visits from the "weaker" staff to stronger PCNBs.
- ✓ Offer psychosocial support to PCNB field staff who wish so, as personal problems can affect some people's attitude. One should not forget that most field staff are also Internally Displaced People (IDPs).
- ✓ Encourage men to participate in PCNBs by forming support groups for example, or adapting education to their role on certain days. This will not compromise PCNB female participants' breastfeeding behaviour, as Haitian women do not have problems to breastfeed in public.
- ✓ To minimise the heat, replace the plastic "sunscreen" sheeting in Parc Colofe and the cable for the fans in Mais Gaté.
- ✓ Negotiate with other NGOs/institutions having policies that are potentially harmful for young babies. Breastfeeding and pregnant women should be accepted for cash-for-work activities, but it could be proposed to have them do the cleaner work. Even better would be to come up with a "cash for breastfeeding" intervention[16].

[16] At the time of the evaluation Save the Children is in the process of evaluating a "Cash for Breastfeeding" intervention in Myanmar.

- ✓ Hang the "model mother" criteria in every PCNB to avoid jealousy of co-mothers and to avoid problems with camp leaders when they hear of "distributions".
- ✓ Provide extra training on IYCF counselling with the new national IYCF counselling cards, using the interactive training manual from Management Sciences for Health (MSH). Also the two MSPP brochures are part of this same set of materials.
- ✓ With permission from the MSPP, enlarge some of the counselling cards for the group education sessions.
- ✓ Improve the quality of breastfeeding counselling, it is recommended that a lactation consultant is hired to spend one day in each PCNB.
- ✓ In a setting where caretakers only attend once a week for a short time, like in the PCNBs in health centres, it is suggested that the daily education is done on an IYCF-topic and not on a general health topic (like malaria or STDs). If the new MSPP IYCF cards are used, this means that the first card/two cards are addressed in the first week, another card the next week etc. until all cards have been discussed over a period of two months. *In PCNBs in camps* (where caretakers attend several times a week and stay for several hours), the MSPP IYCF cards can be discussed over a period of a month, and IYCF and health topics can be alternated.
- ✓ Psychologists conduct at least one education or play session every day. When they are not busy, psychologists should motivate mothers individually to play with their babies when these are awake.
- ✓ Add some mattresses in some of the PCNBs, chairs for women who want to breastfeed in a sitting position and also pillows to try out more breastfeeding positions (e.g. in Mais Gaté one mother was lame on one side and could only breastfeed in limited positions)
- ✓ Not to include the 12-23 month-olds into the PCNBs, especially not when the decision will be taken to integrate all PCNBs in health structures. It is true that mothers mentioned the babytent space as a perfect learning space for babies to learn how to walk but these older children tend to overcrowd the PCNB. They distract the project from the real objectives of the babytent, which are to offer a quiet space for breastfeeding and to teach caretakers about complementary feeding. Of course mothers who have both a new-born and a toddler should be allowed to also bring the latter.
- ✓ Organise a more confidential space for PSS individual counselling in Diquini.
- ✓ Provide PPS clients with an appointment paper, mentioning the date and the hour (non-literate clients will always have an acquaintance who can read). The psychologist on his/her turn could write the appointments in his/her agenda and conduct a home-visit when the client did not show up. Those home visits could be conducted in the quiet morning hours, when the PSS clients have not arrived yet.
- ✓ In integrated PCNBs, follow-up appointments for IYCF and PPS could be given in the afternoon, so that the mornings are kept for new clients.

## 5. Evaluation of Concern's PCNBs: Findings, discussions and recommendations

For the write-up of the findings of this evaluation, the consultant followed the format provided by Concern in the Terms of Reference (annex 1).

### 5.1 Relevance

By co-developing and implementing the PCNB approach, Concern has correctly addressed the IYCF needs in post-earthquake Port-au-Prince. Below the operational and technical relevance are discussed separately.

**Operational Strategy & context**

Project design

From the beginning, Concern has been very involved in the development of the PCNB guidelines, which have been adapted to the Haiti and Port-au-Prince post-emergency context from the start. International IYCF policies, more specifically the Operational Guidance on IFE are being respected in all areas of the PCNB approach. The guidelines describe the IYCF approach as well as the psychosocial support (PSS) approach, although the PSS part is limited. Therefore Concern has developed its own PSS protocol, which is being amended now.

Immediately after the earthquake, problem analysis among Concern staff and cluster members revealed the need for an intervention to protect IYCF in Haiti. With the earthquake and large numbers of the Port-au-Prince population living outside and/or in unsanitary conditions in quickly established IDP camps, concerns were raised about the nutritional vulnerability of children 0 – 11 months. Young babies are amongst the most vulnerable in

terms of morbidity and mortality and moreover, this period is most important in terms of physical, mental and emotional development. Indeed, from 0 to 6 months babies need only breast milk and due to the cultural beliefs surround breastfeeding (see "3.2. The infant and young child feeding practice context"), this practice could have been affected seriously. Children are also at great risk for malnutrition after 6 months of age, when breastfeeding no longer provides enough energy and micronutrients. The introduction of appropriate complementary foods is needed at 6 months with continued breastfeeding to ensure that children continue to grow and thrive. The earthquake had deprived most caretakers in camps from all resources, including money, food, cooking utensils etc. to provide an appropriated diet to their children. Following a babytent proposal, the Concern's rapid nutrition assessment confirmed these fears.

Project activities were well defined since the inception of the project and the choice of the pregnant women and carers of children under 12 months of age was appropriate. Caretakers from all income classes and even those living outside the camps were welcome. Anything related to how effectively the target beneficiaries were reached is described under "5.2 Effectiveness".

Due to the scope of the emergency, there has been no time for problem and solution analysis involving other stakeholders than cluster members. The camp committees, or camp leaders where a committee was missing, were involved in site selection for the babytents, in the gathering of curriculum vitaes for all babytent personnel as well as in the actual putting up of the tents. Many of these early camp leaders have already changed by now though. As described under "5.3 Efficiency", the collaboration with camp management in Haiti has not been easy and it is unclear how the approach could have been improved. Some suggestions can be found under the same paragraph. It does not seem that there is there are other development coordination groups that could have played a role in the development or the implementation of the project.

Project flexibility

Three situations influenced the smooth implementation of the project as it was planned, particularly the cholera outbreak that started the end of October and peaked in November 2010, hurricane Tomas in November and the troubles surrounding the elections in November/December 2010. The risks and assumptions did not really mention the two last ones, but the project was flexible enough to adapt to them. During high unrest/cyclone days, the babytents were closed and some babytents vulnerable to the elements were even removed during the days that the cyclone would pass. Due to the cholera epidemic, the PCNB hand-washing facilities with soap were made larger and more accessible to other camp members beyond PCNB beneficiaries. Also the hygiene education messages were prioritised during that period and since then, many toys were hung on the ceiling instead of given for play sessions (in March, the consultant observed that some toys were used though).

**Technical Approach**

Objectives

The project objective[17] was general as it covered several emergency interventions. The proposed project results were not SMART[18] (see examples below under recommendations), neither for nutrition activities nor for psychosocial activities, which is probably because the intervention is still very new to Haiti and the world (see recommendations below). PCNB activities were sufficient and appropriate to accomplish the specific objective, as well as to protect and support optimal infant feeding for children 0-12 months. The same is true for children enrolled in the RUIF program, also in this stratum it appears that lots of lives have improved and been saved although an impact evaluation was not possible to carry out to confirm this (see 5.2 Effectiveness). A large effort was taken to minimise the risks related to artificial feeding, and the effort has born its fruits.

Suggestions for improvement from staff and beneficiaries

It is felt that the proposed activities for PPS are appropriate in the given context, although the addition of a socio-economic/ livelihood or food security component to the support would be an important add-on. Psychologists expressed the frustration of not being able to help many of their clients because their home situation, especially economic, was so bad that they would easily lose hope. Also in-charges complained about the bad financial

[17] Contribute to the protection of the most vulnerable members of the earthquake-affected population through the provision of safe drinking water, sanitation facilities and hygiene and health promotion, and through the prevention and treatment of severe acute malnutrition among children under the age of five

[18] SMART: Specific, Measurable, Appropriate, Realistic, Time-bound.

situation of the caretakers, sometimes causing weight loss in the children as soon as they were started on complementary food or weaned from RUIF. All PCNB personnel expressed the wish that Concern would also implement socio-economic and/or livelihoods and food security activities.

Another suggestion by caretakers, PCNB personnel and the managers to improve the babytent approach is to offer additional services like vaccination, deworming and administration of micronutrients in the PCNBs. Save the Children already does this in its PCNBs. This addition has in fact already been written into the new PCNB proposal, in which it is suggested that this will be organised by the nearest health centre. The add-on of the "model mother" system will hopefully address the high defaulter rate (See "Innovation" above).

Another important proposition to improve the PCNB approach came from the PCNB's PSS and IYCF managers: to intensify prenatal support in order to start working on the caretaker-child relationship and breastfeeding from before birth. This would include amongst others education on breathing during delivery, foetal development and a video on early initiation, as well as the provision of iron folate.

