

Emergency Infant and Young Child Feeding Assessment among internally displaced persons - Kramatorsk – Slovianske - Svitohirske Ukraine

02 – 13 June 2015

FINAL REPORT



A partnership between UNICEF and Save the Children



PART ONE: IYCF-E ASSESSMENT

Executive summary

In April 2014, fighting began between pro-Russian separatist groups and pro-Ukrainian groups in Donetsk and Luhansk, which together form the 'Donbas' region of the east of Ukraine. The region, no longer under the control of the Government of Ukraine, has been declared by separatists as the 'Donetsk People's Republic' and the Luhansk, People's Republic'. A complex humanitarian crisis has increasingly developed, with insecurity and displacement. The majority of internally displaced people (IDPs) from the conflict area are geographically located in areas close to their homes, in particular residing in the Ukraine government-controlled areas (GCAs) within Donetsk and Luhansk oblasts. Given Ukraine's poor pre-crisis infant and young child feeding (IYCF) practices, this vulnerable population affected by the conflict are of particular concern

In June 2015, a purposive cross-sectional assessment on the feeding practices of infants and children under-two years of age among the IDP population was facilitated by Save the Children, with support from UNICEF. The key objectives of the assessment were to enhance understanding of IYCF practices inform the evidence base for appropriately intervening to protect, promote and support IYCF for children <2 years of age and to identify information gaps and needs.

The assessment was facilitated in the three urban areas of Kramatorsk, Slovianske and Sviatohirst, in the GCAs of Donetsk oblast; locations which serve as a transit point, as well as a place for temporary relocation for many IDPs fleeing the active conflict zones.

Household questionnaires (HHQs), focus group discussions (FGDs)/ community based discussion (CGD) and interviews with key informants (KIIs) were employed, providing both quantitative and qualitative information. Save the Children collaborated with the Centre for Disease Control (CDC) and UNICEF to develop the HHQs and the FGD and KII guides.

For the HHQs, households were randomly selected from telephone lists of IDPs with children 0-23 months of age, provided by two local non-government organizations (NGOs) currently working with conflict-affected families. The HHQs were administered face-to-face, by five teams of two enumerators, to the primary caregiver at each of the households visited. All children under the age of 2-years for which the selected respondent was the primary caregiver were included, with separate questionnaires facilitated for each child. Mid-upper arm circumference (MUAC) was measured for children 6-23 months of age.

FGDs were facilitated with four groups of primary caregivers of children under-two years, identified by the Chief Paediatricians in each location and a CBD was held at a collective centre in Kramatorsk. KIIs were conducted with senior health personnel working in pre- and post-natal and delivery services, and representatives from City Administrations/Councils and distribution centres. The FGDs, CGD and KIIs were facilitated by the IYCF Technical Advisor and the dialogue recorded.

The total sample comprised 258 HHQ interviews (106, Slovianske; 79, Kramatorsk; 68, Svitohirske), 4 FGD (45 caregivers), 1 CGD (24 women and men in Kramatorsk) and 16 KIIs (10 health facility staff, 3 city/municipal administration representatives, 1 representative from a local NGO and 2 representatives from distribution centres).

Household demographic data revealed that the mean household size was four, with one child under 2-years and 0.3 children between 2-5 years of age. The average age of the mother/primary caregiver was 30 years. Average displacement time for a household was 8.3 months (range 0-16 months). The majority (87.4%) of IDPs in Slovianske and Kramatorsk were living in rented accommodation, compared with Svitohirske where 41.2% were housed in rented accommodation and 41.2% in collective centres. Over all three locations only 9.7% lived with relatives. There was no

significant difference between income level nor education level of the mother/primary caregiver across the three clusters.

A total of 139 boys and 119 girls were included in the HHQ survey: 29 infants 0-5 months; 76 children 6-11 months; 66 children 12-15 months; 37 children 16-19 months; 50 children 20-23 months of age.

In accordance with the recommendations of the WHO, UNICEF and the Ukraine Ministry of Health, infants should receive breast milk exclusively until the age of 6 months, followed by the introduction of soft, semi-solid and solid complementary foods, while continuing breast-feeding up to the age of two years or beyond

Some key results from the assessment are presented in the table below. They show low rates of exclusive breastfeeding and high rates of use of other foods and fluids before 6 months of age. Teas (typically camomile, dill or fennel tea and dill water) are commonly given as digestives and calmatives, and plain water given in hot ambient conditions, practices encouraged by some health professionals. Infant formula and home-made or commercial baby foods are given before 6 months of age due to the belief that breast milk is not nutritionally adequate (“does not have enough fat”, “child is hungry”), and some information leaflets and packets from commercial baby food companies advise giving non-breastmilk foods and liquids at 3 to 4 months. Of children aged 4 and 5-months, 33.3% and 83.3% were consuming soft, semi-soft or hard foods. Breastfeeding on a schedule, rather than on demand, was also a problem, practiced by 19.4% of children 0-23 months.

It can be inferred from the assessment that financial constraints, unstable access to food through assistance and markets and stress associated with the conflict are implicated in the feeding practices identified in the IYCF assessment. The main reason given for stopping breastfeeding reported in HHQs was stress due to the conflict (28.1%) followed by being out of milk (13.2%), and in a minority of cases (6.1%) the reason was insufficient food for mother. There were limited reports of extended exclusive breast feeding (one to 10-months of age) due to lack of affordability of food and cooking facilities. “Milk drying up” was reported by FGD participants and health professionals to be a more common in IDP mothers. Breastfeeding difficulties, such as mothers suffering from full, sore breasts and cracked nipples due to the cold weather, and, since the onset of the conflict also due to lack of hot water in some dwellings, were additionally cited by health key informants and focus group discussion participants.

The feeding practices reported for HHQ infants:

| Feeding indicators | % [95% CI] |
|--|--------------------|
| Ever breastfed (children 0-23 mo) | 85.8% [81.3, 89.9] |
| Early initiation of breastfeeding, within 1 hour of birth) (children 0-23 mo) | 76.3% [70.1, 81.5] |
| Early initiation of breastfeeding (within 24 hours of birth (children 0-23 mo) | 16.2% [11.7, 21.5] |
| Exclusive breastfeeding (children <6 mo) | 13.8% [0.4, 27.1] |
| Predominant breastfeeding (children <6 mo) | 20.7% [5.0, 36.4] |
| Continued breastfeeding at 1 year (children 12-15 mo) | 31.8% [20.3, 43.4] |
| Continued breastfeeding at 2 years (children 20-23 mo) | 14.0% [4.0, 24.0] |
| Age-appropriate breastfeeding ¹ (children 0-23 mo) | 33.3% [27.5, 39.1] |
| Age of introduction of solid, semi-solid, or soft foods, months (mean (xSD)) | 4.8 (1.71) |
| Receiving solid, semi-solid, or soft foods at 6-8 mo | 100.0% |
| Minimum dietary diversity ¹ (children 6-23 mo) | 77.7% [72.3, 83.2] |
| Minimum meal frequency (children 6-23 mo) | 94.7% [91.8, 97.6] |
| Age stopped breastfeeding, (mean (x SD)) | 7.9 mo (5.91) |
| Formula introduction, age in months (mean (x SD)) | 4.2 (3.72) |

¹ Minimum Dietary Diversity (MDD) is typically calculated based on the WHO food groups, however this was not possible due to limitation in the food group categories in the household questionnaire 24-hour recall and 7-day recall, therefore dietary diversity was scored based on the following six groups¹: grains (porridges, breads, noodles, vermicelli, crackers); dairy (infant formula, animal milk, cheese); fruit and vegetables (including potatoes); peas/beans; eggs; meat sources (red meat, poultry, fish, offal)

| | |
|---|-------|
| Artificial feeding alone (children <6 mo) | 13.8% |
| Bottle feeding (children 0-23 mo) | 72.5% |
| Breastfeed on a schedule (children 0-23 mo currently breastfeeding) | 19.4% |

Commonly given first foods, including for infants under-6 months of age, were commercial porridge, semolina porridge and commercial baby fruit/vegetable puree (potato, pumpkin, zucchini, and cauliflower). Additionally to these health professionals recommended curds and fruit juice as first foods, with introduction of egg yolk at 7-8 months, meat and poultry around 7-8 months, fish at 9 months, cow's milk for drinking at 10-12 months. Of HHQ infants aged 6-8 months over 90% were consuming commercial fruit/ vegetable purees, 58% had consumed fresh fruits and 54% fresh vegetables, over 80% commercial porridges and 27% homemade porridges. Of infants 6-23 months, 73.4% ate meat the previous day and 9.6% commercial meat puree (mean 4.5 (range 0-7) times in the past 7 days); frequency of consumption constrained by affordability.

Significance tests showed that exclusive breastfeeding, breastfeeding at 1 year and 2 years, age-appropriate breastfeeding and age stopped breastfeeding showed no significant difference by sex, household income, type of accommodation, or having a child over 2 years. However predominant breastfeeding was significantly affected by having a child over 2-years of age. Considering duration of breastfeeding, those earning over 4500UAH were more likely to have the opinion that breastfeeding should be continued until 6-11 months and less likely to have the opinion that breastfeeding should be continued until 12-18 months than the other income levels. Age of introduction of complementary foods was not significantly associated with education status, job status, household income or accommodation type, however for minimum dietary diversity there was a significant association with age-group, location and type of accommodation, with a smaller number of children reaching minimum dietary diversity in the younger age groups, in 'other' accommodation type, collective centres and in Svitohirske.

Compared to the data available for eastern Ukraine from the Multiple Indicator Cluster Survey (MICS) 2012, the assessment indicated that in the surveyed population, there are lower rates of exclusive breastfeeding (21.3% in 2012), proportion of children born in the last 24 months who were ever breastfed (96.7% in 2012), predominant breastfeeding of infants <6 months of age (49.5% in 2012); and continued breastfeeding at 1 year and 2 years (33.4 and 31.1% respectively in 2012). There were higher rates of bottle feeding (59.2% at <6 months and 66.6% at 6-23 months in 2012). Breastfeeding initiation within 1 hour after birth was higher (61.5% in MICS 2012) as was minimum meal frequency for children 6-23 months (67.2% in MICS 2012)

For preparing food and drinks for infants, the majority of primary caregivers in Kramatorsk and Slovianske use bottled or tap water; in Sviatohirst well use is more common. All HHQ participants had access to soap, primarily through self-purchase, which 22.7% of primary caregivers used 5-10 times and 75.7% used >10 times in the past 48 hours before the survey.

There was an expressed need by both NGOs and mothers in all locations for hygiene products including diapers, baby creams, shampoo, wet wipes, children's laundry detergent and soap, as well as teething gel.

No cases of malnutrition were identified in the surveyed population (range 132 - 202mm) and medical professionals who participated in interviews reported not having seen any cases of malnutrition.

Considering access to assistance, of children under 2-years, 98.8% were registered at their local policlinic; no significant difficulties with registration were highlighted. Registration for displacement and registration for assistance were high at 97.2% and 90.5% respectively; of these, 99.2% were registered as displaced with the Ministry of Social Policy and the majority 96.2% registered for assistance with humanitarian organisations.

Since January 2014, 87.4% of mothers had received cash or voucher assistance, 86.2% food

assistance, 71.2% non-food assistance and 88.9% baby-food assistance. On average, HHQ respondents had last received baby-food assistance a month ago in all assessment areas. Monthly baby food aid was reported to last 1-2 weeks. It appears that distributions in Svitohirske were more frequent than in Slovianske and Kramatorsk; those in privately rented accommodation appeared to receive baby food assistance less frequently than those in collective centres as well as those displaced for 0 - 6 months. Mothers received information on available humanitarian aid/distributions via the telephone, online searches, health professionals or NGO volunteers. Some mothers had experienced misunderstandings about eligibility, distribution point locations and scheduling of humanitarian aid.

The main baby-food assistance items received were fruit/ vegetable purees, porridges/cereals and infant formula; FGD participants also specified fruit juice. Some humanitarian assistance packages were appropriately targeted. Infant formula had been received by 78.3% of HHQ infants under 1 year regardless of their feeding status –including four exclusively breastfed infants under-6 months. FGD participants reported that no foods freely received were considered not be priority foods, however many infants did not like the taste of the commercial porridges (eg Karipus) and Malutka infant formula was commonly reported to be allergenic and cause diarrhoea.

Priority items for children, identified through FGDs and interviews with key informants, were: mixtures of cereals (rice, buckwheat and barley were specified in one group), infant formula (including non-dairy/lactose-free brands), fruit and vegetable puree, fresh vegetables (eg cabbage, carrot, beetroot, cucumbers), meat products, bottled water, butter, cottage cheese, keffir, ingredients to make yoghurt, sunflower oil, sugar, salt and tea for young children, and humana tea for maternal lactogenesis. The majority of FGD mothers expressed a preference for cooking food for their children, rather than use of commercial baby foods. However those living in collective centres had constrained access to fridges and facilities for cooking food, expressing the need for blenders and multifunctional electric pans.

Since the onset of the crisis, health services have been generally limited by their capacity (available skilled human resources, educational materials, funding) to support safe and appropriate IYCF, in relation to the increased (IDP) population to be served.

The assessment indicates that although breastfeeding is promoted, and verbally conveyed during individual pre- and post-natal consultations and at delivery, skilled support for re-lactation and moving mothers away from mixed feeding to exclusive breastfeeding and associated combined psychosocial is lacking, as are education on complementary feeding and post-natal group education sessions.

Printed informational material on breastfeeding and complementary feeding (other than random leaflets from food companies) to share with caregivers is not available at clinics; a need expressed by both by clinic staff and caregivers.

Mothers however are seemingly pro-active in seeking advice on IYCF, with doctors, nurses and other health care staff, the internet, grandmothers and friends cited as the key sources of information; some mothers also viewed commercial product packaging for advice on when to introduce foods. However hot-line numbers available for infant feeding advice from health facilities were not widely known about by FGD participants. Community-based IYCF support services are lacking, and pre-crisis Breastfeeding Support Groups no longer functional.