Referrals

A list with addresses and phone number for referrals (internal and external to Concern) was posted in every PCNB, as a reference for the PCNB staff. However, the PCNB manager complained that some referred caretakers had not found some of the addresses, suggesting that the list was not updated. In the past year, very few PCNB-participating children needed to be referred, and if they were, it was mostly to Outpatient Therapeutic Care (OTPs) where severely malnourished children without complications are treated and receive Ready to Use Therapeutic Food (RUTF). Other referrals happened very sporadic and included referrals to institutions specialised in psychiatric care or to Nutrition Stabilisation Units (NSUs) where severely malnourished children with complications are being hospitalised. The caretakers of referred children, or those who were referred themselves, were explained where to go and received a referral card mentioning the reason of referral and the phone number of the PCNB in-charge for possible follow-up.
For referrals to Concern-lead OTPs or NSUs, the babytent in-charge ensured follow-up by phone. Although from the OTP and NSU-side there was no follow-up when a child was referred back to a PCNB or when a child was discharged and needed feeding support. The reason for this is unclear, but more consistent follow up from the OTP / NSU side is recommended
For referrals outside the Concern-services, psychologists and PCNB in-charges thought that caretakers might not have gone because of lack of money to pay for transport or out of fear not to find the service.

Feed-back of data

A lot of data is being collected on paper, both on nutritional as on PSS activities, but not much of it is being used to guide the program because it is not electronically available. On the other hand, some data is missing to be able to calculate additional outcomes of the project (see 5.2 Effectiveness). Concern staff is actually working on the revision of the monitoring and reporting tools used in the PCNBs. For both nutrition and PSS, they are working on a database, which should be able to capture all relevant information electronically and to link the nutrition activities with the PSS activities (see "5.7 Monitoring" for comments). Also the reporting system has been discussed under "5.7 Monitoring".

*Recommendations on relevance:*

- ✓ Use the toys that can be washed. The guard could be held responsible to disinfect them on a daily basis.
- ✓ Improve proposed project results by making them SMARTer.
  *For example*, result 4 in the ECHO proposal said: Carers of children under 12 months of age are supported in giving appropriate feeding practices through 4 centres offering technical, educational, logistical and emotional support. This could be rephrased by saying: The percentage of PCNB beneficiaries who feed their babies 0-11 months according to the national IYCF guidelines practices will have increased with xx% by the end of 2010. Another result would probably be needed for the pregnant women. Already from the inception of the project it should be decided how this is going to be measured, to make sure the practices are monitored from day 1.
  *Another example,* result 6 said: Carers of children under 59 months, and pregnant women in distress receive counselling to help them resume care-giving practices. This could be rephrased by saying: The percentage of PCNB beneficiaries with children under 59 months and pregnant PCNB beneficiaries in distress having received counselling to help them resume care-giving practices will amount xx% by the end of 2010.

- ✓ The PCNB project should facilitate caretakers to have access to other services provided by Concern or other NGOs in the camps, especially those services that could improve their way of life like food security or cash for work activities. Refer to the recommendation section under "4. Observations" for more ideas.
- ✓ Offer additional services like vaccination, deworming and administration of micronutrients in the PCNBs linked to the nearest health facility.
- ✓ Follow-up of children counter-referred to PCNBs from the NSUs and OTPs (if dropped out of PCNBs) should be given more importance in order to prevent regression. The NSU program manager suggested using the young volunteers, who are in charge of tracing missing OTP clients, to do so.
- ✓ Update the list with referral institutions and addresses.
- ✓ Providing transport allowance or voucher to the needy PCNB beneficiaries would significantly lower the barrier to access referral services, especially when the place they are being referred to is far. Typically a caretaker walks 1-2 hours no the nearest OTP site (for some PCNBs this is 4 hours) and s/he needs to do this every week. Where necessary and possible, referred beneficiaries like the ones requiring psychiatric care or the very ill/malnourished beneficiaries could be accompanied by a Concern-staff, using a Concern-vehicle. Considering the workload of the IYCF babytent staff, supervisors or the young volunteers might be able to help with this.

**5.2 Effectiveness**

**Expected Outcomes/ Results**

No population surveys were conducted, all outcomes represented below are measured for programme beneficiaries.

The table below presents a summary of program results, indicators and targets as outlined in the UNICEF emergency project proposal, which was written for the period February until July 2010. Results reflect the same period.

| Expected Results | Indicators/targets | Reach |
|---|---|---|
| 10 PCNBs are functioning. Technical, educational, logistical and emotional support is offered in order to support breastfeeding and non-breastfeeding mothers, caretakers of orphans less than 1 year old, pregnant women to adapt adequate feeding practices. | 10 PCNBs opened | 15 PCNBs were open in July 2010 (a few have merged now) |
| | 2000 caretaker-child couples reached | 5969 caretaker-child couples reached from February 2010 until July 2010 |
| | 300 pregnant women reached | 1823 pregnant women from February 2010 until July 2010 |
| Caretakers of beneficiaries (children less than 1 year old and children suffering from severe malnutrition) and pregnant women with psychological troubles related to the earthquake, receive psychosocial support. | 1592 persons receive psychosocial support | 660 individual psychosocial support sessions were carried out between June 2010 and July 2010 |

**Table 2: Program results, indicators and targets as outlined in the UNICEF emergency project proposal**

Despite "teething" problems in the beginning, this evaluation shows that Concern has been effective in rapidly answering to the IYCF needs by quickly mounting PCNBs in selected camps. Concern's PCNBs and their dates of opening and closure are shown in annex 7. In March, the target of 10 PCNBs was already reached, and by May, an additional 5 had opened. All nutrition targets were exceeded and Concern was able to open more PCNBs than originally planned. Psychosocial targets had not been reached because the staff member charged with managing this sub programme was only hired in late May 2010 and PSS in PCNBs did not start until June-July 2010. Excluding the caretaker-child couples having babies 12-24 months, the project has reached 11826 beneficiaries in

the past year, with 8938 of them caretaker-child couples, of which 13% were children requiring RUIF (10% estimated when writing the project proposal). 2888 individual pregnant women have participated in the program.

In order to provide some background on the outcomes discussed in the paragraphs below, the PCNB UNICEF/MoH required indicators are explained in the table below.

| **Indicator** | **Denominator** | **Limitations** |
|---|---|---|
| Number of enrolled infants who are exclusively breastfed (< 6 months) (%) | Total beneficiaries 0-5 months in the beginning of the month + the number of new admissions 0-5 months | Exclusive breastfeeding is reported by the mother who might want to please the PCNB staff |
| Number of enrolled infants who are mixed fed (< 6 months) (%) | Total beneficiaries 0-5 months in the beginning of the month + the number of new admissions 0-5 months | - |
| Number of enrolled infants who are fed RUIF only (< 6 months) (%) | Total beneficiaries 0-5 months in the beginning of the month + the number of new admissions 0-5 months | Exclusive feeding of RUIF is reported by the mother who might want to please the PCNB staff |
| Number of enrolled infants who are breastfed and complementary fed (6 – 12 months) (%) | Total beneficiaries 6-11 months in the beginning of the month + the number of new admissions 6-11 months | - |
| Number of enrolled infants who are receiving RUIF and who are complementary fed (6 – 12 months) (%) | Total beneficiaries 6-11 months in the beginning of the month + the number of new admissions 6-11 months | - |
| Number of pregnant women enrolled | - | - |
| Number of children who change from one feeding method to another (e.g. from mixed feeding to exclusive breastfeeding) (%) | Total beneficiaries in the beginning of the month + the number of new admissions | Exclusive breastfeeding is reported by the mother who might want to please the PCNB staff |
| Number of discharges: > 12 months, died, referral outside the program and default; childbirths for pregnant women (%) | Total amount of discharges | - |
| Number of children who died (%) | Total beneficiaries in the beginning of the month + the number of new admissions | - |
| Number of beneficiaries of each category at the end of the month | - | - |
| Prevalence of diarrhoea of each category of children (%) | Total children asked about the presence of diarrhoea | -Is closer to measuring incidence instead of prevalence, although it does not only involve new cases as a same child could be counted several times in the month.<br>-It cannot be compared to DHS prevalence (diarrhoea in the last two weeks) |

| | | |
|---|---|---|
| Number of children referred for severe malnutrition (%) | Total beneficiaries in the beginning of the month + the number of new admissions | - |
| Number of individual psychosocial support sessions carried out | - | This does not allow to calculate the percentage of PCNB beneficiaries who receive PSS because of double counting |
| Number of individual follow-up sessions carried out | - | This does not allow to calculate the percentage of PCNB beneficiaries who receive PSS because of double counting |
| Number of mothers/caretakers who participated in a focus group discussion (and not the number of participants, we do not count the same mother several times) (%) | Total beneficiaries in the beginning of the month + the number of new admissions | - |
| Number of mothers/caretakers who participated in a caretaker-child play session (%) | Total beneficiaries in the beginning of the month + the number of new admissions | - |

**Table 3: PCNB UNICEF/MoH required indicators**

IYCF, morbidity and mortality outcomes

Key measurable IYCF outcomes of the project, which are calculated with the data collected with the UNICEF reporting form, are represented below. They have been calculated for February 2010 until January 2011, and only for children 0-11 months as children >12 months have only been participating in PCNBs since August 2010 and are not the focus of the PCNB intervention.

- *Increase in exclusive breastfeeding.* 889 mothers of babies younger than 6 months (17.6%) shifted from mixed feeding to exclusive breastfeeding (a mother who changed their baby's feeding habit several times could have been counted several times). The other way round, only 58 (1.2%) of women who were exclusively breastfeeding changed to mixed feeding. It has to be noted though that this indicator is reported by the mother to the counsellor, possibly creating a reporting-bias.
- *Incidence of diarrhoea.*
    - Only 14% of children 0-5 months suffered from diarrhoea, which is low compared to the 22% found by the 2005-2006 DHS for the same age group. One has to be cautious though with this comparison because the two datasets used a different definition. The UNICEF form looked for incidence (does your child have diarrhoea now?) and a baby could have been counted several times if they came to the tent frequently, while the DHS looks for diarrhoea incidence in the two weeks before the survey. Only 7.6% of PCNB babies 0-5 months exclusively breastfed suffered from diarrhoea and 14.3% in the group of babies 0-5 months feeding exclusively on RUIF, which is still much less than the national incidence mentioned above.
    - 13.5% of children 6-11 months suffered from diarrhoea, while the 2005-2006 DHS found 40.9% but again one has to be careful with the comparison. This relatively low incidence is remarkable knowing that these children are being complementary fed in very difficult and unhygienic circumstances.
    - Diarrhoea incidence amongst PCNB children 0-11 months during the cholera epidemic in November 2010 reached its lowest point with 10.9% (the average for the year for this age group was 13.8%). The incidence started to increase again to a maximum of 14.2% in February 2011, probably because caretakers are becoming less worried.
- *Mortality rate.* Only 31 babies 0-11 months died, meaning 0.3% of the total number who participated in a PCNB. This is 7% of the number of expected deaths (429) when using the 2005-2006 DHS infant mortality figure for the Port au Prince region (48 per 1000 babies born). Regarding the challenging environment this is very low and can be attributed to the project. The deaths occurred evenly spread over the year and none of the age groups had a significant higher incidence.

Psychosocial Outcomes

The psychosocial support information comes from two different sources: 1) the same UNICEF reporting form as for IYCF information (# who received PPS, # who participated in PPS group discussion, # who participated in play session). These outcomes were calculated for the period June 2010-September 2010 only. The consultant did not feel that the information collected in the consequent months was reliable enough to include in the analysis. 2) Concern's PSS database (% depression, % PTSD, % PTSD/depression), calculated for July 2010-December 2010.

- 1100 individual psychosocial support sessions were carried out between June 2010 and September 2010 (3.4 % of total PCNB beneficiaries) (the same person could have been counted several times as the reporting format was monthly). When the project proposal was written it was estimated that 40% of PCNB beneficiaries would receive PSS support, hence 3.4% seems very low, although the basis for the original target is not clear. It may have been based on the assumption that new mothers are considered particularly vulnerable for psychosocial problems. Additional research would be needed to find out why so little women were seen for psychosocial support. Some hypotheses for the low percentage are: the initial screening tool (used by the PCNB IYCF staff) was not sensitive enough, IYCF staff were not convincing enough when referring caretakers, the stigma of seeing a psychologists who are considered for mad people, low quality of PPS services, beneficiaries who thought they did not need PSS anymore several months after the earthquake (the PSS activities started 4 months after the IYCF activities).
  The low participation in PPS is probably not related to the care they received because 16 out of 18 mothers interviewed did not have any recommendation about how the psychologist could do better, and said s/he should continue as s/he is doing (the other two did not like it because s/he asked so many personal questions). It seems it is not related to the lack of confidentiality either because only two women interviewed had doubts about confidentiality, and both were from Diquini, which opened in November (after the reporting period) and where crowds were an issue.
- 457 individual follow-up sessions were carried out between June 2010 and September 2010 following referral after initial screening (1.6 % of total PCNB beneficiaries) (again, there could have been double counting as the reporting format was monthly). Also during individual interviews conducted for this evaluation, it was found that 5 out of 18 mothers interviewed for this evaluation had discontinued their sessions, although they had all received a follow-up appointment from the psychologist (sometimes months ago). However, they all said they would come again when need be, or when they would have more time.
  As for the total PSS case load figure above, the portion of PCNB beneficiaries participating in follow up PSS sessions is fairly low and the possible causes are likely similar. Additional explanations for low follow up include screening that is too broad in the beginning (and inviting people to a first visit who did not really need/want it) or the caretakers being too busy (this is the reason the interviewed caretakers gave themselves, although they did continue to go for IYCF support). Losing patients in follow-up is considered a problem when giving PSS[19] therefore, the need for a sound explanation of the benefits of continued PSS during the consultation, and even a sensitisation of the whole population on the need to unwind after a natural disaster. There is no information on how or whether this motivation/sensitisation is done, but one recommendation under "5.3 Efficiency" is that home visits by psychologists should be given more attention.
- 1433 PCNB beneficiaries have participated in PSS group discussions and 638 participated in a caretaker-child play session between June 2010 and September 2010 (5.1% and 2.2% of beneficiaries). Even though some beneficiaries only come once a week and/or on days the psychologist is not present, one would expect a higher percentage of PCNB caretaker-child couples to benefit from group sessions. As above, this seems low and it was already recommended under "4.Observation" that psychologists carry out at least one group education session a day.
- 56.3% of PPS beneficiaries were diagnosed by the psychologist to be suffering from Post Traumatic Stress Disorder (PTSD) between July 2010 and December 2010. Extrapolated to the whole PCNB beneficiary population, this would mean a prevalence of 4.5%, which is low, compared with prevalences found during and after other disasters and even in the general population. In India for example, they found that 23% of the total population suffered from PTSD after a major earthquake (it has to be noted though that they used the DSM III criteria and not the DSM IV criteria like in Haiti)[20]. A literature research article, conducted by the John's Hopkins University found that the prevalence of PTSD among direct victims of disasters was 30–40

[19] Personal communication with Ilse Casteels, psychologist for Medecines Sans Frontières in DR Congo.
[20] Sharan et al, Am J Psychiatry 153:4, Preliminary Report of Psychiatric Disorders in Survivors of a Severe Earthquake, April1996.

percent on average[21]. In the US, it is estimated that every year, 5.2% of women go through an episode of PTSD[22].

Caution is required when comparing these data with the Haiti results because the PCNB data are not representative of the whole population: PCNB women might be a self-selective group and the test for depression is not taken on all the PCNB beneficiaries but only on those ones that were already positively screened and who have decided to come for at least one visit to the psychologist.

- 43.9% of PPS beneficiaries (3.5% of total PCNB beneficiaries) were found by the psychologist to be suffering from PTSD linked with a depression between July 2010 and December 2010. In India, 7% of earthquake victims were found to suffer from this (again using an older version of the DSM criteria than in Haiti). The same caution is required when interpreting the 3.5% on the whole population as the sample seeing a psychologist might not contain all women suffering from these ailments.
- 3.6% of the total PCNB population was depressive between July 2010 and December 2010. The psychologists diagnosed that 11.4% of PPS beneficiaries (0.9% of total PCNB beneficiaries) suffered from a depression linked to causes before the earthquake and 33.7% of PPS beneficiaries (2.7% of total PCNB beneficiaries) suffered from a depression linked to events surrounding earthquake. In India, they found that 21% of all beneficiaries suffered from depression after a severe earthquake (see caution above about criteria). Following a WHO source, 9.5% of women worldwide suffer every year from an episode of depression[23]. The WHO 2001 world health report describes prevalences of depression in Brazil (15.8%), Chilli (29.5%) and the US (6.3%)[24]. The same comparison rationale as above applies for these percentages.

Default rate

50.1% of all children and pregnant women exiting from the program were defaulters. When looking closer to admission and defaulter data for the past year, it shows that for each 100 new beneficiaries admitted about 1/3 left the program. If you compare defaulters with the total number of participants, about 10% of the total number of participants (new admissions not included) leaves the program every month. There was no target set for default rate. According to field staff the high defaulter is caused by several factors i.e. initial disappointment of not receiving anything else than education (except for two BP5 biscuits a day), women needing to work, shame when the baby's weight goes down, people moving away from the camp and pregnant women going to the country side to give birth to receive the cultural postnatal care (See "3.2. The infant and young child feeding practice context"). As discussed above under "Innovation", the "model mother" innovation is trying to keep the pregnant women in Port au Prince in order to avoid them being subjected to the negative cultural practices surrounding birth and to properly start exclusive breastfeeding.

Behaviour change outcomes

As the project proposal was written quickly in the wake of the earthquake and before the babytent model was fully developed, other additional, measureable outcomes could be expected, especially in the field of behaviour change. Behaviour change outcomes could be measurable but not well assessed with the actual monitoring system (see "5.7 Monitoring").

Many of the respondents during interviews and focus groups felt there had been a perceptible shift in some very old and persistent taboos (newly delivered women who take their babies out, bad breast milk) as well as breastfeeding practices (prolongation of breastfeeding, improved breastfeeding positioning, increased exclusive breastfeeding) and more frequent hand-washing and bathing since the PCNBs were established. Changes in complementary feeding was also mentioned but only after more probing, which suggests that IYCF staff and beneficiaries may have given this topic less importance than breastfeeding and hygiene. All ex-RUIF clients in the focus groups were able to explain how to correctly to use RUIF, and all focus group participants mentioned the low incidence of illness in their children. "my baby has never been sick except for a "short cold", "my baby has never had any diarrhoea", even concluding that no babies would die anymore. They also thought that the

[21] Galea at al, Epidemiologic Reviews, Vol 27, The Epidemiology of Post-Traumatic Stress Disorder after Disasters, 2005.
[22] Ronald C. at al, Prevalence, Severity, and Comorbidity of Twelve-month DSM-IV Disorders in the National Comorbidity Survey Replication (NCS-R), July 2007.
[23] OMS, Aide mémoire : Rapport sur la Santé dans le Monde 2001.
[24] WHO, The world health report 2001 - Mental Health: New Understanding, New Hope.

knowledge and behaviour changes would not only benefit themselves but also their future generations, as well as their neighbour's and relative's' babies.