Based on the results of this assessment the following actions are recommended:

Recommendation 1:

Support targeted, clear context-specific and evidence-based communication on IYCF through a variety of delivery channels

- a. Develop a maximum of ten priority key positive messages targeted for primary caregivers of infants and young children <24 months of age, to be clearly and consistently disseminated by key stakeholders in the humanitarian response

Priority message topics should include: Benefits of early initiation of exclusive breastfeeding for the first 6 months; risks of introducing other liquids (infant formula, tea, water) before age 6 months; risks of using bottles or teats; breastfeeding on demand rather than on a schedule; temporary effects of stress on milk flow; when infant formula use may be required; age-appropriate introduction of complementary foods; continuing breastfeeding up to 2 years or beyond; maternal benefits of breastfeeding

- b. Provide targeted IYCF informational materials (pamphlets and brochures) in baby food baskets, hygiene kits and delivery kits
- c. Develop a website, or online social forum, providing IYCF guidance
- d. Investigate the feasibility and support for establishing and managing a central/Ukraine IYCF-specific hot-line service
- e. Widely disseminate guidance documents to promote adherence to nationally and globally recognised standards for the protection, promotion and support of optimal IYCF

Recommendation 2:

Strengthen the capacity of primary health care services to provide appropriate training and support to caregivers on safe and appropriate breastfeeding and complementary feeding in prenatal, perinatal and postnatal periods

- Provide trainings and educational resources and tools for healthcare worker (facility and mobile)
- Provide healthcare worker trainings and educational resources and tools, including psychological first aid
- Promote adherence to the International Code of Marketing of Breastmilk Substitutes at health facilities, through incorporating The Code in trainings and the monitoring of certified Baby-friendly Hospitals
- Integrate specific IYCF messages into the Health Cluster disease outbreak plans/interventions

Recommendation 3:

Build and enhance community-based support for safe and appropriate IYCF

- Identify and train a pool of mobile community-based breastfeeding-psychological first aid counselors to provide peer support group education at health facility and community levels and to facilitate home visits for mothers requiring one-to-one skilled support
- Develop guidance protocols and establish community-based referral systems for caregivers to access support, including primary caregivers of children <2 years with indicated mental health issues, stress or depression and infants dependent on infant formula
- Support the revitalization of breastfeeding support groups existing pre-crisis

Recommendation 4:

Build the capacity of humanitarian agencies to implement IYCF specific and IYCF sensitive interventions

- Provide orientation sessions to relevant agencies/clusters staff on safe and appropriate IYCF-E within the current context, the linkages with their cluster and guidance on potential modalities for integration of IYCF-specific and -sensitive actions into their sectoral programmes
- Advocate for agencies to endorse/develop a policy on IYCF-E, highlighting protocols for ensuring no indiscriminate distributions of infant formula
- Advocate to and support food distribution agencies to implement appropriate and acceptable complementary food distribution activities: Provide IYCF-E orientations for staff of agencies distributing baby food highlighting adherence to The Code' Provide priority messaging information pamphlets in food baskets' Provide group IYCF education at distribution points; Design food basket/voucher commodities considering priority requested and less preferred foods; Ensure risk mitigation for diversion of baby food for children 6-23 months to younger age groups through point of distribution eligibility targeting, group education and informational materials; Clearly communicate information about food distributions; Ensure the distribution efficiency

- Advocate for, needs-based, provision of non-food items to support safe and appropriate IYCF: cooking equipment (eg multi-cookers); hygiene products (including teething gels, baby creams, children's laundry detergent, shampoo, soap, wet wipes and diapers); cups accompanied by guidelines to minimize the risks of using infant formula for the non-breastfed child, concurrently with goods of equal or greater value for breastfeeding mothers

Recommendation 5:

Support the prevention and treatment of iron deficiency anaemia

- Strengthen anaemia systematic monitoring of pregnant women and children 6-23 months years at health facility level
- Investigate and support modalities for the supplemental micronutrient intake of pregnant and lactating women and young children 6-23 months of age, based on identification of need

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A special thanks to the internally displaced caregivers and their families who welcomed us into their homes or travelled to participate in group discussions, and to the key informants interviewed for taking time to participate within their busy schedules.

Acronyms

| | |
|--------|--|
| ACAPS | Assessment Capacities Project |
| BMS | Breast milk substitute |
| CI | Confidence interval |
| FGD | Focus group discussion |
| GCA | Government controlled area |
| Hb | Haemoglobin |
| HH | Household |
| HHQ | Household questionnaire |
| IBFAN | International Baby Food Action Network |
| IDP | Internally displaced person/people |
| IYCF-E | Infant and young child feeding in emergencies |
| KIs | Key informant |
| KII | Key informant interview |
| MICS | Multiple Indicator Cluster Survey |
| MoH | Ministry of Health |
| MUAC | Mid-upper arm circumference |
| NFI | Non-food item |
| NGCA | Non-government controlled area |
| NGO | Non-government organisation |
| OCHA | United Nations Organization for the Coordination of Humanitarian Affairs |
| UN | United Nations |
| WASH | Water, sanitation and hygiene |
| WHO | World Health Organization |

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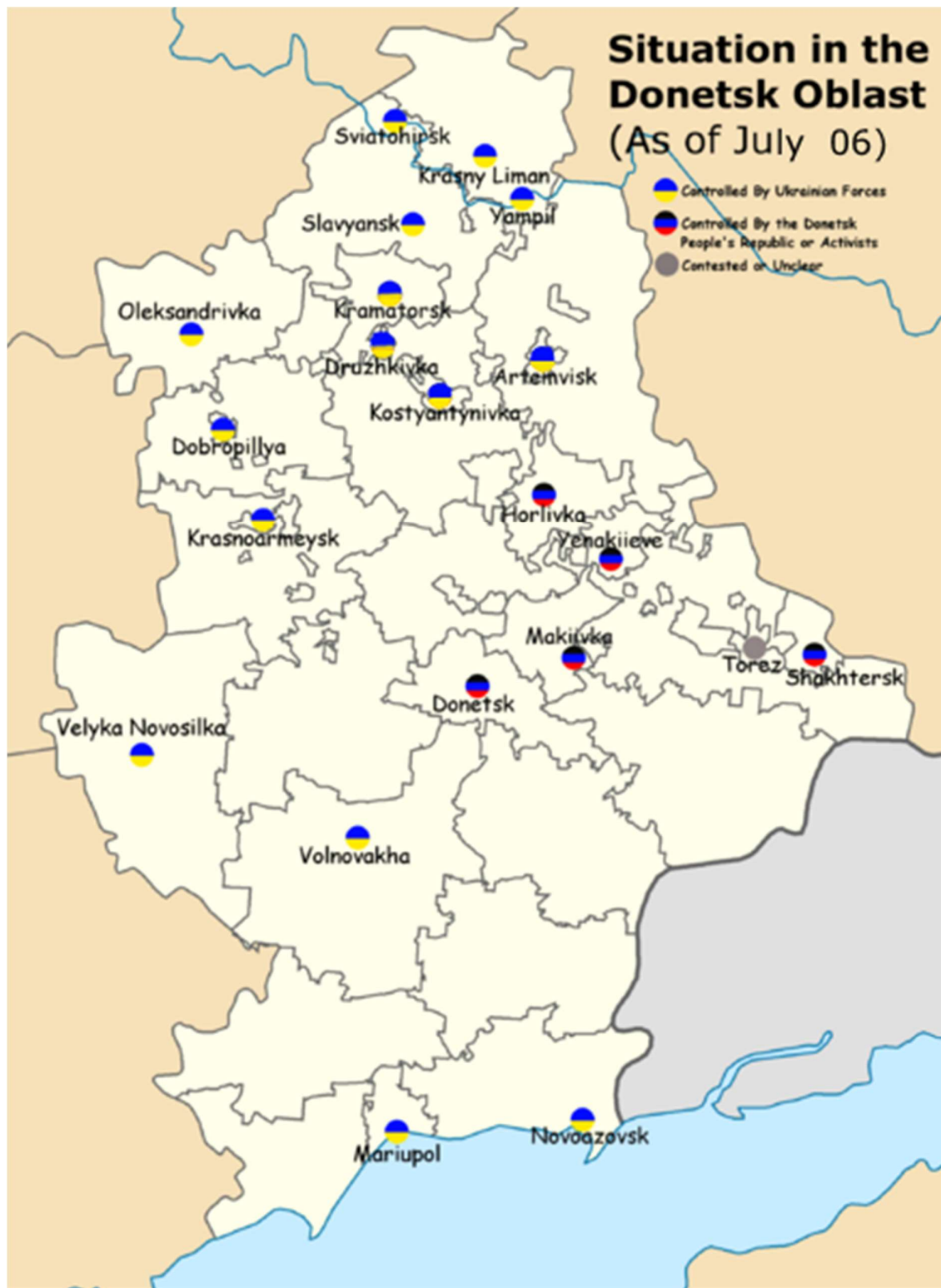
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Introduction to the IYCF-E Assessment

Purpose and Objectives

The United Nations Children's Fund (UNICEF), in partnership with Save the Children, conducted the Infant and Young Child Feeding in Emergencies (IYCF-E) Assessment in government-controlled areas (CGAs) of eastern Ukraine to address the need for timely and reliable information on the status and practices related to infant and young child feeding (IYCF) among the vulnerable conflict affected populations under 2 years of age.

UNICEF Ukraine is the lead of the Nutrition Cluster and in charge of generating and disseminating evidence in relation to nutrition-related issues in the area of nutrition.

Save the Children, a registered charity within Ukraine, globally has extensive experience in infant and young child nutrition, as part of its child focussed programming.

The key objectives of the assessment were to:

- Enhance understanding of IYCF practices
- Inform the evidence base for appropriately intervening to protect, promote and support IYCF for children <2 years of age
- Identify information gaps and needs

The IYCF Assessment contributed to meeting the objectives included in the Health and Nutrition Cluster 2015 response plan^{2,3,4} to:

- Contribute to prevention of excessive nutrition-related morbidity and mortality of vulnerable groups
- Provide reliable health and nutrition information for evidence-based emergency response, monitoring and policy decision-making
 - Ensure a predictable, timely, and effective nutrition response
 - Provide reliable information on the nutritional status (including IYCF practices) of the most vulnerable groups for evidence based emergency response, monitoring and policy decision making.

The Save the Children assessment, conducted in Sviatohirst, Slovianske, Kramatorsk in the GCAs of Donetsk Oblast, was one of two IYCF assessments funded by UNICEF. The other was concurrently facilitated by the Centre for Disease Control (CDC) in Kharkivska, Zaporizhska and Dnipropetrovska Oblasts.

² Commitment 1: Effective leadership is established for nutrition cluster interagency coordination, with links to other cluster/sector coordination mechanisms on critical inter-sectoral issues. Benchmark 1: Coordination mechanism provides guidance to all partners regarding common standards, strategies and approaches, ensuring that all critical nutrition gaps and vulnerabilities are identified; also provides information on roles, responsibilities and accountability to ensure that all gaps are addressed without duplication. Commitment 2: Timely nutritional assessment and surveillance systems are established and/or reinforced. Benchmark 2: Quality assessments are reported on in a timely fashion and provide sufficient information for decision-making, including the scope and severity of the nutritional situation, the underlying causes

³ OCHA. Ukraine Humanitarian Response Plan (revised) January to December 2015. February 2015

⁴ Ukraine Health Cluster Strategic Response Plan. 2015

Methodology and Tools

Preparation

Assessment sites - Kramatorsk, Slovianske and Sviatohirst (*See Annex 2*)- were agreed between the Save the Children and UNICEF prior to the assessment

The three clusters were selected based on the following location specifications and characteristics:

- Geographic areas of key concern as a result of high numbers of IDPs
- Variation in population area characteristics (eg location size, dwellings)
- Sufficient number of households having children 0-23 months of age
- Field accessibility and security of access
- In Save the Children and partners' area of operation

Save the Children worked with the Centre for Disease Control (CDC) and UNICEF to develop standardised assessment questionnaires and guides. They were designed to be able to be used in a variety of locations to provide reliable data for informing the IYCF-E response activities, and to be used in future assessments to enable comparability of data from different assessments over time.

Triangulation of household questionnaires (HHQs) with focus group discussions (FGDs)/ community based discussion (CBD) and interviews with key informants (KIIs) was applied, to provide for diversity and plurality of information, both qualitative and quantitative information, which might not otherwise have been revealed through the HHQs alone.

Selection of respondents for HHQs, FGDs, CBD and KIIs was based on who could provide the most accurate and useful information about IYCF practices, who or what influences those practices, and who or what needs to be considered in facilitating change in the practices.

The HHQs and FGD, CBD and KII guides relevant to the current context were developed considering concerns and conditions, as identified from secondary data reviews and key and informant interviews in the pre-planning phase of the assessment design, and with incorporation of globally recognised IYCF indicators.

The household questionnaire comprised the categories of household information, mother's information, child's information, humanitarian assistance, water use and hygiene; both open and closed-ended questions were included. To assess the child's feeding practices information was sought on breastfeeding practices and complementary practices including age of introduction of soft, semi-solid and solid food, 24-hour recall and 7-day diet history. MUAC measurement was included for children 6-23 months of age. The questionnaires were uploaded in Russian language onto *KoBo* software on tablets.

FGD guides and KII guides provided predefined sets of structured open-ended questions directed at understanding IYCF-E related practices, perceptions and expressed concerns, needs and priorities. The FGD guide questions were targeted for primary caregivers of children under-2 years of age. The KII guides questions were targeted for staff from health facilities (segregated into the categories of birth, pre- and post-natal), local city administrations, distribution centres and humanitarian organizations.

The HHQ, FGD and KII guides, were tested and validated in the field by CDC and UNICEF, and some modifications (sentence structure and some variables) later made by Save the Children based on peer review and feedback from enumerators during their training and field testing.

The assessment team consisted of a team leader (Save the Children humanitarian nutrition advisor), data analysis manager, 10 female enumerators and a translator.

The ten enumerators for the household questionnaire interviews (HHQ) were selected from a local organization working with conflict affected people, which was known to Save the Children staff and had a credible relationship with humanitarian agencies working within the current response.

All enumerators for the HHQs participated in a three-day training, using action-oriented adult learning techniques, which covered the purpose and methodology of the assessment, HH level data collection techniques, HHQ facilitation using tablets, MUAC measurement, field practicum. (See Annex 3 for training agenda).

Data collection

Data collection was facilitated between 02 – 13 June 2015 (See Annex 1)

Household questionnaire

The HHQs were administered by 5 teams of 2 enumerators (an interviewer and an information entry enumerator; each using a tablet with the questionnaire loaded onto *Kobo* software. Enumerator pairs ensured that the questions were asked exactly as written, and to support security of the enumerators visiting the households.

Households were coded and randomly selected using Microsoft Excel, from telephone lists of households with children under two years of age shared with Save the Children by two local NGOs currently working with conflict-affected families. This ensured that every household was anonymous and had an equal chance of being included in the survey.

The randomly selected households were contacted by telephone on the day prior to the planned visitation, to confirm their availability for the interview. Those who refused, had left the area or could not be contacted were recorded. Addresses were verified for those who were willing to participate and location for the interview agreed based on preference by the household respondent. Each cluster location -Kramatorsk; Sloviansk; Sviatohirst- was divided into sub-areas in which the confirmed households were located and the enumerator teams allocated according to specific sub-areas.

On the morning of the day planned for the interview, households who had confirmed their participation were called again to re-confirm their availability. If a dialled telephone number was not answered, the primary caregiver was unavailable at the planned time of visitation or the house was unoccupied at the time of a visit, the household was telephoned again and when possible revisited later that day or on another day.

The standard IYCF questionnaire was administered to the primary caregiver of children 0-23 months of age at each of the participating households. Where a selected primary caregiver had more than one child under-2 years of age, both children were included in the survey, with a separate interview facilitated for each child.

HHQ data collection time was 8 working days. The average time taken for conducting a household interview was 30 minutes.

Focus Group Discussions

FGDs were facilitated with IDP primary caregivers of children under-2 years of age, identified by the Chief Paediatricians in each location. FGD participants did not participate in HHQ interviews.

Four focus group discussions were facilitated, two in Sviatohirst (with 13 mothers and 1 father; 7 mothers and 1 father), one in Slovianske (10 mothers) and one in Kramatorsk (11 mothers and 1 father), covering a total of 42 mothers and 3 fathers. They were held at health facilities and the Save the Children office and lasted an average of 75 minutes. Additionally a community group discussion was facilitated with 24 men and women IDPs, of a variety of ages, at a collective centre in Kramatorsk; it lasted approximately 45 minutes. Participants in the FGDs and training practicums were not included in the final HHQ sample.

FGDs and KIIs were facilitated by the IYCF Advisor/Team leader through a translator, with the sessions recorded and later transcribed into narrative.

Key informant interviews

Interviews were conducted with 16 key informants, including 10 health personnel (2 from birth clinics, 6 from post natal clinics and 2 from pre-natal clinics), and representatives from a local NGO (in Svytahirsk), City Administrations/Councils (one each from Sviatohirst, Slovianske and Kramatorsk) and from distribution centres (one each from Slovianske and Kramatorsk)

Diapers were provided to all primary caregivers who participated in the HHQs, FGDs and enumerator training practicum. This provided motivation for their participation while concurrently providing priority requested supplies.

Data entry, processing and analysis

The completed HHQ data was electronically sent to/uploaded onto the Save the Children central KoBo server at the end of each survey day, then electronically downloaded into an excel data base for cleaning and sorting prior to being exported into STATA/IC 13.0 software⁵ for analysis. Dietary data and qualitative data were analysed using Excel utilising sum, count and average functions. WHO indicators for assessing HHQ IYCF practices were calculated based on WHO IYCF indicators^{6,7}. Where household characteristics were calculated, only the entry for the first child of each household was included (n=253) and for infant characteristics all 258 entries were included. Microsoft Excel was used for creating tables and producing graphs.

Focus group discussions and key informant interviews were transferred to Excel and categorised and sub-categorised by topic of discussion to allow easy identification of key messages and alternative opinions for each sub-category.

Data quality focus

Reliability and accuracy of HHQ data collected was promoted through enumerator performance being assessed during the training, use of enumerator pairs, a small number of teams (5), use of tablets, field supervision, review of recorded data at the end of each day, and follow-up with the relevant team about any queries found during data cleaning.

Use of *Kobo* software loaded on tablets with electronic data entry capture reduced the risk of errors due to constraints on what could be entered or incurred through retrospective data entry, ensured no missing data, and assured maintaining the defined question sequencing. Each paired enumerator and interviewer had a tablet, so the enumerator concurrently ensured that the interviewer asked the questions as presented on the tablet. Recording and later transcribing FGDs and KIIS, helped to ensure that all dialogue was well captured. Additionally, end of day debriefs, facilitated with the team by the team leader, provided a platform for discussing the day's activities, sharing case studies, concerns, challenges and motivators and providing advice.

⁵ STATA software was selected based on the information needed/research questions. STATA software enables efficient statistical analysis on large datasets and manipulation of data to produce frequencies and averages, with options for multivariate analysis with a large variety of capabilities including all the most-used predictive models. Additionally, STATA allows for data to be set to survey type to control for survey design in terms of clusters, stratification and weightings where required and the "Do-files" allow the analysis to be tracked and reproduce the same analysis on each survey area and cluster)

⁶ WHO. 2008. Indicators for assessing infant and young child feeding practices. WHO Press

⁷ <https://www.humanitarianresponse.info/en/applications/ir/indicators/global-clusters/11?search=&page=1>

Results and Findings

Survey outcomes

For the household questionnaire, 440 households were randomly selected in total from the household lists, and from these 253 households completed the questionnaire. Enumerators experienced difficulty contacting many households. It was explained that this was due to problems with the mobile transmission signal nearer to the conflict areas. There was also a large amount of relocation, with 20.9% (n=92) households having left the area, from those on the base list of households. This number was particularly high in Svitohirske at 36.3%.

Table 1. Survey outcomes across the three assessment locations

| Number of households (n) | All | Region | | |
|------------------------------|------|-------------|------------|------------|
| | | Svitohirske | Kramatorsk | Slovianske |
| Number of households sampled | 440 | 168 | 130 | 142 |
| Response Rate (%) | 57.5 | 40.5 | 60.8 | 74.6 |
| Completed | 253 | 68 | 79 | 106 |
| <i>Refused</i> | 36 | 8 | 21 | 7 |
| <i>Left</i> | 92 | 61 | 23 | 8 |
| <i>Couldn't be contacted</i> | 59 | 31 | 7 | 21 |

Household demographics

Mean household size was 4.0 (SD=1.42) people, very similar across all locations. The mean number of children per household under 2-years was 1.0 (SD=0.21). The mean number of children aged between 2 and 5-years was 0.3 (SD=0.55). Table 2 summarises the main household characteristics by assessment location.

Average displacement time for a household was 8.3 (SD=3.14) months, ranging from 0 to 16 months. As many families had been in a number of places and there was a large amount of ongoing movement, this result was not stratified by assessment location.

Table 2. Household characteristics for all 253 households who completed the HHQ

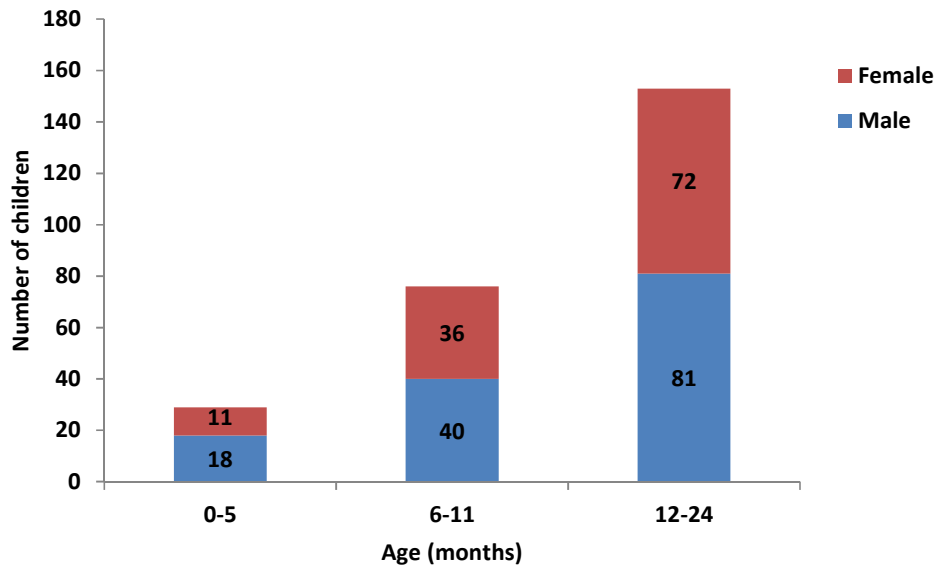
| Household characteristic (%) | All | Region | | |
|--|------------|-------------|------------|------------|
| | | Svitohirske | Kramatorsk | Slovianske |
| Number of Mothers (n) | 243 | 63 | 78 | 102 |
| Number of other caregivers (n)* | | | | |
| <i>Fathers</i> | 5 | 3 | 1 | 1 |
| <i>Grandmothers</i> | 4 | 1 | 0 | 3 |
| <i>Aunt</i> | 1 | 1 | 0 | 0 |
| Children sampled (n) | 258 | 69 | 81 | 108 |
| Households with more than one child aged under 2-years (n) | 5 | 1 | 2 | 2 |
| Average age of mother/primary caregiver (years) (\bar{X} (SD)) | 30 (5.3) | 30 (5.9) | 30 (5.0) | 30 (5.1) |
| Education level of mother/primary caregiver | | | | |
| <i>Incomplete secondary school</i> | 1.6 | 0 | 5.1 | 0 |
| <i>Complete secondary school</i> | 19.8 | 16.2 | 22.8 | 19.8 |
| <i>Professional secondary education</i> | 24.1 | 23.5 | 24.1 | 24.5 |
| <i>Incomplete higher education</i> | 7.1 | 4.4 | 12.7 | 4.7 |
| <i>Complete higher education or above</i> | 47.4 | 55.9 | 35.4 | 50.9 |
| Average number of alive children to mother (\bar{X} (SD)) | 1.9 (1.24) | 1.8 (0.93) | 2.2(1.46) | 1.7 (1.20) |
| Monthly Household Income (UAH) | | | | |
| <i>No one employed</i> | 73.6 | 87.0 | 65.4 | 71.3 |
| <2500 | 52.9 | 44.4 | 67.9 | 41.9 |
| 2250-4500 | 39.7 | 44.4 | 28.6 | 48.4 |
| >4500 | 7.4 | 11.1 | 3.6 | 9.7 |

* The aunt (n=1) is looking after the children as the parents disappeared in Sept 2014. One grandmother cares for the child as her daughter is studying. Information on why the other 8 participants are not the mothers was not specified. Of those respondents who were not the mother (n=10), infants were significantly younger ($p=0.006$), significantly more likely to be bottle fed ($p=0.047$) and significantly less likely to be age-appropriately breastfed ($p=0.023$). There was a significant difference in water used for food ($p<0.0001$) and drink ($p<0.0001$), which may be explained by significantly less access to running water in these households ($p<0.0001$) so more seem to be using a well for water (40% for drink, 30% for food preparation). All mothers were alive, except one where it was unknown if the mother was alive. Of the 10 respondents, 6 of the infants were breastfed yesterday with the inference that the mother was not available for the questionnaire. There was no significant difference in assistance received, including no difference in baby food frequency.

From the 253 households who participated in the household questionnaire, five households had two infants under the age of 2-years. Therefore, 258 infants under 24 months were included in the survey sample, with 29 infants aged 0-5 months, 76 children 6-11 months and 153 children 12-24 months; There was a total of 119 girls and 139 boys.

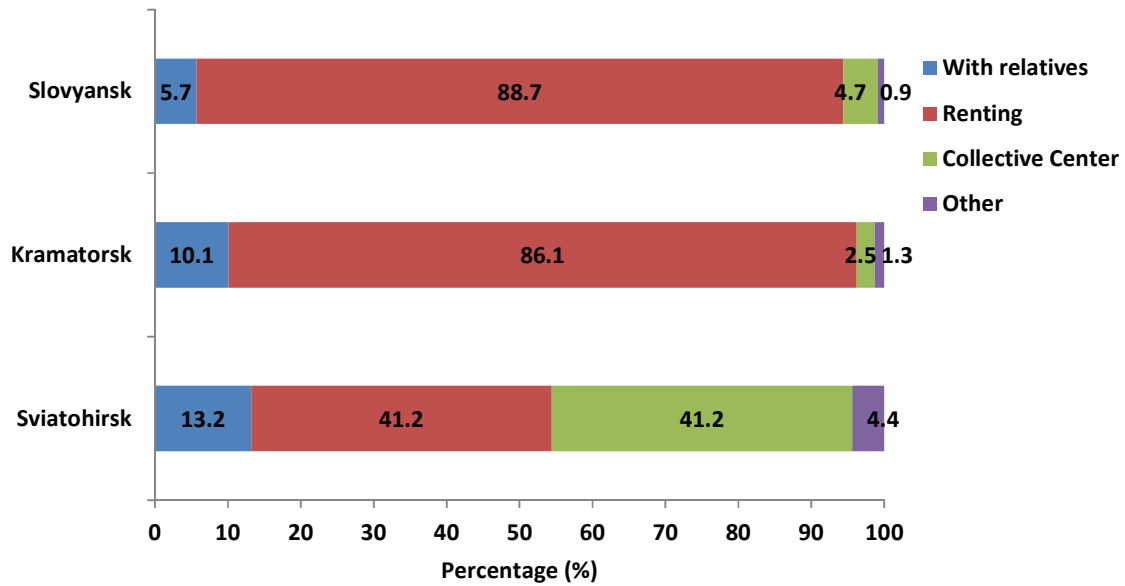
Figure 1 presents the age and sex distribution of the infants.

Figure 1: Age of all children (n=258) in the three assessment locations, by sex



The majority (71.6%) of IDPs were living in rented accommodation. However, in Svitohirske there were a large number (41.2%) in collective centres. Figure 2 presents the number of IDPs in the different dwelling types in each assessment location.