When probed on the benefits of PPS during the individual interviews with PPS clients, "less violent interactions with all the children of the household" came out as the number one response in 6 out of 18 individual interviews. A better relationship with the neighbours/husbands was mentioned in 3 out of 18 PSS interviews and less fear of buildings was mentioned once. PCNB IYCF staff said to observe that women who have frequented PCNBs for a while are happier, make more jokes with their new friends and give more attention to how they look compared to when they had just entered the PCNB. Following the PSS manager, another outcome of the PCNBs is that caretakers accept to be helped by a psychologist who is generally perceived as someone who helps "mad people". While this was overcome to some degree with PCNB clients, psychologists explained that they preferred to be called "doctors" by beneficiaries to avoid this association when doing home visits.

Referrals to other programmes

The referral information available is on malnutrition, from the UNICEF form, and has been calculated for February 2010 until January 2011.

- Only 1.4% of children <12 months had to be referred for severe malnutrition. This is slightly lower than what might be expected according the prevalence of severe acute malnutrition during the 2005-2006 Demographic Health Survey (DHS) which suggests 3.9% of children <12 months suffered from severe acute malnutrition (<=-3 SD W/H). A strong correlation, however, might not be expected due to the time lapse and the use of MUAC and oedema as additional referral criteria.
- Referrals for moderate acute malnutrition only took place in the months June until August 2010, as that is when Concern conducted distributions of supplementary food in the camps it operated in. Only 0.9% of total beneficiaries 0-11 months were referred in that period for moderate acute malnutrition (<= -2SD W/H and >-3 SD W/H). Again this is lower than the 5.1% prevalence suggested by the 2005/2006 DHS, but the same limitations apply as for SAM above.

Capacity building outcomes

Measurements of capacity building outcomes were not in the original plan. From observations the evaluator can state that Concern Worldwide has effectively built the capacity of its own staff in the management of PCNBs, especially in anthropometry and breastfeeding counselling. PCNBs and breastfeeding activities are new in country, and babytent personnel expressed gratitude to Concern for having been exposed to this type of activity. Behaviour change, discussed under "Outcomes" above, can also be considered a form of capacity building. In this respect, Concern Worldwide has been able to build the capacity of its beneficiaries. Also, in some PCNBs, beneficiary mothers with a special skill are asked to teach other mothers (e.g. embroidery in Mais Gaté). But other than this and informal mouth-to-mouth mobilisation, beneficiaries have not been implicated in the implementation of the activities themselves (see recommendations under "6.8 Concern Worldwide policies and guidelines"). Concern (and other agencies) merit recognition for its active role in the nutrition Cluster, and its role in building the MSPP's capacity in IYCF and the PCNB approach. Hopefully, this will have lasting effect as a longer strategy is developed for the PCNB to integrate them into the health system. Concern staff was also invited on several occasions to participate in training of other NGOs implementing PCNBs, contributing to capacity building of their staff as well as MSPP members.

**Programme coverage**

Coverage of the camp beneficiaries is difficult to estimate because no exact information exists on the total population in the camps, except for International Organisation for Migration (IOM) figures and estimates by camp committees. The health and nutrition coordinator explained that there has not been an updated head count in the last six months, when the last food distribution took place and at the time and that numbers used for estimations mostly come from the camp committees. However, he observed that the camp committees tended to exaggerate the numbers when the population was counted for food distribution.

In table 2 below, the consultant tried to estimate the coverage in a few camps (in stead of Diquini she used Dahomey because Diquini is not situated in a camp), based on March camp population estimates by the camp committee received from camp committees and using the national demographic parameters to estimate the population of pregnant women and children <1. For example, the Dahomey population was estimated at 1136

families, meaning 5680 people. The national demographic parameters show that 2.75% of women is pregnant at any given time, meaning that it is estimated that 156 women were pregnant in Dahomey camp. The coverage in the table calculates the percentage of this number, using the "total of pregnant women at the end of the month" as numerator[25].

| PCNB | Coverage of children < 12 months (%) | | | Coverage of pregnant women (%) | | |
|---|---|---|---|---|---|---|
| | June 2010 | November 2010 | January 2011 | June 2010 | November 2010 | January 2011 |
| Akra Nord | 40.7 | 39 | 40.7 | 17.5 | 14.3 | 40.7 |
| Dahomey | 59.2 | 179 | 207.8 | 27.5 | 67.9 | 59.2 |
| Mais Gaté | 252.8 | 178 | 142.2 | 20.2 | 25.1 | 13.7 |

**Table 4: Percentage of beneficiaries covered by some sampled PCNBs**

There was no coverage target in the original project proposals, but in general it can be stated that coverage is good. The PCNB manager explained the findings by saying that some staff are more motivated and there is variation from centre to centre. It was also mentioned that some women do not want to come, especially pregnant women, who are often too tired or weak to make the trip or who do not want to admit to PCNB staff that they are not going for antenatal counselling. The reason for more than 100% coverage in some PCNBs is twofold: many of the PCNB beneficiaries do not actually live in the camp (they used to live in the camp, they live close to the camp or they have a relative in the camp) and population estimates were for the month of March 2011, while camps are much emptier now than what they used to be in the first months after the earthquake. Ways to improve community mobilisation are discussed under "5.8 Concern Worldwide policies and guidelines".

*Recommendations on effectiveness and outcomes:*

- ✓ Try to involve the beneficiaries themselves in more in activities. Examples could be: have them prepare an educational piece of drama or a song, have them do some home-visits to missing beneficiaries coming from their area.
- ✓ Carry out additional research to find out why the participation in psychosocial support is low.
- ✓ Strengthen community mobilisation on the need for psychosocial support after a major natural disaster.
- ✓ In order to be able to compare PPS prevalences with international data, test each PCNB beneficiary on depression and PTSD with the tool used by the psychologist, and not with the initial screening tool used by the IYCF staff member.
- ✓ More recommendations on improving outcome indicators and monitoring systems can be found in "5.7 Monitoring".

### 5.3 Efficiency

Considering the positive outcomes mentioned above and given the context of the camps and the densely populated urban camps, the PCNB approach was a very efficient way to reach and engage women on the issues around IYCF and child interaction. Again, the quality of the PCNBs observed was very high, especially considering that this is such a new approach. Beneficiaries were all positive about the babytent in-charges and said they felt very welcome and understood. This was also the case for the least performing babytent, where the in-charge seemed less emphatic. Over and over again participants stressed they felt like a family in the babytents, creating friendships that would not be possible in the hostile environment of the camp. The evaluator believes that the resulting synergy improved the efficiency of the intervention.

PCNBs have been running for one year, and its original objectives have been met and expectations exceeded. The processes are more efficient than in the beginning., but now is the time to improve on project quality while continuing to increase efficiencies.

[25] i.e. Pregnant women at beginning of month + new admissions – those who left the PCNB.

**Cost-efficiency**

Without comparative mortality data linked to the intervention, which would be unethical to collect, it is not possible to measure the true cost-effectiveness of the intervention for comparison with other health interventions. Nonetheless, the approach has proven to be economical with a cost per beneficiary of 10 Euro per month, which would have been 7 Euro per beneficiary if transport costs were excluded. The budget has been spent as originally intended and there were no changes made to the original budget or narrative thanks to savings on staff costs. The cost-saving amounted to 90 000 dollars in 2010, which has been used for opening more PCNBs than stipulated in the proposal and a no-cost extension of the project.

As for all NGOs and institutions, transport costs are high because cars need to be rented to implement activities. Concern's nutrition section secretary manages the "PCNB cars" itself. This reduces the burden on Concern's central transport support systems, but the transport manager claimed that the vehicles are only used about 25-30% of the times.

The extra cars are especially used by the three supervisors who are on the field on a daily basis. Although it seems that the cars are necessary for ensuring the PCNB quality, the consultant does think fuel and maybe even cars could be used more efficiently.

**Supervision**

The PCNB manager evaluates the supervision system as efficient: the three PCNB supervisors go out on a daily basis and use supervision checklists which they use to make recommendations to the PCNB nutrition staff. Improvements between two visits are tracked with the checklists and all problems are discussed during the monthly meetings. At the end of the month, each supervisor draws a report for the PCNB manager, which is also shared with field staff during the same monthly meeting. Besides supervision, they also pass by the office every morning for information sharing and make sure the PCNBs get their supplies like water, cups and BP5 biscuits.

After one year of implementation, three supervisors for 12 tents seems a lot, and the quality of their work could be improved. The consultant cannot claim to have observed how supervision is normally done, but she was accompanied by one of the supervisors during all of the fieldwork and conducted interviews with supervisors and babytent staff. This revealed that supervisors visited 2 to 3 tents a day which does not leave much room for in-depth observation/supervision and they always arrived late in the morning after having passed by the office meaning that she always misses the community mobilisation. There were also quite some annoyances expressed by all field staff who felt unappreciated by their supervisor.