Figure 2: Percentage of households (n=253) who completed the HHQ in each type of dwelling of displacement, by assessment location



Humanitarian assistance

Registration

HHQs showed that 98.8% of children under 2-years were registered at their local polyclinic. No significant difficulties with registration at polyclinics were highlighted through HHQs, with only 18 mothers experiencing any difficulty registering; the reasons being 6 mothers did not have the

required documents, 7 mothers were not yet registered as an IDP, 1 had problems with payment for registration, 2 mothers experienced long queues, 1 mother did not have a residence permit and 1 mother reported neglect by medical personnel. All health facility key informants (ten medical professionals across the three assessment locations) reported that IDPs undergo the same registration process as the local population. Clinic staff were aware that IDPs may not have the documents they required to register, but said that they would not refuse anyone care. In one interview it was shared that children who are not registered will not receive government financial assistance/social benefits.

Table 3 shows that registration for displacement and registration for assistance was high in HHQs at 97.2% and 90.5% respectively. The majority of mothers (99.2%) were registered as displaced with the Ministry of Social Policy and the majority (96.2%) registered for assistance with humanitarian organisations.

Table 3: Registration status and assistance of households (n=253), self-reported in HHQs, by assessment location

| Registration status (% (n)) | All | Region | | |
|--|------------|-------------|------------|------------|
| | | Svitohirske | Kramatorsk | Slovianske |
| Child registered at Polyclinic | 98.8 (255) | 97.1 (67) | 98.8 (80) | 100 (108) |
| Household registered as displaced | 97.2 (246) | 92.7 (63) | 100.0 (79) | 98.1 (104) |
| <i>Ministry of Social Policy (%)</i> | 99.2 | 100.0 | 98.8 | 99.1 |
| <i>Migration Service (%)</i> | 50.6 | 42.2 | 54.3 | 52.8 |
| <i>State Emergency Service (%)</i> | 1.2 | 0.0 | 1.2 | 1.9 |
| <i>Humanitarian Organisation (%)</i> | 60.2 | 53.1 | 71.6 | 55.7 |
| <i>Other (%)</i> | 1.2 | 0.0 | 1.2 | 0.0 |
| Household registered for assistance | 90.5 (229) | 98.5 (67) | 98.7 (78) | 79.3 (84) |
| <i>Ministry of Social Policy (%)</i> | 39.7 | 17.6 | 48.8 | 48.8 |
| <i>State Emergency Service (%)</i> | 1.3 | 1.5 | 0.0 | 2.3 |
| <i>Humanitarian Organisation (%)</i> | 96.2 | 94.1 | 97.5 | 96.5 |
| <i>Other (%)</i> | 3.4 | 4.4 | 3.8 | 2.3 |

During a small number of interviews, it was established that in some clinics higher numbers of IDPs than the local population were attending, but mainly to receive humanitarian assistance and medicines provided. It was thought that some social groups were now registered who would have been less likely to register before the conflict for this reason. No other differences in health seeking behaviour were highlighted.

For those registered with organisations as either displaced or for receiving assistance, Table 4 shows the number of households per different organisations in the different assessment locations.

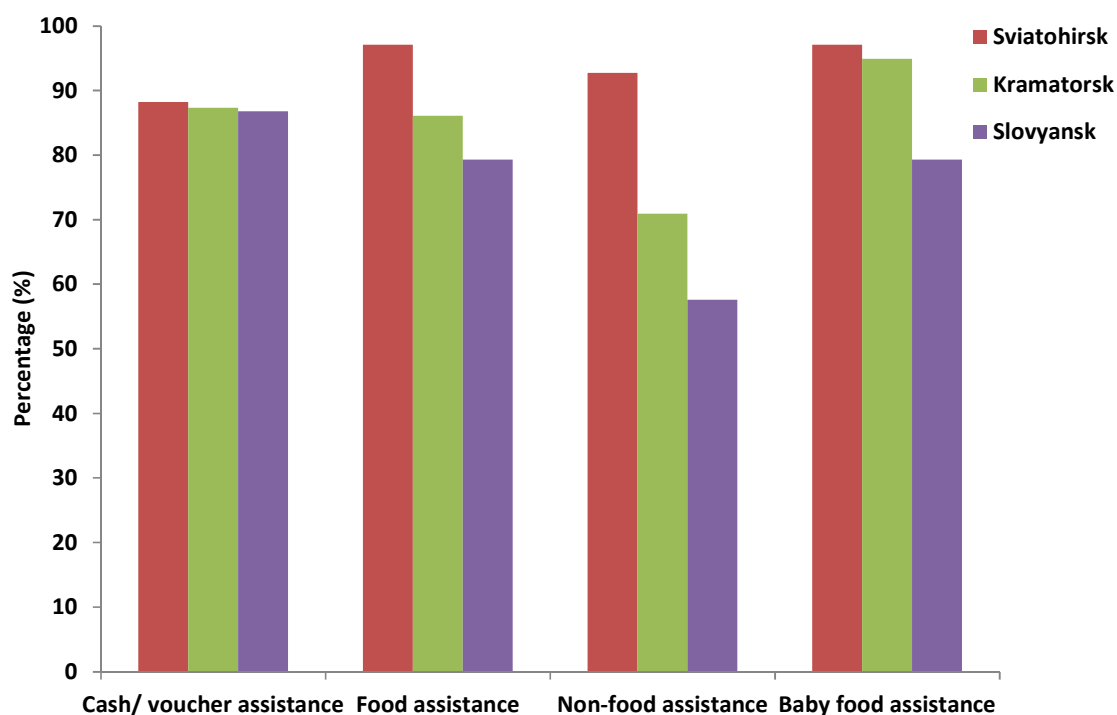
Table 4: The number of households (n=253) which reported to be registered as displaced and/or for assistance with the humanitarian organisations, by assessment location

| Registered with humanitarian organisation | Svitohirske | Slovianske | Kramatorsk |
|---|-------------------------|--------------------------------|--------------------|
| As displaced | 31 Slavyansk Heart | 40 Kramatorsk SOS | 43 Pomozhem |
| | 7 Pomozhem | 21 Pomozhem | 7 PIN |
| | 1 Svitohirske Monastery | 8 Red Cross | 7 Red Cross |
| | | 7 PIN | 5 Caritas |
| | | 2 Caritas | 2 Church |
| | | 1 Protection of family & youth | 2 City Council |
| | | | 2 Romanovskys Fund |

| | | | |
|-----------------------|--|--|--|
| | | 1 Temple of the Holy Spirit 1 UN | 1 Slavyansk Heart 1 UNICEF |
| For assistance | 63 Slavyansk Heart 15 Pomozhem 1 Adra 1 Caritas | 58 Kramatorsk SOS 26 Pomozhem 4 Caritas 4 Red Cross 2 Country Singles 2 PIN | 61 Pomozhem 9 PIN 9 Red Cross 8 Caritas 4 Church 3 Romanovskys Fund 3 UN 2 Adra 2 Slovianske Heart 2 UNICEF |

Overall since January 2014, 87.4% of mothers had received cash or voucher assistance, 86.2% food assistance, 71.2% non-food assistance and 88.9% baby-food assistance. Non-food assistance and baby-food assistance were received by a lower percentage of mothers in Slovianske than the other locations. Figure 3 shows the number of households receiving assistance by assessment location.

Figure 3: Assistance received since January 2014 as self-reported by HHQ participants (n=253), by assessment location



KIIs with health professionals showed that aid was coming from charitable organisations and local volunteers to clinics for distribution to the local population. The Hospital in Slovianske was also accessing food through a government programme.

Table 5 lists the humanitarian organisations reported in HHQs as distributing assistance in each assessment location.

Table 5: The number of households (n=253) who have reported to have received assistance since January 2014 from organisations, by assistance type and assessment location

| Type of Assistance | Svitohirske | Slovianske | Kramatorsk |
|----------------------|---|---|--|
| Cash/ Voucher | 59 PIN 23 Caritas 1 STC | 66 PIN 17 Caritas 2 Kramatorsk SOS 2 UN | 79 PIN 17 Caritas 3 UN 2 Adra 1 Pomozhem 1 Red Cross |
| Food | 53 Pomozhem 47 Slavyansk Heart 1 Svitohirske Monastery 1 Red Cross 1 Romanovskys Fund | 58 Pomozhem 12 Red Cross 10 Kramatorsk SOS 2 Caritas 2 UN 1 ATS Kramatorsk 1 Products from Poland 1 Romanovskys Fund 1 Volunteers | 73 Pomozhem 16 Church 5 Red Cross 3 Romanovskys Fund 2 Clinic 1 Caritas 1 Slavyansk Heart 1 The Good News 1 UN |
| Non-food | 36 UNICEF 29 Slavyansk Heart 4 UN 3 Pomozhem 1 Monsters Inc 1 Red Cross 1 STC 1 Scarlet Sails 1 Svitohirske Monastery | 19 Kramatorsk SOS 17 Red Cross 11 UNICEF 4 UN 3 Pomozhem 2 Church 1 Caritas | 23 Red Cross 17 UNICEF 7 Church 7 Slavyansk Heart 5 Pomozhem 3 UN 2 Scarlet Sails 1 Caritas 1 Czech 1 Ira Usaich 1 PIN |
| Baby-food | 53 Pomozhem 31 Slavyansk Heart 2 Clinic 1 MSF 1 Red Cross 1 UNICEF | 76 Pomozhem 4 Kramatorsk SOS 4 Red Cross 1 Country Singles 1 Youth Board | 77 Pomozhem 5 Clinic 4 Church 1 Nursery 1 Slavyansk Heart |

Baby-food assistance

Overall, the main humanitarian organisation named in HHQs as providing baby-food assistance were “Pomozhem” (n=208) and Slavyansk heart (n=32). FGD participants in Svitohirske, Kramatorsk and Slovianske commonly cited the Rinat Akhmetov Foundation as providing baby food assistance, and this was supported by key informants reporting that the Rinat Akhmetov Humanitarian Centre was the main supplier of baby-food assistance, with their products distributed through clinics and local NGOs. In Kramatorsk mothers also reported receiving food from The Centre for Social Services, and in Svitohirske from the Rinata Humeda Fund and IOM. Small local NGOs are distributing baby food (including infant formula) and other items, on an adhoc case-by-cases basis as requested. A representative from the Kramatorsk Social Services distribution centre expressed concern that lack of registration documents or vulnerability category certificate (e.g. not all single mothers have relevant papers) created barriers to receiving humanitarian aid.

On average, HHQ respondents had last received baby-food assistance a month ago in all assessment areas. There were a small number of households who had not received baby-food assistance for a period ranging from 3-5 months; this did not appear to be in one particular assessment location and was the minority at 5.2% of households.

Table 6 shows the frequency of baby-food assistance reported to have been received by HHQ respondents since January 2014.

In Slovianske, 64.3% of households had only received baby-foods 1 to 2 times whereas in Svitohirske, 57.6% of households had received baby-foods 5 to 6 times. During FGDs in Svitohirske, mothers were receiving monthly baby-food assistance, but did not specify for how long they had been receiving this assistance. From the HHQ information it would appear that monthly distributions to 58.2% had been in place for 5 to 6 months. There was no report of frequency of distribution in Slovianske and Kramatorsk in FGDs or KIIs, but it appears from HHQs that there had been less frequent/less consistent distribution in these locations than in Svitohirske, particularly in Kramatorsk with household distributions spread across 1 to 6 times.

IDPs in privately rented accommodation appear to receive baby-food assistance less frequently than those in collective centres, as well as those displaced for 0-6 months.

Regression analysis showed that there was no linear relationship between frequency of baby-food assistance and time since displacement ($p=0.226$; $[-0.033, 0.137]$).

FGD participants and informants from distribution centres and city administrations expressed the need for distributions to be better coordinated between agencies, perhaps through a central coordination platform.

Table 6: Percentage of households (n=253) completing the HHQ receiving baby-food assistance by frequency group since January 2014, by assessment location and type of accommodation

| | Frequency | | | |
|---|-----------|------|------|-----|
| | 1-2 | 3-4 | 5-6 | 7-8 |
| All | 39.1 | 25.8 | 32.9 | 2.2 |
| Location | | | | |
| <i>Svitohirske</i> | 10.6 | 25.8 | 57.6 | 6.1 |
| <i>Kramatorsk</i> | 36.0 | 32.0 | 32.0 | 0.0 |
| <i>Slovianske</i> | 64.3 | 20.2 | 14.3 | 1.2 |
| Type of accommodation | | | | |
| <i>Displaced with relatives</i> | 27.8 | 27.8 | 38.9 | 5.6 |
| <i>Displaced in rented</i> | 46.8 | 26.0 | 26.0 | 1.2 |
| <i>Displaced in collective centre</i> | 9.1 | 18.2 | 66.7 | 6.1 |
| <i>Other^a</i> | 20.0 | 60.0 | 20.0 | 0.0 |
| Time since displacement (months) | | | | |
| <i>0 – 6</i> | 41.4 | 29.3 | 27.6 | 1.7 |
| <i>7 – 12</i> | 38.9 | 25.3 | 33.3 | 2.5 |
| <i>13 – 16</i> | 20.0 | 0.0 | 80.0 | 0.0 |

^a *Other: Monastery, hostel, living with local residents for free*

Note: Table 10 in a later section details items received.

Financial support

KIIs and FGDs revealed that social benefits are received by some. A person of employment age can receive 440 UAH/month; this sum reduces to 220 UAH/month if they do not find employment within 2-3 months and stops if they do not find employment within 6-months. Pensioners and families with a baby registered as an IDP receive 880 UAH/month. The maximum a family of four or more can receive is 2004 UAH/month. The NGO 'People in Need' had twice given voucher assistance valued at 700 UAH in Svitohirske.

Breastfeeding

Breastfeeding practices

Table 7 presents the percentage of children demonstrating specified breastfeeding practices as related to sex, location, mother's education, monthly household income, type of accommodation and having a child over two years of age in the household.