There is one supervisor for the PSS component, who also became the PPS manager after the expatriate PSS manager left. Because of the transition and as she is working on restructuring the PPS database and tools, she has had no time in the field since taking up her new role.

**Staffing and opening hours**

It looks like the right decision to cut the number staff has been taken at the right time (see "4. Observation") though a full-time psychologist (expressed by Diquini focus group participants) and extra nutrition person in the Diquini PCNB would definitely be a plus due to the high caseload in that centre. The health and nutrition manager, however, explained that the hospital was supposed to have a personnel member helping in the Diquini PCNB, but this has not happened yet. PCNBs are open every day from 8 am until 4 pm except on Sundays. The babytent nutrition staff takes an additional half day off in the week or on Saturday. The two staff members do not take this day on the same day, so that at least one staff member is present on all six days. Personnel complained about them having to work 5.5 days a week while the psychologists do not work in the weekend and recommended closing the PCNB one additional day, the day depending on the caretakers' preferences. The Diquini set-up is different as this PCNB depends on the clinic, which is closed on weekends.

The project is doing fine without an expatriate PCNB program manager since October, although she was much needed at the outset of the project.

**Training**

PCNB nutrition personnel participated in an intensive 3-day training before starting to work (February-June 2010), covering material related to breastfeeding and infant feeding practices, nutrition and detection of malnutrition, the national protocol on PCNB, activities and structure of PCNB, and the working documentation required for each PCNB. Haitian breastfeeding specialists, recommended by the MSPP, conducted the training sessions on breastfeeding and RUIF. This was efficient because breastfeeding counselling requires special skills and because the RUIF component needed special attention. Bimonthly training sessions were organised during bimonthly meetings (now monthly) by the Concern PCNB manager and the supervisors. These occasions were used to review topics related to infant feeding practices and nutrition, data collection and reporting but also on new topics like malaria and Sexually Transmitted Diseases (STDs). They also received on-the-job training by supervisors and attended a two-day refresher training in February 2011. Because of the emergency context that forced implementation to start fast, there has been little time for practical training. Especially extra training on IYCF counselling would be an asset to all PCNBs observed (See "4. Observation"). The health and nutrition coordinator said that this was already planned in the next proposal, as well as extra training on complementary feeding (only feeding quality had been addressed until now, no feeding frequency or quantity).

Concern was one of the NGOs involved in the writing of the psychosocial section of the national babytents guidelines, and they developed their own training modules. Concern also provided a three-day training in collaboration with WHO on psychosocial activities in babytents for all national and international NGOs. The consultant does not feel well placed to comment on the length and quality of trainings. All PCNB psychologists are trained psychologists, just graduated thus with little practical experience but very motivated. They were initially trained for three days, and assisted in three other trainings, an extra four days in total. Trainers were all international psychologists.

**Integration of PSS and IYCF activities**

The lack of integration between the nutrition and the PSS activities of PCNBs was the most striking observation, at all levels. Nutrition staff refused to comment on PSS activities and vice versa, and both did not know about the work of the other. Babytent IYCF staff did not really know what the work of the psychologist consisted of.

The lack of integration of the monitoring system has been discussed under "5.7 Monitoring".

**Psychosocial support**

The efficiency of PPS services is described under "4. Observation".

**Project tools**

As will be discussed in "5.7 Monitoring", project tools are pretty straightforward and staff gave the impression to be able to work with them. That is without taking into account the reporting format developed by the cluster, which still confuses the personnel, even after having been trained and retrained over and over again. UNICEF is actually working on the revision of this form.

**Collaboration with other actors and within Concern**

Cluster

Except for two misunderstandings when other NGOs put up a babytent in the same camp as Concern did, collaboration among all cluster members, including the MSPP, has been positive and supportive. Nutrition cluster and sub-cluster (PCNB and CMAM, which are not so regular anymore) meetings are attended regularly by Concern and they have been asked several times already to assist in national PCNB trainings. The PSS manager attends the mental health cluster where she has good relations.

It does not seem that efficiency could have been improved by involving other development coordination groups than cluster members in the development or the implementation of the project.

Camp committees

According to the babytent manager, a major factor for achievement of the PCNB objectives is improving the communication between the field office staff and the babytent in-charge with the camp committees. Although Concern has involved camp leaders since the beginning (see "5.1 Relevance") of the project implementation, collaboration with camp authorities seems to be a complicated matter.

The consultant conducted interviews with camp leaders in two camps: one where Concern is not responsible for camp management (Parc Colofe) and another one where they are (Dahomey). In the first experience camp leaders were even threatening to close the babytent. They complained that Concern never involves them, that they do distributions without informing them (referring to the presents for model mothers), that they do not know what the babytent is about, that they do not know the babytent personnel, that Concern does not reply to the letters etc. What disturbed them most was that the babytent was lifted for a few days during hurricane season and was then put back, without a word from anybody from Concern. They also claimed that the babytent covered only about 10% of the children and women it is supposed to cover, saying that mobilisation was never done in most of area the tent is supposed to cover (focus group mothers in this camp estimated coverage as 80% and field staff claimed that 100% attended at least once). In the other camp, leaders were much friendlier and not hostile and they estimated coverage at 85-90% but adding that every family knows there is a babytent. Here, babytent personnel did not attend to any camp meetings either, but the babytent guard was part of the camp committee.

The evaluator would not want to suggest hiring guards from the committee members in the future, as those guards tend to be the ones who are never happy and always want more pay. The former PCNB manager shared that the problem of managing babytent guards had been very difficult since the beginning, and was even suggesting not to have a guard like most other NGOs. The consultant's Save the Children experience however taught her that not having a guard was very time consuming as materials had to be moved in and out the tent on a daily basis and the personnel had to clean the tent themselves. Concern's camp management and PCNB managers did not like the idea of having regular meetings with camp authorities. They also revealed that camps where Concern is responsible for camp management cause the most problems because they always want more and are never happy. Indeed, during the two weeks the consultant was there, Concern staff was not allowed into two camps because of problems, and these were camps managed by Concern itself.

Within Concern

Concern's emergency response nutrition advisor's trip report[26] commented on the lack of communication within Concern in the beginning saying "Within Concern itself, it's not surprising that there might be some room for strengthening of communication between different sectors (nutrition, WASH, education, etc.) in such a busy emergency response. There were miscommunications/lack of communication between sectors during my 6 weeks in Haiti at times, but not really more than one would expect in this emergency environment and the PCNB programme has been greatly supported by other sectors and support systems, in particular the WASH sector and the logs team." With a program director on board, one would expect these communication issues to be solved. Although, according to the camp management project manager, field staff from different sectors does not easily work together unless the expatriate managers have asked so. Concern hopes that organising biweekly or monthly coordination meetings will improve this.

It has been evaluated that referral between nutrition programs could slightly be improved and has been discussed under "5.1 Relevance". Referral to the protection program is discussed under "5.8 Concern Worldwide policies and guidelines".

**Feeding in the PCNBs**

Some mothers and children stay in the PCNB for most of their day, sometimes not even having the means to prepare a meal at home. Of all the 66 caretaker-child couples observed, the consultant saw only one child being fed a complementary meal. Staff explained that women sometime leave the tent to prepare and eat their meal, although not many women were observed to move from the tent. The latter to explain that the BP5 biscuits play an important role in meeting the dietary recommendations of women but also of their children. The insufficiency of BP5s was raised by all focus group participants, babytent staff as well as by the Concern PCNB manager.

[26] Nutrition PAP 16Feb-31Mar 2010 JM trip report.

**Supplies management**

During my 14 field days, the PCNB ran out of BP5 three times. The supervisor explained that Concern had recently changed its storage policy and that it takes so much longer now to receive a new supply. Unlike before, also procurement has to be done using the logistics department and seems to take long, as the presents for the model mothers had still not been bought when the consultant left, 3 weeks after it had been ordered.

Although Concern did not have experiences with the handling and distribution of large quantities of artificial milk, this has gone smoothly considering the general hectic times.

*Recommendations on efficiency:*

- ✓ Reduce the number of supervisors to two and improve in-depth supervision of every aspect of the PCNB, including community mobilisation, by focusing on one tent a day and leaving earlier in the morning. This way each PCNB would be visited roughly every 10 days.
- ✓ Provide some additional training on supervision skills, especially focusing on how to keep subordinates motivated.
- ✓ Make IYCF supervisors are also responsible for the overall functioning of the babytent, thus asking them to also give suggestions on how to improve the work on the psychologist.
- ✓ Another way to improve integration would be to discuss client cases. Once a week IYCF and PSS staff could meet and discuss the condition and progression of certain clients and examine the influence of their situation on feeding and care practices, while maintaining confidentiality on PSS specifics.
- ✓ Improve cost-saving turning off the engine while waiting for the supervisors to return.
- ✓ Have the psychologists conduct home visits on a daily basis to motivate their clients to come to the appointment, they can do this in the early morning.
- ✓ See "4. Observation" for recommendations on how to make counselling more efficient.
- ✓ In health-centre based PCNBs: give afternoon appointments for women coming for a follow-up visit. That way, new clients, who actually came for other health services in the clinic, can be served in the morning so that "old clients" have to wait less time in the afternoon.
- ✓ Close the PCNBs on weekends, as Saturday the PCNBs are not very frequented anyways. If the tents would remain open 6 days a week it is recommended that the supervisor assists on days that there is only one staff present. This recommendation is not applicable in the emergency phase.
- ✓ The health manager calls for a meeting with Parc Colofe camp authorities to explain the situation and to even draft an MOU with them as they suggested.
- ✓ The babytent staff passes by the camp management tent to "say hello" on a regular basis, this for all camps, as Haitian society highly values polite greetings.
- ✓ Inform the camp committee of big events, like distributions or removal of the tent.
- ✓ Prepare porridge from a BP5 biscuit for every complementary fed child at least once a day, and feed it in the tent. It is hard to be educating about feeding frequency and seeing that it is not being practiced because of the babytent. Especially in the health centre-based PCNBs this is true because caretakers live far and the caseload causes many caretakers to wait for hours.