Table 7: Percentage of children demonstrating specified breastfeeding practices

| | Ever breastfed (%) | Number of children 0-23 months (n) | Of children ever breastfed | | | | Of children 0-5 months | | | Of children 12-15 months | Of children 20-23 months | Of children 0-23 months | | | |
|-----------------|--------------------|------------------------------------|----------------------------|------|-----|--|---------------------------|-----------------------------|-----------------------------------|--------------------------|-------------------------------------|--------------------------|-------------------------------------|--|------------------------------------|
| | | | <1 | 1-24 | >24 | Average age stopped breastfeeding (months) ((\bar{X} (SD))) | Exclusively breastfed (%) | Predominantly breastfed (%) | Number of children 0-5 months (n) | Breastfed at 1 year (%) | Number of children 12-15 months (n) | Breastfed at 2 years (%) | Number of children 20-23 months (n) | Age appropriate breastfeeding ^a (%) | Number of children 0-23 months (n) |
| Sex | | | | | | | | | | | | | | | |
| Male | 82.7 | 139 | 78.1 | 13.2 | 8.8 | 8.7 (6.37) | 11.1 | 22.2 | 18 | 23.2 | 30 | 7.1 | 28 | 33.1 | 139 |
| Female | 89.0 | 119 | 74.3 | 19.1 | 6.7 | 6.9 (5.24) | 18.2 | 18.2 | 11 | 38.9 | 36 | 22.7 | 22 | 33.6 | 119 |
| Location | | | | | | | | | | | | | | | |
| Svitohirske | 86.8 | 68 | 84.5 | 6.9 | 8.6 | 7.1 (5.82) | 25.0 | 0.0 | 4 | 25.0 | 16 | 18.6 | 16 | 34.8 | 69 |
| Kramatorsk | 85.2 | 69 | 79.7 | 14.5 | 5.8 | 7.2 (6.77) | 18.8 | 37.5 | 16 | 29.9 | 24 | 0.0 | 12 | 32.1 | 81 |
| Slovianske | 85.2 | 92 | 68.5 | 22.8 | 8.7 | 8.9 (5.20) | 0.0 | 0.0 | 9 | 38.5 | 26 | 18.2 | 22 | 33.3 | 108 |

| Mother's education | | | | | | | | | | | | | | | | |
|---|-------|-----|-------|------|------|----------------|------|------|----|------|----|------|----|------|-----|--|
| <i>Incomplete secondary school</i> | 100.0 | 4 | 100.0 | 0.0 | 0.0 | 4.0 (2.83) | 0.0 | 0.0 | 1 | 50.0 | 2 | 0.0 | 1 | 25.0 | 4 | |
| <i>Complete secondary school</i> | 72.6 | 51 | 78.4 | 8.1 | 13.5 | 6.1 (5.92) | 11.1 | 33.3 | 9 | 15.4 | 13 | 12.5 | 8 | 25.5 | 51 | |
| <i>Professional secondary education</i> | 87.3 | 63 | 72.2 | 16.7 | 11.1 | 6.4 (4.61) | 0.0 | 16.7 | 6 | 45.8 | 24 | 14.3 | 7 | 42.9 | 63 | |
| <i>Incomplete higher education</i> | 83.3 | 18 | 86.7 | 13.3 | 0.0 | 8.2 (7.76) | 0.0 | 33.3 | 3 | 20.0 | 5 | 0.0 | 2 | 16.7 | 18 | |
| <i>Complete higher education or above</i> | 90.1 | 121 | 75.2 | 19.3 | 5.5 | 9.1 (5.96) | 30.0 | 10.0 | 10 | 27.3 | 22 | 15.6 | 32 | 34.4 | 122 | |
| Monthly household income (UAH) | | | | | | | | | | | | | | | | |
| <i>No one employed</i> | 85.7 | 189 | 75.2 | 18.0 | 6.8 | 7.7 (5.61) | 5.6 | 22.2 | 18 | 34.0 | 50 | 17.7 | 34 | 34.7 | 190 | |
| <i><2500</i> | 83.3 | 36 | 76.7 | 10.0 | 13.3 | 7.2 (6.22) | 0.0 | 20.0 | 5 | 33.3 | 12 | 0.0 | 6 | 25.0 | 36 | |
| <i>2250-4500</i> | 85.2 | 27 | 78.3 | 13.0 | 8.7 | 8.9 (6.86) | 50.0 | 16.7 | 6 | 0.0 | 2 | 11.0 | 9 | 33.3 | 27 | |
| <i>>4500</i> | 100.0 | 5 | 100.0 | 0.0 | 0.0 | 10.7 (9.87) | - | - | 0 | 0.0 | 2 | 0.0 | 1 | 40.0 | 5 | |
| Type of accommodation | | | | | | | | | | | | | | | | |
| <i>With relatives</i> | 77.3 | 22 | 52.9 | 35.3 | 11.8 | 8.0 (5.03) | 0.0 | 0.0 | 2 | 14.3 | 7 | 12.5 | 8 | 82.6 | 23 | |
| <i>Renting</i> | 85.5 | 193 | 77.4 | 14.6 | 7.9 | 8.0 (6.18) | 13.0 | 21.7 | 23 | 31.2 | 48 | 14.3 | 35 | 32.6 | 193 | |
| <i>Collective centre</i> | 89.2 | 37 | 84.9 | 9.1 | 6.1 | 7.2 (5.11) | 0.0 | 50.0 | 2 | 40.0 | 10 | 16.7 | 6 | 43.2 | 37 | |

| | | | | | | | | | | | | | | | |
|--|----------------------------------|------------|----------------------------------|----------------------------------|--------------------------------|-----------------------|---------------------------------|---------------------------------|-----------|----------------------------------|-----------|---------------------------------|-----------|----------------------------------|------------|
| <i>Other</i> ^b | 100.0 | 5 | 60.0 | 40.0 | 0.0 | 1.0 (n/a) | 50.0 | 0.0 | 2 | 100.0 | 21 | 0.0 | 1 | 60.0 | 5 |
| Child over 2 years in household | | | | | | | | | | | | | | | |
| <i>Yes</i> | 82.9 | 70 | 69.0 | 19.0 | 12.1 | 7.1 (4.67) | 16.7 | 41.7 | 12 | 41.2 | 17 | 0.0 | 7 | 35.2 | 71 |
| <i>No</i> | 86.6 | 187 | 78.9 | 14.9 | 6.2 | 8.1 (6.22) | 11.8 | 5.9 | 17 | 28.6 | 49 | 16.3 | 43 | 32.6 | 187 |
| Total (% [95% CI]) | 85.8 [81.3, 89.9] | 258 | 76.3 [70.1, 81.5] | 16.2 [11.7, 21.5] | 7.8 [4.9, 12.2] | 7.9 (5.91) | 13.8 [0.4, 27.1] | 20.7 [5.0, 36.4] | 29 | 31.8 [20.3, 43.4] | 66 | 14.0 [4.0, 24.0] | 50 | 33.3 [27.5, 39.1] | 258 |

^a 0-5 months: exclusive breastfeeding, 6-23 months: receiving breastmilk and solid, semi-solid or soft food.

^b Other: Monastery, hostel, living with local residents for free

Significance tests showed:

- Age stopped breastfeeding: no significant difference by sex ($p=0.10$), mother's education ($p=0.35$), household income ($p=0.64$), type of accommodation ($p=0.50$) or having a child over 2 ($p=0.44$).
- Exclusive breastfeeding: no significant difference by sex ($p=0.59$), income ($p=0.10$), having a child over 2-years ($p=0.71$).
- Predominant breastfeeding: no significant difference by sex ($p=0.79$), income ($p=0.79$) but was significantly affected by having a child over 2-years ($p=0.019$).
- Breastfeeding at 1 year: no significant difference by sex ($p=0.18$), income ($p=0.50$), location ($p=0.62$), type of accommodation ($p=0.33$) or having a child over 2 years ($p=0.34$).
- Breastfeeding at 2 years: no significant difference different by sex ($p=0.12$), income ($p=0.28$), location ($p=0.28$), type of accommodation ($p=0.33$) or having a child over 2 years ($p=0.34$).
- Age appropriate breastfeeding: no significant difference by income ($p=0.67$), job ($p=0.42$) or type of accommodation ($p=0.12$).

Ever breastfed

Breastfeeding is common with 85.8% of HHQ infants having been breastfed at some point and nearly all mothers in FGDs reported having initiated breastfeeding.

Early initiation of breastfeeding

Health clinic professionals reported that mothers are supported with early initiation of breastfeeding after birth and that breastfeeding, and its benefits, are promoted in health clinics, although the majority could not specify the targeted messages being conveyed.

It is common practice to initiate breastfeeding within 1-hour (76.3%) and breastfeeding on demand (only 19.4% of infants were breastfed on a schedule), as supported by FGD participants.

According to a Paediatrician at the Ambulant Clinic, feeding colostrum is common practice.

From interviews with health professionals we found that the low percentage of mothers who do not initiate breastfeeding are primarily mothers with HIV, TB or other medical reasons where breastfeeding is not recommended.

A key health informant reported that in Slovianske, 5/400 mothers were infected with HIV this year. There is a specialised HIV clinic in the city with access to medicines. In one clinic there have been no cases of TB so far this year; last year there were 2/7200 cases of children with TB.

Exclusive breastfeeding and predominant breastfeeding

Five of the 10 health clinic key informants specifically mentioned promoting exclusive breastfeeding to 6-months. However, even though 44.8% of HHQ infants aged 0-5 months (n=29) were being breastfed, exclusive breastfeeding (13.8%) and predominant breastfeeding (20.7%) were not common practices.

Predominant breastfeeding was significantly more likely in households with another child over 2-years-of-age ($p=0.019$). Other common practices were not breastfeeding at all (n=12), use of formula (n=17), giving tea (n=12), and/or hard, semi-soft or soft foods (n=9).

Four clinics specifically mentioned promoting to not give water until 6-months. In FGDs we see a variety of beliefs, with mothers giving water at 3-months, 5-months and 6-months, the main reason being that their child was thirsty, due to either the accommodation being hot and stuffy or the weather being hot. It was suggested that because in previous generations it was considered that young children needed water this is influencing practices of the current generation, which we do find in a small number of mothers who were advised by their families to give water to their child before 6-months of age.

Another cultural practice highlighted was that of giving medicinal teas to children under 6-months. We saw this in HHQs, in FGDs where a number of mothers self-reported giving teas and from four KIIs with health care professionals who specified advising mothers to give infants under 6-months tea when they have colic or stomach problems. Common herbal teas given are camomile and dill or fennel tea and dill water.

The majority of key informants had not observed a difference in breastfeeding practices between IDP and local/host community infants. However, a representative of the Ambulant Clinic in Slovianske had observed that IDP mothers are more stressed, have little space with their child and not much equipment and these would contribute to difficulties with breastfeeding.

However in both Slovianske and Kramatorsk, health professionals had observed an increase in breastfeeding since the conflict, reflecting that this was likely due to financial constraints associated with the expense of formula. There were also three self-reported cases of extended exclusive breastfeeding in FGDs, one to 10-months, and three infants in HHQs who were not given foods until 9-12 months-old.

"..I think there are some cases when mothers don't have anything to eat for their children so they breastfeed without introducing complementary foods for as long as they can.." (Pre-natal Clinic, Kramatorsk)

Use of infant formula and bottle feeding

During an interview with a Paediatrician in Slovianske it was highlighted that there was an era when mothers thought infant formula was better for their child.

However, artificial feeding alone for infants under 6-months is not a common practice at only 13.8% of HHQ infants and limited self-reports in FGDs. Mixed feeding of breastmilk and infant formula was reported for 24.1% of HHQ infants.

Infant formula brands used were mainly the Ukrainian brands 'Malutka' and 'Malysh', currently the cheapest at 57-200UAH per packet for a 3-day supply and the dominant infant formulas being distributed. A one-time assistance last summer from the Czech Republic provided 'Nunn' and 'NutriOne' infant formulas.

Bottle feeding is very common with 72.5% (95%CI=[67.0,78.0]) of HHQ infants bottle fed the previous day; this percentage is consistent across all assessment areas. FGD participants in Svitohirske reported that the majority fed infant formula from a bottle even though 'Malysh' and 'Malutka' infant formula come with a spoon. Slavyansk Heart in Svitohirske had been given bottles to distribute; aware of the adverse effects of bottle feeding, the organisation had provided one distribution of cups with covers to their beneficiaries.

Duration of breastfeeding

The general consensus of health professionals was that mothers should breastfeed to 1-year of age, with the specified age varied from 1-year to 2-years. One informant explained that they did not promote a duration as this was up to the mother to decide. The majority of mothers in FGDs intended to breastfed up to a range of 18 to 24 months in Sviathirsk and to 12-months in Kramatorsk. This was not discussed in Slovianske.

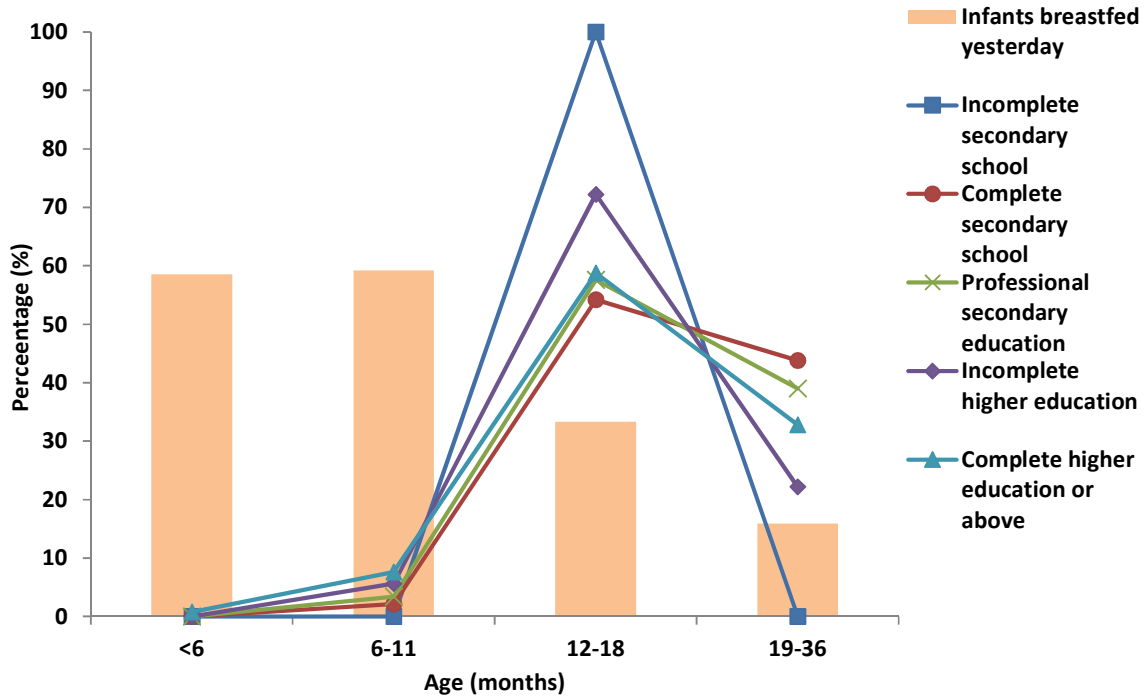
Figure 4 a) shows the relationship between HHQ primary caregiver's opinion of age to stop breastfeeding and their level of education. All levels of education show similar trends except those who did not complete secondary school (n=4) whom all have the opinion that breastfeeding should be continued to 12-18 months; however the number of mothers in this category are very small.

Figure 4 b) shows the relationship with HHQ household income level. All income levels are very similar except those earning over 4500UAH who are more likely to have the opinion that breastfeeding should be continued until 6-11 months and less likely to have the opinion that breastfeeding should be continued until 12-18 months than the other income levels.

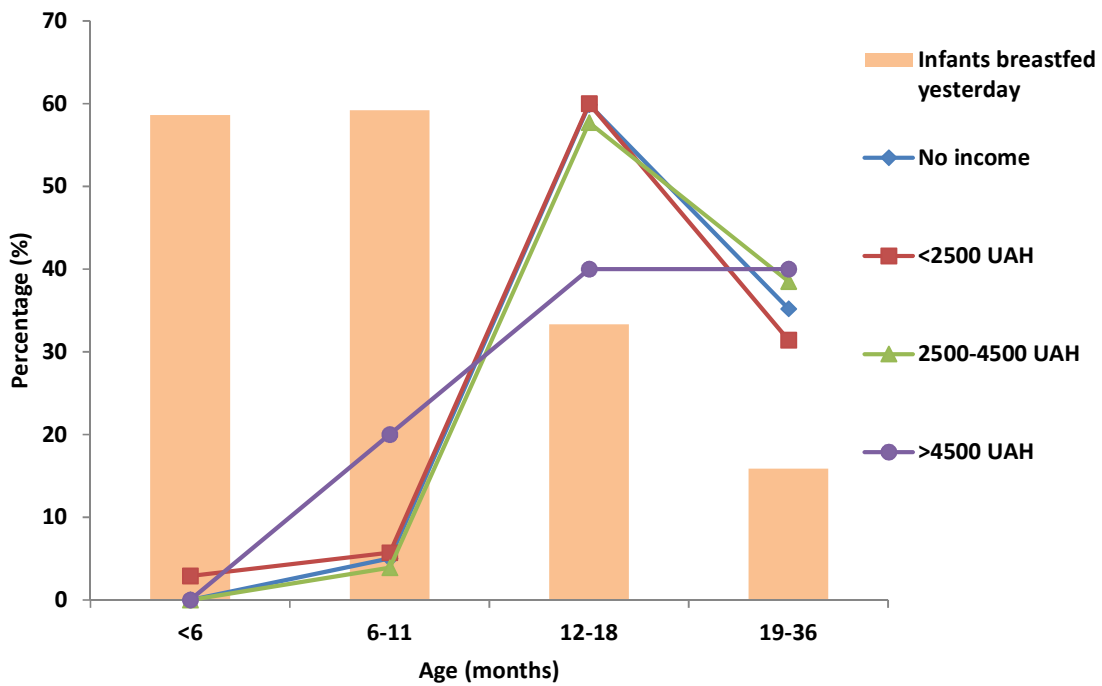
Both graphs show that the majority of respondents believe breastfeeding should be continued to 12-18 months.

Figure 4: The opinion of HHQ respondents (n=253) as to what age a child should be breastfed to and the number of infants breastfed yesterday, by a) mother/ primary caregiver's education level and b) household income level

a)



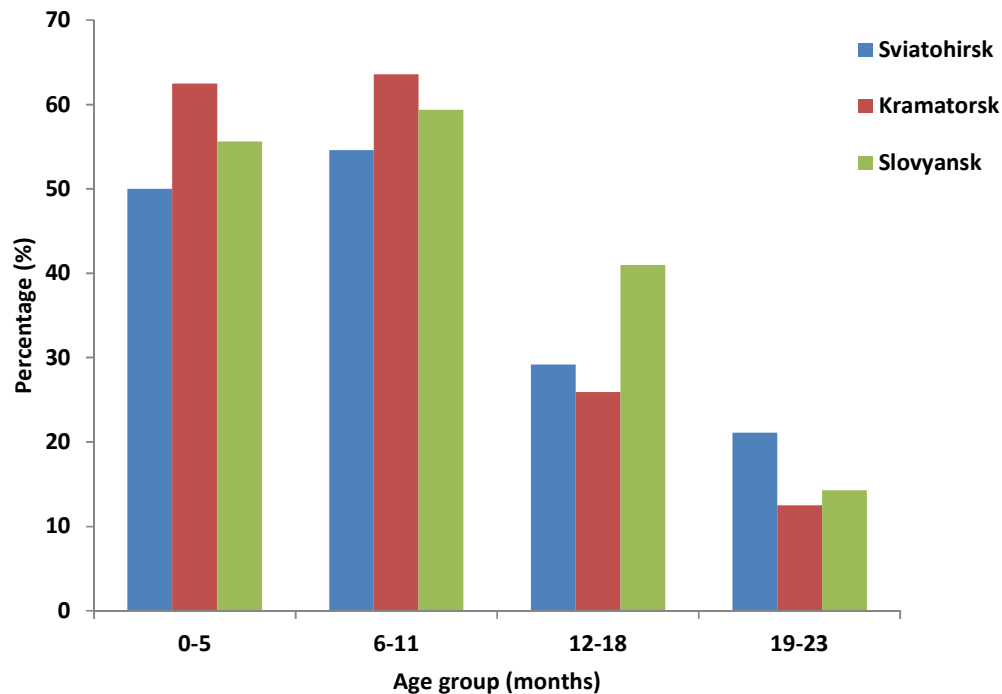
b)



Although health professionals generally specified breastfeeding at least until 1 year of age, the HHQ data shows only 31.8% of infants continued breastfeeding at 1-year.

Figure 5 demonstrates the percentage of children from HHQ's with continued breastfeeding at different age groups up to 2-years. Similar trends are seen across assessment locations. Slovianske appears to have a higher number of children still breastfed at 12-18 months however there is not a significant difference compared to other locations ($p=0.388$).

Figure 5: Percentage of infants who were breastfed yesterday (the previous 24 hours) (n=103) in HHQs, by assessment location and age category

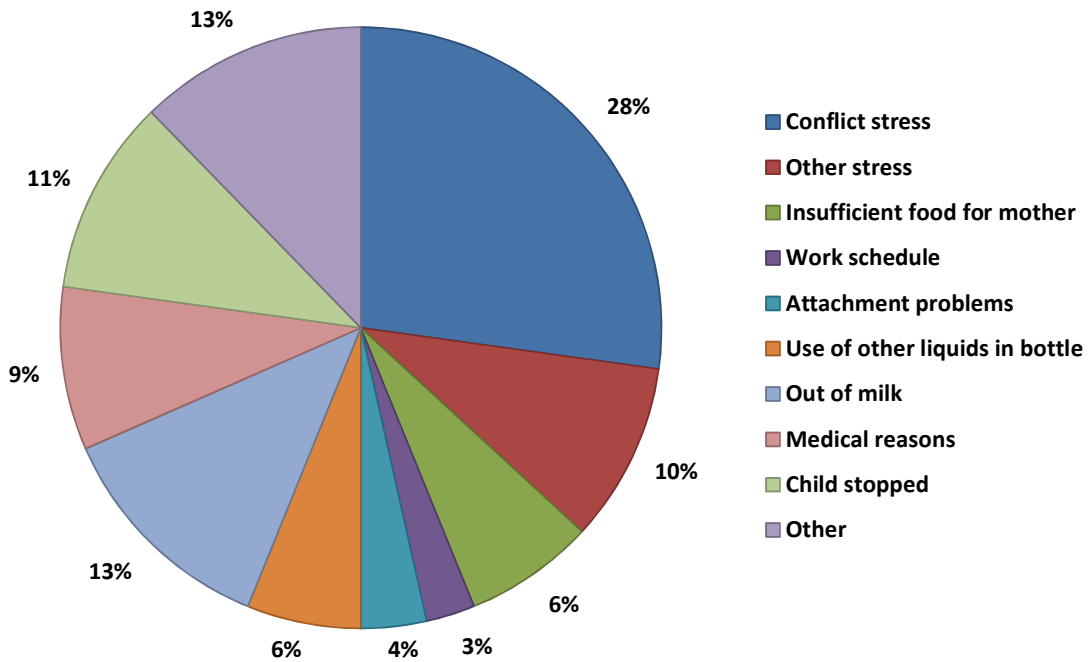


In HHQs the main reason given for stopping breastfeeding was stress due to the conflict (28.1%) followed by being out of milk (13.2%). In a minority of cases (6.1%) the reason was insufficient food (Figure 6).

In all FGDs women also reported breast milk drying up due to stress associated with the conflict. Paediatricians in Slovianske and Svitohirske had also noticed this, observing that IDP mothers complained of their milk drying up more often. A few mothers in FGDs reported that they were separated from their infants due to the conflict and had trouble to re-establish breastfeeding.

At the Slovianske polyclinic one health professional stated that mothers often suffer from full, sore breasts and cracked nipples due to the cold weather, and since the conflict also because of a lack of hot water in some dwellings. Breastfeeding in cold weather was also reported as a concern by some mothers in FGDs.

Figure 6: HHQ respondents (n=114) reasons for stopping breastfeeding of the child under-2 years

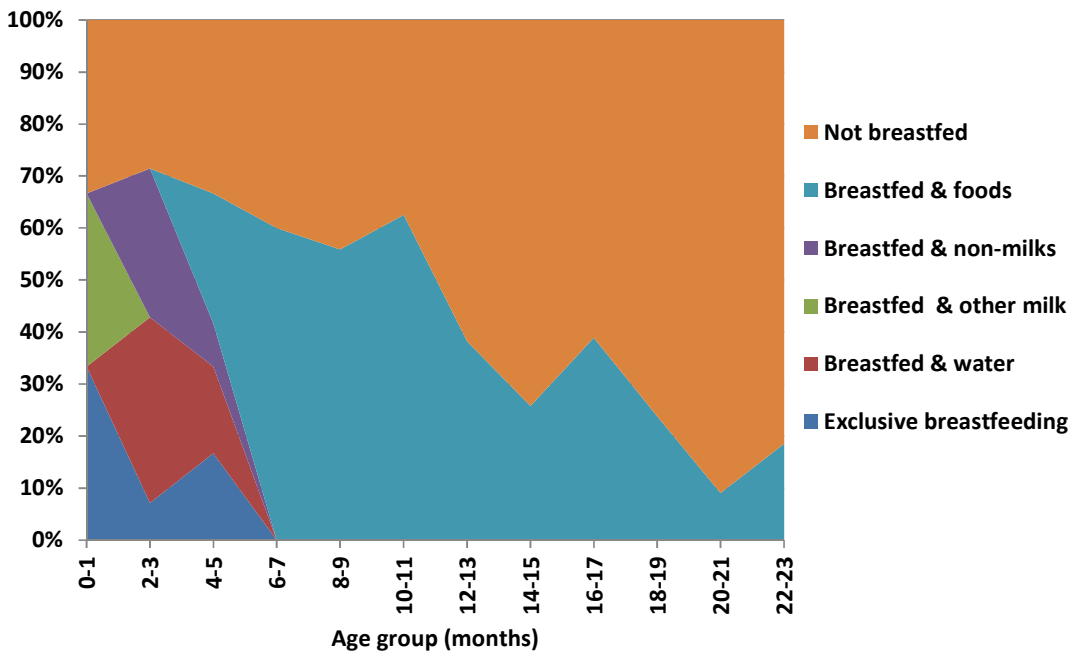


Other: pregnancy, mother's decision, child's age, no mother, 'stress and poor diet'

Age-appropriate breastfeeding

Figure 7 below shows breastfeeding practices by age, with each colour representing the percentage of infants at the given age interval demonstrating the specified practice.

Figure 7: Area graph of breast feeding practices of infants (n=258) by age and percentage of children



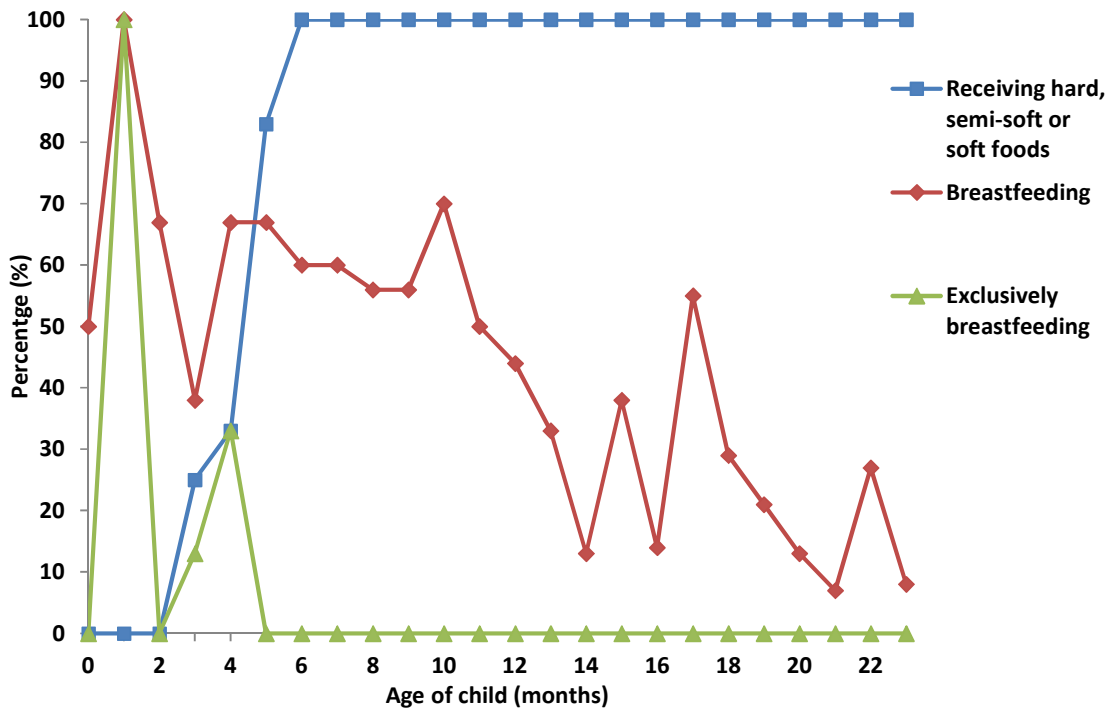
Note about interpreting the area graph:

General: A child can only be categorised once i.e. categories are non-overlapping, meaning the definitions of the first 4 feeding categories indicate that some children may have also been given other items. The sum of the percentages for all of the feeding categories at any age interval is 100%. The graph can tell you what feeding categories are highly prevalent at different age groups and which are not. The x-axis of the area graphs represents point estimates for the age intervals indicated meaning the line connecting two age groups is artificial and does not represent any data in particular.