### 5.5 Coherence, alignment and integration

Concern's PCNB implementation was very coherent, aligned and integrated with all national and international guidelines. As discussed under "3.4. The (inter)national IYCF context", the PCNB approach was developed by and with the nutrition cluster, which is lead the Haitian Ministry of Health (MSPP). During the development process, the local and the international context was taken into account. Babytents were placed in IDP camps, where the need was highest in terms of population covered. As most, if not all, government structures had been damaged during the earthquake there was no possibility to integrate babytents into the existing health structures. Moreover, those rare functioning structures were overwhelmed with wounded people and not situated in or near camps.

Initially, psychosocial activities taking place in PCNBs were seen as separate projects, but this is no longer the case, although further integration is needed (see above). With the revised databases, it will be possible to link beneficiaries receiving both IYCF and PPS services.

### 5.5 Sustainability, Phasing Out and Exit Strategy

**Sustainability**

The assistance has been provided in a way that took into account the emergency context and has been discussed under "5.1 Relevance". Unlike other emergency interventions, the PNCB approach seems to be sustainable for two reasons. All data suggest that behaviour change on IYCF and other care-giving practices have occurred, in a way that will also benefit future generations. Also, the approach has been supported by the MSPP from its inception, it is very likely that it will continue to exist, even after the closure of the IDP camps and departure of emergency actors. The MSPP wants to ensure that the PCNBs are not only to be continued in earthquake-affected areas but in the entire country, although with a slightly adapted approach. The head of the nutrition bureau explained she purposely called the activity PCNBs and not babytents. With calling the "points" she wanted to make sure that the intervention is not restricted to tents. The idea is growing to link PCNBs to perinatal care, which would make the complementary feeding aspect of PCNBs less important.

In terms of capacity building, the capacity of staff (who are often also IDPs), the MSPP and the beneficiaries have definitely increased substantially. In one focus group the participating women said they would easily be able to run the babytent themselves if Concern were to leave. In another focus group, participants said they could also help in community mobilisation and convince other mothers to join the PCNB. Capacity building of camp leaders did not really happen through this project, the problems related to this are discussed under "5.3 Efficiency".

**Phasing out and exit strategy**

Ready to Use Infant Formula

The provision of the RUIF was intended as a short-term emergency intervention, to try and safeguard the health and lives of infants that did not have any possibility of being breastfed in the immediate aftermath of the earthquake. The 'emergency' period is generally recognized to be 6 months following an earthquake. In the particular case of Haiti, the huge scale of urban destruction and the large numbers of people displaced, as well as the slow progress with providing services have lead the RUIF component to be extended beyond six months. A draft exit strategy of RUIF has been developed in June 2010[27] but even though it is still in its finalization phase, the admission criteria for RUIF have already become much stricter in September-October 2010, only accepting orphans and children of very sick mothers who are not able to breastfeed.

Towards integration of PCNBs in health centres

In terms of the other PCNB activities, no exit strategy has been developed yet. Concern has initiated discussion about phasing out within the nutrition cluster, proposing to transfer existing PCNBs to health structures where possible. Discussions within the nutrition cluster suggest that the MSPP would prefer to have PCNBs in the perinatal ward.

The consultant would like to stress the importance of developing new national PCNB guidelines for this new phase. Focus group participants at the health centre were as enthusiastic about the staff, the approach, the care, the weighing, etc. as in other PCNBs but they did complain about the small space, the lack of confidentiality, the lack of mattresses and chairs, the long waiting times and the heat. The caseload might not allow for weekly weighing of the babies. When it was suggested to staff to decrease weighing frequency they warned that this could cause more defaulters as the weighing itself is an important motivator for many caretakers. Indeed, in all focus group discussions with beneficiaries, the weekly weighing was one of the first motivators mentioned when asking about what makes them come regularly to the PCNB. However, Save the Children only does weekly weighing of the malnourished and RUIF children and monthly weighing of the other children. Other modifications could be: a narrower selection of the age group or using admission criteria (e.g. only pregnant women who promise to stay in the program for 6 months after giving birth).

If the MSPP and the nutrition cluster decide that PCNBs will be under the perinatal umbrella of the health centres, the focus of staff training and education will also change and data collection tools will have to be adapted accordingly.

[27] RUIF transition strategy 5 June Cmnts ABR_SC_"JM

Community aspect

It is important to ensure that the practices shown in PCNBs become a sustainable behaviour by offering home-based support. It is observed that the health centre based staff does not have time for home visits, meaning that another strategy for community-based breastfeeding support will need to be developed. Concern could learn from Save the Children's breastfeeding promoters in Haiti or from the experience in the Dadaab refugee camps (northeastern Kenya) where community resource people provided IYCF counselling at home. In Haiti, successful mothers could be used for this purpose, or maybe the young volunteers. In most places in Haiti, there are health agents (they normally do gowth monitoring and vaccination) but these tend to be overwhelmed with tasks and might not have time for IYCF counselling at home.

Timeline

The government is putting pressure on IDPs to leave the camps but the process is slow as not much alternatives have been offered to them yet. Continuing to offer services might also slow down the process. A "phasing out and exit strategy" of the camp-based PCNBs should be developed, except maybe for Tabarra Issa as it seems that the population will be allowed to stay in the camp where semi-permanent structures are currently being set up. Concern has already closed down/merged some of its babytents and others have been integrated with health structures.

It is advised that all 8 camp-based PCNBs (not Tabarre Issa) will be closed by the end of the year 2011, taking sufficient time to prepare the process. Care should be taken not to loose beneficiaries of the current PCNBs, ideally they would all continue to receive services in the new PCNBs. Therefore it is recommended that the beneficiaries, the camp committees and other key camp members (like NGOs) are asked their opinion on where they would prefer the service to be moved to by organising focus group discussions (FGDs) in each one of the camps. On a timeline, the exit strategy would look like this:

-May/June: conduct FGDs in the camps and locate possible health centres.

-July/August: discuss with the health centres in question and select the most suitable ones.

-September: develop and finalise MOUs.

-October/ November/December: Inform the population about the imminent move of the PCNBs out of the camps to their new location. And at the same time prepare the new sites (space, logistics, materials, staffing, training etc.)

*Recommendations on sustainability, phasing out and exit strategy:*

- ✓ As a member of the nutrition cluster, assist the MSPP and UNICEF to develop the post-emergency PCNB guidelines, and help them to pilot the new approach in any future IYCF programs.
- ✓ Assist in the development of the PCNB guidelines in a non-emergency context, Concern's lessons learned will be very valuable. Modifications to the current approach could be: a narrower selection of the age group, using admission criteria (e.g. only pregnant women who promise to stay in the program for 6 months after giving birth) or decreasing the frequency of weighing[28]. Also a new community-component will have to be developed.
- ✓ Develop a phasing out and exit strategy as described above.

**5.6 Impact**

Both qualitative and some quantitative data suggest that the intervention ultimately impacted psychomotor development positively and reduced morbidity and mortality. As presented under "5.2 Effectiveness", project data suggest that PCNB beneficiaries may have had less frequent diarrhoea and acute malnutrition than what would be expected in the population at large. Although no mortality surveys were conducted, these improvements ideally reduced the risk of dying among infants attending the baby tents. Furthermore, rough estimates of coverage of infants <12 months and pregnant women appears relatively good, meaning a sizeable portion of the intended target group have hopefully benefited from this reduced mortality risk. In the absence of

[28] Examples from Save the Children are: caretakers never stay longer than 2 hours, some tens have different days to invite different age groups or pregnant women and weighing occurs only once a month except for malnourished babies and babies on RUIF who are weighed weekly.

a robust baseline and endline survey at population level, however, impact is difficult to confirm. Recommendations are made in Monitoring section on how this impact could be better assessed in the future.

Potentially, the most important impact found in this evaluation is linked to behaviour, as this suggests a more sustainable impact. Although the exclusive breastfeeding rate is based on reporting rather than on direct observation, the increase is substantial, and this practice will also benefit future generations. The other behaviour changes, like improved caretaker-child relationships, improved IYCF practices, improved hand washing practices etc. are based on qualitative findings from focus groups and interviews but could be assessed more quantitatively in future evaluations with a sound baseline. No proof of any negative impact of the intervention has been found.

Although the portion of PCNB who availed of the PPS component was relatively small, those who did generally described positive effects. While the true impact of the PPS component is difficult to assess, it should be note that compared to other NGOs implementing PCNBs, only Concern and ACF have added the psychosocial support component.

As stated above, the evaluation did not go into a detailed evaluation of the Ready to Use Infant Formula component largely because that service had been discontinued by the time of the evaluation and because it was covered in more detail by an earlier study (CDC, results pending). Nonetheless, the evaluator thinks that the introduction of RIUF has not impaired the Haitian market negatively and did not cause any negative effects on breastfeeding rates. There might have been a few mothers who managed to falsely claim they were not breastfeeding at the very start of the program, but this was very limited. This finding has been confirmed by the beneficiaries, the MSPP and field staff. Some mothers said to be a little jealous in the beginning when they heard they would not receive anything, but they added they were very happy they had been exclusively breastfeeding. The other way round, caretakers of babies receiving RUIF said to be jealous on the breastfeeding mothers.

*Recommendations on impact:*

✓ Suggestions to increase the evidence of the project's impact are described under "5.7 Monitoring" below.

**5.8 Monitoring**

**Monitoring system**

The system which is in place to gather IYCF data can be summarized as such: data are being collected with monitoring tools (on paper in the registers), some of it is summarized for UNICEF (see sample reporting form in annex 6), the data from all PCNBs are added up and reported to UNICEF. The PCNB manager carefully looks at monthly reports and PCNB supervisor visits the PCNB in question when there are suspected mistakes. Data are also used to improve the quality of the programme. When they show that activities become sloppier for example, the supervisor is asked to find out what is happening. The UNICEF reporting forms are put on the Concern network on the 5th of each month and data flow ensures feedback of reports to all levels: back to the field as well as to donors and the clusters and Dublin Health Support Unit together with the CMAM quarterly reports.

For PPS activities, the system is similar, with the difference being that the individual psychologists are invited to the office to go over suspected mistakes in their reports.

In general, there is room for improvement of the monitoring system for PCNBs. Given the emergency context and the fact that PCNBs are new, it is not surprising that at the time of the project's inception, there was uncertainty regarding the most appropriate indicators to use and, realistically, what data could be collected and what indicators could be calculated. The urgent need for response has meant that the monitoring systems have been a 'work in progress' to some degree.

**Indicators**

As this was an emergency project, only process indicators were defined in the project proposal and design. Therefore some information is missing to be able to calculate higher-level outcome and impact indicators. Now is the time to come up with outcome and impact indicators and to learn lessons for the next emergency infant feeding response.

The information collected in the current monitoring system that is able to provide some idea about possible behaviour change is which education sessions have passed in the PCNBs, as well as the number of mothers who shifted feeding practice. Although it is difficult to measure behaviour change in a monitoring system, knowledge

(to know) and/or attitude (to believe) change can be measured. Questions about certain behaviours can be asked on a monthly basis to evaluate whether there is a change.

Some suggested PCNB-indicators are:

- % of women having participated in the PCNB for at least 3 months during pregnancy
- % of women having participated in the PCNB until the baby was 6 months old
- % of women having participated in the PCNB for at least 3 months during pregnancy and until the baby was 6 months old
- % of women with a baby less than 1 month who claimed they practiced early initiation
- % of women who managed to relactate
- % of women who reported to have changed from mixed feeding to exclusive breastfeeding
- % of children being exclusively breastfed at 4/5/6 months
- % of children being breastfed until 12/18/24 months
- % of women who know the 3 food groups which are supposed to be contained in complementary foods
- % of women who believe that providing complementary food containing the 3 food groups is the best for her baby's development
- % of women who know what feeding frequency to offer to her baby of 6 months/7-8 months/9-11 months
- % of women who believe that providing the correct feeding frequency to her baby is the best for her baby's development
- % of women who know what food quantity to offer to her baby of 6 months/7-8 months/9-11 months
- % of women who believe that providing the correct food quantity to her baby is the best for her baby's development
- % of children 0-5/6-11 months who have not increased weight or have lost weight in the past month
- % of children 0-5/6-11 months suffering from malnutrition (calculate <=2 SD and <=3 SD for W/H and W/A; also use MUAC benchmarks)
- % of babies who suffered from diarrhoea in the past two weeks
- % of women who know that cuddling/touching contributes to her baby's development

Ideally their benchmarks would also be designed from the start of the project.

**Existing data**

The indicators that could be calculated with the data being collected are described under "5.2 Effectiveness".

The evaluator had two major observations about the existing data:

1. Anthropometric data are collected but not used, other than for in-tent monitoring and referral purposes.
2. IYCF and PSS registers are not linked, so there is no easy way to investigate the impact of the psychological support on the actual breastfeeding practices nor on the nutritional status of the child.

If Concern would really like to know what the impact was of the PCNBs, this information should be analysed. Ideally, this would mean investigating a representative sample of children and compare their growth rate with a control group who was not followed in a PCNB. To investigate the link between PSS and IYCF, the change in infant feeding behaviour after psychosocial counselling could be investigated in a sample of caretakers followed in PSS. It would also be interesting to look into the IYCF and PSS problems caused by the earthquake.

If Concern would really like to know what the impact was of the PCNBs, this information should be analysed. Ideally, this would mean investigating a representative sample of children followed in PCNBs: a sample of all children for the anthropometry and a sample of caretakers followed in PSS to investigate the link between PSS and IYCF. It would also be interesting to look into the IYCF and PSS problems caused by the earthquake.

During the month of March 2011, Concern was in the process of producing an electronic database linking both nutrition and PSS activities. The evaluator shared her thoughts and recommendations at that time. In summary they were:

1. Use 4 datasheets, one linked to the other by a mother-child specific file number: one for pregnant women, another for children 0-5 months, a third one for children 6-11 months and a fourth one for PSS.
2. For the nutritional status, do not only capture malnourished children but also those children who are doing better than the norm, because that is what we are expecting with baby tents. This could be captured using 5 categories: >median, median, <=-1SD W/H, <=-2SD W/H, <=-3SD W/H (referral). The nutritional status should be captured at several intervals and not only at the first visit, e.g. on a quarterly basis.
3. Find a ways to also capture multiple changes in feeding method. E.g. a baby of 1 months who is mixed feeding, who is exclusively breastfed starting at 2 months, but goes back to mixed feeding at 5 months.
4. Other information the evaluator is recommended to add in the draft database were: relactation, parity (especially to see if first pregnancy), length in the program, orphan, abortion (to capture why a pregnant woman is lost in follow-up), improvement in caretaker-child interaction (with a scale) and improvement on a PSS level (with a scale like is done now).

**Data-collection tools**

The forms used for data collection in the PCNBs are described and discussed in the tables below. The discussion is only considering their current form.

Nutrition-related tools

| Tool | Staff member compiling it | Comments / suggestions |
|---|---|---|
| Monitoring tools | | |
| The nutrition screening tool for babies 0-5 months and those 6-11 months | PCNB nutrition staff | User-friendly, the question on earthquake related changes can be removed at this point in time |
| The breastfeeding observation form | PCNB nutrition staff | User-friendly. |
| The tool for anthropometry and plotting of the weight | PCNB nutrition staff | User-friendly but not adapted for older children. For children more than 3 to 4 months, plotting of the weight could be monthly instead of weekly. There is no space to put the next appointment date. |
| The screening tool for pregnant women | PCNB nutrition staff | User-friendly |
| Notebooks for data collection on diarrhoea and admissions | PCNB nutrition staff | Very useful for as staff in the past had to go through every register in the past in order to know how many diarrhoea cases there had been and who did not come for weekly monitoring |
| *Reporting tools* | | |
| Monthly report on home visits | Babytent in-charge | Clear, containing details (written on blank paper). |

| | | |
|---|---|---|
| Monthly narrative report | Babytent in-charge | On education messages, methods used and some numbers, straightforward |
| Monthly report on UNICEF Excel sheet (a sample is reproduced in Annex 6) | Babytent in-charge | Not user-friendly, after so many trainings in-charges still struggle. It is able to capture some useful information, but lacks other important PCNB data to be able to calculate more performance indicators (see above). It calculates the following information per feeding type: admissions, exits and feeding changes, as well as diarrhoea, referral and PSS. UNICEF is working on improving the form to allow for more outcome calculations. It will be important for Concern to review their updated monitoring system once UNICEF has officialised the form. |
| Monthly supervision report with strong points and points to improve | Supervisor | Clear (typed). |
| Monthly electronical UNICEF Excel sheet (see above). | Health and nutrition educator/PCNB manager | This is the sum of the sheets filled out by field staff for each individual PCNB. |
| Quarterly reports to the donors | Health and nutrition educator | Especially narrative, with data from the UNICEF form and any other data that can be provided. |

**Table 5: Nutrition-related PCNB data collection tools**

Psychosocial support-related tools

| **Tool** | **Staff member compiling it** | **Comments / suggestions** |
|---|---|---|
| Monitoring tools | | |
| Screening tool for caretakers | PCNB nutrition staff | Straightforward. |
| Screening tool for pregnant women | PCNB nutrition staff | Straightforward. |
| Monitoring tool for first visit (in combination with anamneses tools described below) | Psychologist | User-friendly. |
| Anamnesis checklist for depression and PTSD | Psychologist | User-friendly. |

| | | |
|---|---|---|
| Anamnesis checklist to detect caretaker-child interaction problems | Psychologist | User-friendly. |
| Follow-up tool (one for every visit) | Psychologist | User-friendly but does not include a summary that would make reporting easier. |
| Reporting tools | | |
| Weekly report on individual counselling sessions | Psychologist | Specifies personal details of the client as well as the diagnosis, straightforward. |
| Weekly report on group sessions | Psychologist | Half of it is not used and it does not have enough space for the information it is supposed to report on, revision is in process |
| Monthly reporting tool | Psychologist | The narrative part is clear but the quantitative part is being revised now. The information on which the psychologists are supposed to report on is not clear, definitions can be understood in different ways possibly causing that information is reported on consistently or misinterpreted.<br>Progress is measured with the Clinical Global Impression (CGI) scale at each visit. For reporting purposes and to be able to report on "real" change, it might be better to report progress only after a few counselling sessions (e.g. after 4 sessions), instead of each time. Even better would be to report on the progress at discharge. |
| Monthly reporting tool | Psychosocial support manager | The monthly report is confusing as reported data are not explained and no a definitions are provided, under revision. |

**Table 6: Psychosocial support-related PCNB data collection tools**

## Budget

Monitoring of the PCNB budget has been slow, especially in the beginning when the mangers had to wait up to three months for the budget (now a delay of 1 month), affecting the way financial information should ideally guide activities. The reason was that monitoring both UNICEF and ECHO grants took considerable time to administer and report on, having a significant impact on the overall efficiency of the finance department.