Figure 7: Any colour other than dark blue before 6-7 months is not desirable and any colour other than teal after 6-7 months is not desirable. Orange is not desirable at any age; except for in a small minority of mothers with HIV, TB or other medical conditions where breastfeeding is not the recommended practice in Ukraine. The non-desirable practices highlight feeding patterns which would need to be changed for optimal child health.

Figure 8 presents feeding practices recommended internationally by the WHO: exclusive breastfeeding to 6-months, continued breastfeeding to 24-months and introduction of soft, semi-soft or hard foods at 6-months. Exclusive breastfeeding for most of the sample population is of shorter duration than the recommendation, and a variety of breastfeeding practices following this. Also, the majority of children aged 5-months are receiving food.

Figure 8: Percentage of children of each month of age demonstrating different feeding practices



Complementary feeding

Introduction and frequency of hard, semi-soft or soft foods

Table 8 presents HHQ infants complementary food practices.

Table 8: Percentage of children with infant feeding practices and average age of introduction of food for infants of HHQs (n=258)

| | Receiving solid, semi-solid or soft foods at 4 months (n=6) (%) | Receiving solid, semi-solid or soft foods at 5 months (n=6) (%) | Receiving solid, semi-solid or soft foods at 6-8 months (n=26) (%) | Of children 6-23 months: Minimum meal frequency (%) | | | Average age for introduction of foods (months) (%) | | |
|---|---|---|--|---|-----------|---------------|--|------------|---------------|
| | All | All | All | All | Breastfed | Not breastfed | All | Breastfed | Not breastfed |
| Sex | | | | | | | | | |
| Male | 33.3 | 33.3 | 100.0 | 95.9 | 97.7 | 94.9 | 4.8 (1.58) | 5.0 (1.41) | 4.8 (1.67) |
| Female | 33.3 | 33.3 | 100.0 | 93.4 | 100.0 | 89.4 | 4.7 (1.85) | 5.1 (1.73) | 4.5 (1.89) |
| Location | | | | | | | | | |
| Svitohirske | 0.0 | 100.0 | 100.0 | 89.1 | 95.5 | 85.7 | 5.0 (2.08) | 5.6 (1.64) | 4.6 (2.22) |
| Kramatorsk | 0.0 | 100.0 | 100.0 | 98.4 | 100.0 | 97.6 | 4.6 (1.72) | 4.8 (1.92) | 4.5 (1.59) |
| Slovianske | 66.7 | 75.0 | 100.0 | 96.0 | 100.0 | 93.3 | 4.8 (1.41) | 4.9 (1.20) | 4.8 (1.5) |
| Caregiver's education status | | | | | | | | | |
| <i>Incomplete secondary school</i> | n/a | n/a | 100.0 | 100.0 | 100.0 | 100.0 | 3.0 (1.0) | 3.0 (n/a) | 3.0 (1.41) |
| <i>Complete secondary school</i> | n/a | 100.0 | 100.0 | 92.9 | 92.3 | 93.1 | 4.7 (1.18) | 4.7 (1.18) | 4.0 (1.76) |
| <i>Professional secondary education</i> | 100.0 | 0.0 | 100.0 | 96.4 | 100.0 | 93.3 | 4.8 (1.25) | 4.8 (1.25) | 4.2 (1.63) |
| <i>Incomplete higher education</i> | n/a | n/a | 100.0 | 93.3 | 100.0 | 91.7 | 5.0 (n/a) | 5.0 (1.0) | 4.3 (1.06) |
| <i>Complete higher education or above</i> | 0.0 | 100.0 | 100.0 | 94.6 | 100.0 | 91.6 | 5.4 (1.81) | 5.4 (1.8) | 5.2 (1.78) |
| Household income | | | | | | | | | |

| | | | | | | | | | |
|------------------------------|-------------|-------------|--------------|---------------|-------------|-------------|-------------------|-------------------|-------------------|
| <i>No one employed</i> | 0.0 | 83.3 | 100.0 | 94.1 | 98.5 | 91.4 | 4.8 (1.69) | 5.2 (1.42) | 4.5 (1.80) |
| <i><2500</i> | 100.0 | 100.0 | 100.0 | 96.8 | 100.0 | 95.2 | 4.5 (1.57) | 4.4 (1.43) | 4.6 (1.65) |
| <i>2250-4500</i> | 50.0 | n/a | 100.0 | 95.2 | 100.0 | 93.3 | 5.1 (2.00) | 4.4 (2.72) | 5.4 (1.50) |
| <i>>4500</i> | n/a | n/a | 100.0 | 100.0 | 100.0 | 100.0 | 5.6 (1.67) | 5.0 (1.41) | 6.0 (2.00) |
| Type of accommodation | | | | | | | | | |
| <i>With relatives</i> | n/a | 100.0 | 100.0 | 95.2 | 100.0 | 94.1 | 5.6 (1.44) | 5.2 (0.84) | 5.7 (1.57) |
| <i>Renting</i> | 40.0 | 80.0 | 100.0 | 94.6 | 100.0 | 91.6 | 4.8 (1.73) | 5.0 (1.70) | 4.6 (1.75) |
| <i>Collective centre</i> | n/a | n/a | 100.0 | 94.3 | 93.8 | 94.7 | 4.6 (1.65) | 5.3 (1.20) | 4.0 (1.75) |
| <i>Other^a</i> | 0.0 | n/a | 100.0 | 100.0 | 100.0 | 100.0 | 4.0 (1.73) | 4.5 (2.12) | 3.0 (n/a) |
| Total | 33.3 | 83.3 | 100.0 | 94.7 | 98.8 | 92.4 | 4.8 (1.71) | 5.1 (1.57) | 4.6 (1.77) |
| | | | | [91.8, | | | | | |
| | | | | 97.6] | | | | | |

^a Other: Monastery, hostel, living with local residents for free
n/a = no infants in this category

Age of introduction

All children aged 6-8 months had received hard, semi-soft or soft foods in the 24-hours preceding the survey. Age of introduction was not significantly associated with education status ($p=0.12$), job status ($p=0.84$), household income ($p=0.46$) or accommodation type ($p=0.76$). Differences were not tested for other variables due to consistent results and/or small sample sizes.

HHQs highlighted that complementary foods were being introduced earlier than the recommended age of 6-months, with 83.3% of 5-month old HHQ infants receiving foods and 33.3% of 4-month olds. The latter was found to be only in infants in Slovianske (n=2). In FGDs, many mothers confirmed these practices although some mothers also reported giving foods at the recommended age. Health professional key informants generally specified promoting the introduction of foods at 6 months, and felt that mothers roughly followed their advice, however one mother in a FGD revealed her paediatrician had advised to start foods at 4-months. Some mothers reported introducing cereals at 3 to 4 months because the packets gave this advice. In Kramatorsk, one FGD participant reported having been pressurised by her family to introduce food at 4-months but was aware that this advice was out-dated and waited until 6-months.

The Slovianske Child Health Clinic had witnessed some mothers giving foods after 1-month and said the reason was because mothers believed their milk was not enough. Another belief expressed by mothers was that breastmilk does not have enough fat, especially when a mother is not eating a good diet, and therefore the child is hungry, a common concern reported to health professionals.

A paediatrician in Kramatorsk had found that mothers sometimes give their sick children under 6-months berries, with a lot of vitamins, and honey.

Also, highlighted were a smaller number of mothers who were introducing foods later than the recommended ages. In FGDs one mother reported introducing foods at 8-months and another at 10-months.

Figure 9 shows that there appears to be a relationship between age of introduction of foods and how long the household has been displaced. We see that the percentage of mothers from HHQs introducing foods at 6 months of age is low at 0-6 months post-displacement, but rises significantly after 7-12 months of displacement. However, in those displaced for over 1 year there are no children who had foods introduced at the recommended time. Instead we see a sharp increase of introduction before 6 months and an increase in introduction after 9 months.

Figure 9: Age of introduction of hard, semi-soft or soft foods by time displaced

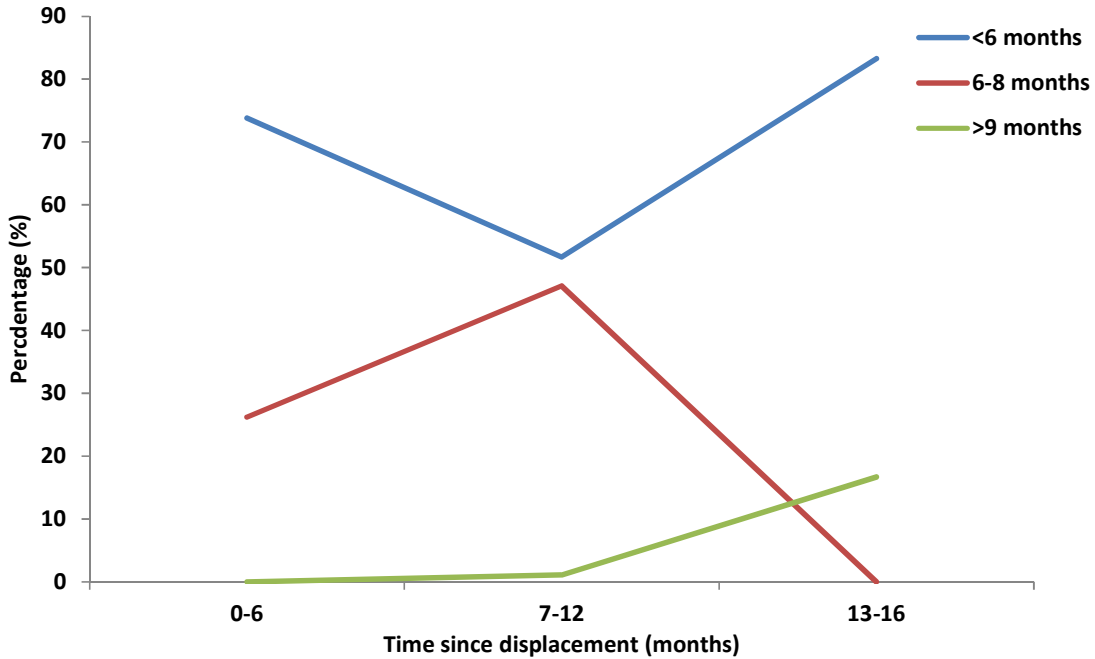
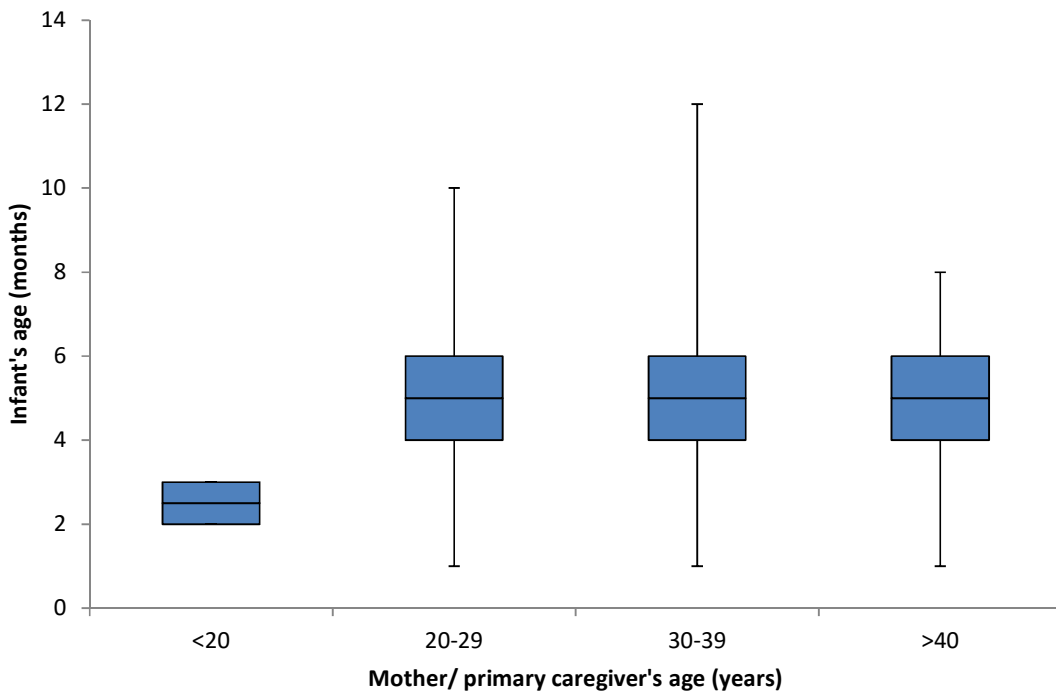


Figure 10 shows that once a mother/primary caregiver is 20-years or older there is no relationship between age of introduction of foods and mother/primary caregiver's age, with a consistent median age of 5-months. However, this figure indicates that mothers younger than 20-years-old (n=2) may be more likely to introduce foods at a very early age of 2-3 months.