**Complaints**

In camps where Concern is responsible for camp management (only 2 out of 12 babytents), there is a mechanism which deals with complaints / dissatisfaction in relation to the program. In those camps, the population can drop its grievances in the mailbox situated at the entrance of the camp. Every week they are analysed by a complaint management committee based in field office staff, which is responsible to call the person who filed the complaint. In the other camps, there is not such a system.

*Recommendations on monitoring:*

- ✓ Decide on PCNB outcome and impact indicators and adapt the data collection system accordingly.
- ✓ If UNICEF does not come up with an updated monitoring sheet by June 2011, Concern should take leadership in the revision of the indicators and the monitoring sheet, in consultation with other cluster nutrition stakeholders.
- ✓ In order to make sure all necessary PCNB data are collected, make sure to update the revised database once the UNICEF new reporting format is known.
- ✓ Have the database set up by a consultant specialised in M&E. This to avoid that Concern collects insufficient data for new indicators while other data could be collected pointlessly.
- ✓ Organise for operational research in order to use the data that has been collected over the past year in the clients' registers.
- ✓ Link the PPS and IYCF databases through a common patient number.
- ✓ It is recommended to have a standard reporting format for PPS, which would allow for additions over time.
- ✓ In the future, it is worth considering the profile of donor's funding to ensure that reporting requirements can be met by current staff capacities. If needed, an extra finance-staff should be budgeted for.
- ✓ Improve communication with the camp committees to ensure that complaints are able to reach Concern staff.

**5.8 Concern Worldwide policies and guidelines**

**Policies**

Concern does not have any Concern policies specific or strategies on infant feeding, until now they have used the Operational Guidance on IFE to guide their IYCF work. IYCF indicators are now being included in their new Results Framework for their global health program strategy. The evaluator thinks that those two tools, combined with the translated PCNB national guidelines (adapted to a more international context), are a good start to guide a well-established babytent approach in future emergencies.

Eligibility criteria for RUIF were subject of many discussions and are specified in the national document (see annex 4). There are no recommendations to change them, as they were appropriate in the given context.

The national guidelines do describe the psychosocial support (PSS) approach, although it is limited. Therefore Concern has developed its own PSS protocol, which is being amended now.

**Equality**

As the project beneficiaries are mostly women, gender issues were not specifically mentioned in the project design. Equality issues were not mentioned either. The consultant expected that caretakers from lower socio-economic layers would have more barriers to participate in the PCNB activity, as they are often seen as treated as inferior in the Haitian society. Although observation and interviews showed that all types of women were present in all PCNBs. Also a handicapped woman was observed to be attending with her baby and staff showed to take very good care of her. In those camps where the staff has good relationship with the camp population (like in Mais Gaté) the staff themselves passed by every tent on a weekly basis to (re)invite (possible) beneficiaries. In other camps (like in Parc Colofe) where the mobilisation happened with megaphones, the approach is less personal which could cause that some caretakers did not dare to come. Concern has already taken a step to improve community mobilisation: it has already formed two "young volunteers" (jeunes volontaires) who will assist in mobilisation in their area and they are looking to recruit more.

**HIV and AIDS**

It is part of Concern policies that awareness of HIV and AIDS is mainstreamed across all Concern programmes with staff trained accordingly. In the PCNB project in particular, IYCF staff has been trained in "IYCF in the context of HIV", following the latest international recommendations which are also reflected in the national

nutrition norms. When a women wanted to have access to RUIF by claiming she was HIV positive, she was asked to prove this by HIV testing, but her results remained confidential and she was encouraged to participate in the babytent activities. This is not mentioned in the national guidelines nor was the practice of putting a baby on the breast of a caretaker who clams not to be the mother. Pregnant women were counselled on the benefits of exclusive breastfeeding, although the babytent in-charges explained that none of the HIV positive women decided to breastfeed as this has always been discouraged in Haiti for a long time. Unfortunately Gheskio has been and still is providing free powdered infant formula and feeding bottles to HIV positive women with infants. Psychologists and guards were not trained on HIV and AIDS but this does not seem necessary.

**Protection**

The protection project started in October and the six protection officers only started to work in December 2010. They are based in the camps where Concern is in charge of camp management, which is only in 2 out of 12 sites where Concern has a PCNB. The protection officers are responsible to follow-up on protection cases as well as to create women's groups that work around protection in their camp (only a group in Dahomey also incudes women who have benefited from PCNB services). In those camps where there is no protection officer, cases can be referred to the expatriate protection project manager who will arrange for follow-up. She informed the evaluator that a few cases had been referred to her by the expatriate psychosocial support manager, but not by babytent in-charges. In case of the PCNBs, the evaluator does not think that protection cases would ever reach "protection" if the expatriate health and nutrition coordinator did not hear of the case. The issue of field staff not working together has been discussed under "5.3 Efficiency". There has been no time yet for protection training and mainstreaming for all staff, but this has been planned. All staff had been trained on P4[29] though, which is to prevent sexual exploitation and abuse in Concern circles.

*Recommendations on Concern Worldwide policies and guidelines:*

- ✓ Standardise PCNB tools for future emergencies and develop/add an IYCF assessment tools. Ideal would be that an international (or Concern) "babytent guide" is established, like what has happened with OTP, CMAM and IFE.
- ✓ Discuss with other stakeholders on the practices around HIV i.e. asking for test results and asking caretakers who claim not to be the mother to breastfeed. The evaluator does not have a strong opinion but advises to include a paragraph in the national guidelines.
- ✓ Improve community mobilisation for the IYCF and PSS component (for the latter, the barrier to come for PSS might even be higher than asking for infant feeding advice):
  - Not using megaphones for mobilisation, recommended by the consultant and babytent staff. It is a good approach when the population does not know about the program yet but at this stage, small gatherings and home visits seem to be more adapted.
  - More involvement of the camp management as they are supposed to meet the population on a regular basis or.
  - Use the beneficiaries themselves as promotion agents.
  - Ideally there would be a/several young volunteer/s for each one of the camps. [30]
  - Psychologists should try to make home visits a more important part of their daily schedule.

## 6. Conclusions

Concern has appropriately addressed the IYCF needs in post-earthquake Port-au-Prince and it has done well in piloting the PCNB approach on such a large scale. Concern is a leading nutrition agency in Haiti and has played and still plays a major role in the strategy development, in collaboration with the nutrition cluster. Moreover it disposes over very qualified and motivated staff, in the field office as well as on the field itself.

Even though this program was very new to Concern, program outcomes as well as interviews with beneficiaries suggest that the services provided by Concern were very satisfying. The program has prevented an increase in diarrhoea, malnutrition, morbidity and mortality in the youngest strata of the population and has brought about

[29] Program Participant Protection Policy

[30] Save the Children uses breastfeeding promoters to do community mobilisation, the number depending on the size of the camp (e.g. 10 in one camp and 8 in another). They also accompany the babytent staff when conducting home visits.

lasting health and care-related behaviour change. Thanks to the provision of RUIF, also non-breastfed children were protect and supported through the program. Thanks to the PCNB approach, Concern and the whole nutrition community have managed to prevent a major influx of infant formula in feeding bottles into the country.

According to other reports, Concern has struggled significantly in the aftermath of the emergency, partly due to the fast growth of the country program and the number of staff. Other challenges regarding the PCNB programme specifically were external to Concern as an organization, but linked to the fact that the nutrition community in Haiti had to develop new strategies, guidelines, tools, exit strategy etc. Most of these early challenges have now been overcome, and time has come to improve the quality of the project, which was developed in the initial rush.

Lessons learned are very valuable for the next phase. Indeed, Concern has started discussions within the nutrition cluster about phasing out and the way forward. Sound planning combined with a good exit strategy are essential to contribute to sustainable recovery and further development of the Haitian society.

Concern's experience is also very important for future emergencies. The PCNB project has achieved a positive impact on people's lives, especially in the population of children 0-11 months. The project has been piloted in one of the most complicated and difficult-to-manage emergencies. If Concern can do so well implementing in such extremely difficult humanitarian circumstances, the evaluator is convinced that they can do it in any other emergency, and even better.