Figure 10: Box plot showing the average age of introduction of complementary foods by mother's/primary caregivers in the HHQ age category

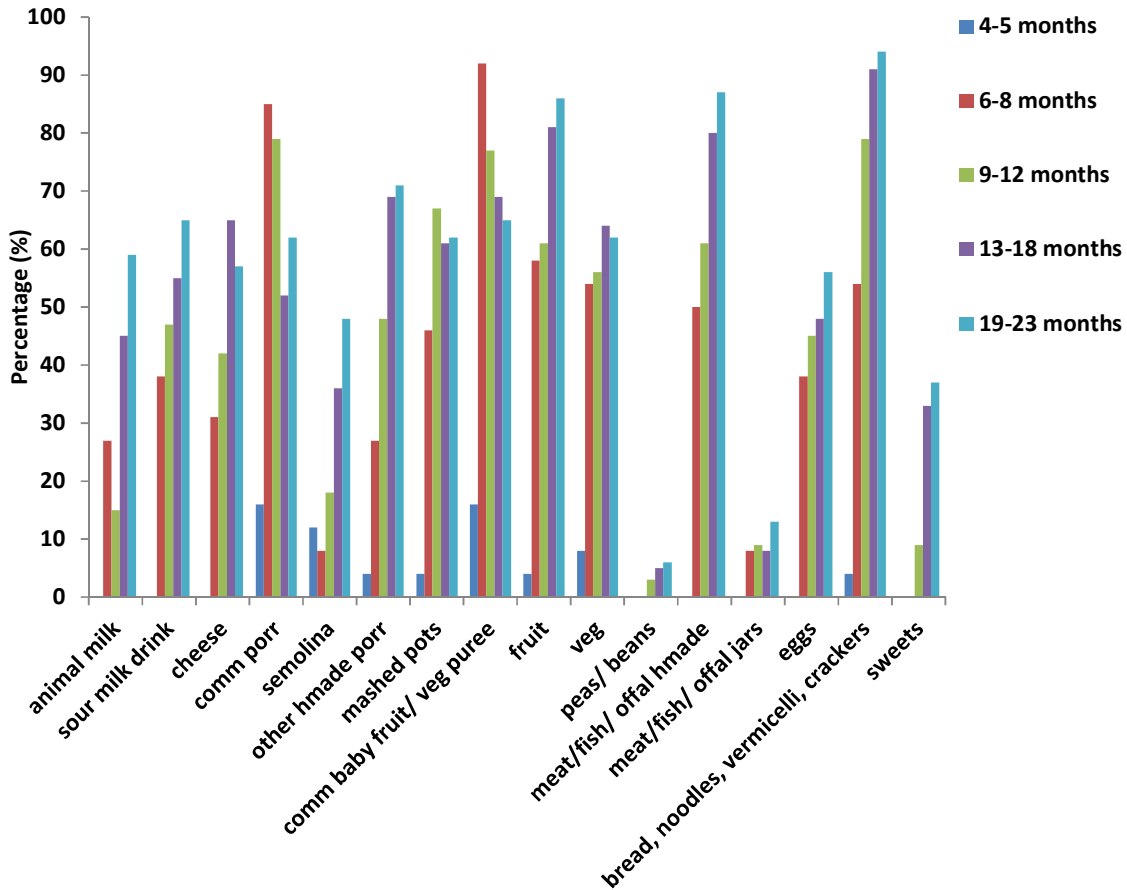


First foods

Considering non-liquid foods given to infants under 6-months, these were mostly commercial porridge (n=4), semolina porridge (n=3) or commercial baby fruit/vegetable puree (n=4). For breastfeeding mothers the most common food given was commercial baby fruit/ vegetable puree (n=2).

Figure 11 shows foods consumed by 4-23 month olds in the day prior to the HHQ, by age category.

Figure 11: Percentage of children 4-23 months (n=241) reported to consume the specified foods in the 24 hours prior to the HHQ, by age group



Typically, HHQs show that the most common first foods are commercial fruit/ vegetable purees and porridges which, when specified, is what clinics were promoting: fruit/ vegetable purees followed by cereals, as well as curds and fruit juice. FGDs also showed the majority were giving these first foods. A Chief Paediatrician specified to firstly introduce cereals with milk if the infant was underweight.

Of HHQ infants aged 6-8 months over 90% were consuming commercial fruit/ vegetable purees, 58% had consumed fresh fruits and 54% fresh vegetables, over 80% commercial porridges and 27% homemade porridges.

FGDs revealed that mothers often make purees themselves as commercial purees are expensive.

FGDs also revealed that the main first vegetables given to children were: potato, pumpkin, zucchini, and cauliflower. Broccoli were mentioned by health professionals, however the assessment team observed that it was not widely available, as was identified to be the case for all green leafy vegetables in eastern Ukraine at the time of the assessment. Soups or 'Borsch' were commonly given by FGD participants to children under 1-year in addition to purees.

The recommendation given by a number of health professionals was to introduce egg yolk at 7-8 months. It appears from HHQs that this is happening in approximately 40% of infants. Health professionals commonly recommended introducing meat around 7-8 months, however one promoted beef at 8-9 months, one recommended poultry at 7-months and additionally one specified fish to be introduced at 9-months. HHQs show that 50% of infants 6-8 months old were receiving homemade meat, with an average age of introduction at 8.0 months. This increased to 80% in infants older than 12-months.

The Child Health Clinic in Slovianske found that many families start to give cow's milk from 7-8 months when they make cereals. They also often recommended using 50% milk and 50% water, with no/little added sugar and olive oil if needed.

One health professional specified promoting oat wheat, corn or buckwheat for first cereals.

During the FGD in Slovianske, mother's specified homemade porridge was prepared with a dry mixture (rice, oatwheat, wheat) with special milk for children and fruit like apple, banana or strawberries. Some initially made porridge with no milk. All mothers said they did not add sugar or fat. Health professionals recommended cow's milk for drinking at 10-12 months of age, but this did not appear to be a common practice amongst mothers in FGDs.

In Svitohirske mothers introduced cottage cheese around 5/6/7months; we see this given to only 30% of HHQ infants aged 6-8 months.

Minimum meal frequency, children 6 - 23 months, at 94.7% for HHQ infants 6 – 23 months of age, was High across all assessment areas (slightly lower in children not breastfed). (See Table 8)

Dietary diversity

Using the following groups, a dietary diversity score was calculated for infants aged 6-23 months:

- Grains (porridges, breads, noodles, vermicelli, crackers)
- Dairy (infant formula, animal milk, cheese)
- Fruit and vegetables (including potatoes)
- Peas/beans
- Eggs
- Meat sources (red meat, poultry, fish, offal)

Overall, minimum dietary diversity (≥ 4 food groups in the last 24 hours) was reached by 77.7%. Table 9 presents this data by age group.

Table 9: Dietary diversity of HHQ infants aged 6-23 months (n=229)

| | Dietary diversity ((\bar{X} (SD))) | Minimum dietary diversity (%) |
|-------------------------------|---------------------------------------|-------------------------------|
| Sex | | |
| <i>Male</i> | 4.2 (0.96) | 77.7 |
| <i>Female</i> | 4.1 (0.85) | 77.8 |
| Age (months) | | |
| <i>6-8</i> | 3.8 (0.95) | 61.5 |
| <i>9-11</i> | 3.9 (0.93) | 68.0 |
| <i>12-18</i> | 4.2 (0.92) | 81.1 |
| <i>19-23</i> | 4.4 (0.75) | 87.3* |
| Location | | |
| <i>Svitohirske</i> | 3.8 (0.97) | 60.0 |
| <i>Kramatorsk</i> | 4.2 (0.98) | 80.0 |
| <i>Slovianske</i> | 4.3 (0.74) | 87.9* |
| Mother's education | | |
| <i>Incomplete secondary</i> | 4.3 (0.58) | 100.0 |
| <i>Complete secondary</i> | 4.3 (0.86) | 83.3 |
| <i>Professional secondary</i> | 4.0 (0.90) | 68.4 |
| <i>Incomplete higher</i> | 3.9 (1.10) | 60.0 |

| | | |
|--|-------------------|-------------------------------|
| <i>Complete higher or above</i> | 4.2 (0.90) | 82.1 |
| Monthly household income (UAH) | | |
| <i>No one employed</i> | 4.1 (0.92) | 75.0 |
| <i><2500</i> | 4.4 (0.92) | 80.7 |
| <i>2250-4500</i> | 4.2 (0.81) | 90.5 |
| <i>>4500</i> | 4.2 (0.45) | 100.0 |
| Type of accommodation | | |
| <i>With relatives</i> | 4.2 (0.81) | 76.2 |
| <i>Renting</i> | 4.2 (0.88) | 82.4 |
| <i>Collective centre</i> | 3.7 (0.96) | 60.0 |
| <i>Other^a</i> | 3.7 (1.15) | 33.3* |
| Child over 2 years in household | | |
| <i>Yes</i> | 4.2 (0.92) | 79.4 |
| <i>No</i> | 4.1 (0.88) | 72.9 |
| Total | 4.1 (0.91) | 77.7 [95%CI=72.3,83.2] |

^a Other: Monastery, hostel, living with local residents for free

There was a significant association between minimum dietary diversity and age-group ($p=0.014$), location ($p<0.0001$) and type of accommodation ($p=0.008$). There were a smaller number of children reaching minimum dietary diversity in the younger age groups, in 'other' accommodation type and collective centres and in Svitohirske.

Iron and protein rich foods

Most health professionals proposed low anaemia rates for infants (1-8%). However, in two interviews with health care professionals in Slovianske the levels were cited as 20% for their service area. No informants had noted differences in anaemia rates between IDPs and locals. Health professionals all reported that the protocol for testing for anaemia in infants is to test at 9 months, unless symptoms are present. In the Ambulant Clinic in Kramatorsk the paediatrician stated that if the mother is breastfeeding they would not suspect anaemia and that if the child is growing well they would not consider nutrition. Anaemia is treated with liquid iron supplements and dietary advice, including not giving whole milk but to give fruit juice and to include vegetables, fruit and meat in the child's food, and to stop giving tea after food.

Considering intake of iron-rich foods, 73.4% of infants had eaten fresh meat and 9.6% commercial meat puree in the 24 hours prior to the survey. On average, infants had eaten meat 4.5 times during the previous week, however this did range from 0 to 7 times. The variation in reports of frequency of meat consumption may be due to intermittent provision of meat. In Svitohirske, meat was being provided to some collective centres, and those who were residing in the monastery had been given meals containing very small amounts of meat during the last few weeks; others had not had any meat through food assistance. Only one HHQ respondent reported having received a donation of meat puree, and only on once. Svitohirske FGDs highlighted a variety of practices: a few mothers were rarely giving meat, one mother sharing that this is because it was too expensive with a small jar costing 40 UAH; another mother was giving meat twice a week; another mother was giving meat daily.

Of HHQ infants 6-23 months just under 50% had eaten eggs the previous day, and just over 50% by those 19-23 months of age. In FGDs, some mothers said that since they were displaced they were not feeding eggs as often as pre-crisis, due to the high price (24UAH for 10 eggs).

Assistance for households with children under 2-years

Through FGDs we found that mothers were having problems with accessing baby-foods due to financial constraints and unstable access to food through both assistance and markets. In Kramatorsk, since the conflict, the main change mothers stated was that vegetables were expensive; easier to access in summer months.

Baby food assistance

Targeting of distributions

Slavyansk Heart, one of the main NGOs working in Svitohirske distributing food and non-food items reported they have the vulnerability targets as typically set by donating organisations, which include: families with children under 3 years or more than two children, single mothers, families with orphans and/or disabled persons and pregnant women.

In Svitohirske, baby-food parcels were given to all children under 3-years with all receiving fruit/ vegetable purees and porridges. Infants up to 1-year were additionally receiving infant formula and children 1 to 3-years were additionally receiving cereals. Similar principles seem to be applied to all distributions, but with items varying between distribution sites.

Infant formula had been received by 78.3% of HHQ infants under 1-year and 19.6% of infants 12-23 months. The four HHQ infants exclusively breastfed had all received infant formula.

In Kramatorsk, one health professional noted that differences between IDPs and locals become apparent when they are formula feeding, as it has become so expensive. However, this also seems to be a problem for local vulnerable people as previously the government were giving infant formula to mothers with HIV/TB or other diseases, but that now this is coming through volunteer organisations. In a number of clinics, assistance items were being distributed to local populations, supposedly targeted at vulnerable families. Slavyansk Heart reported that as prices increase, all families appear to be in need.

Baby-food assistance items

The main baby-food assistance items received by HHQ participants were fruit/ vegetable purees, porridges/cereals and infant formula. FGD participants also mainly received these items; fruit juice and diapers were also mentioned by some.

All but one HHQ infant under 4-months had received baby purees and all but one received commercial porridges, including those exclusively breastfed. During an interview with the Svitohirske city council key informant, it was established that these were not necessarily being fed to the infant at that time, but saved until they were of an older age or given to another child.

Table 10 shows the specifics of baby food assistance received by households in HHQs and food consumption patterns of the infants aged 6-23 months. (Frequency and time since last assistance can be found under 'Humanitarian Assistance' in Table 6.) FGD participants reported that no foods freely received were thought to not be a priority food. However, even though over 80% of households were receiving commercial porridges only 66.8% of HHQ infants had consumed these in the last 24 hours. FGDs mothers reported that many infants did not like the taste of the commercial porridges which could be the reason we are not seeing consumption matching availability. Mothers in Kramatorsk reported food aid lasts only 1-2 weeks; in Slovianske 2 weeks.

Other foods we saw to not be received in baby-food assistance but which were consumed frequently include bread/ noodles/ vermicelli/ crackers and fresh fruit and vegetables. Foods eaten less frequently, but still by large numbers of infants were dairy products: cheese, animal milk/ sour milk, and potatoes.

Priority items for children, identified through FGDs and interviews with key informants, were: mixtures of cereals (rice, buckwheat and barley were specified in one group), infant formula (including non-dairy/lactose-free brands), fruit and vegetable puree, fresh vegetables (eg cabbage, carrot, beetroot, cucumbers), meat products, bottled water, butter, cottage cheese, keffir, ingredients to make yoghurt, sunflower oil, sugar, salt and tea for babies and humana tea for maternal lactogenesis -as well as diapers, children's laundry detergent and shampoo and teething gel.

Table 10: Analysis of food patterns in infants 6-23 months old (n=229) and baby-food assistance given to households (n=253) from HHQs

| Food Group | Consumed in the last | Average weekly | Average age introduced | Households receiving item | Average number | FGD comments |
|------------|----------------------|----------------|------------------------|---------------------------|----------------|--------------|
|------------|----------------------|----------------|------------------------|---------------------------|----------------|--------------|

| | 24 hours (%) | consumption (\bar{X} (SD)) | (months) (\bar{X} (SD)) | in aid (%) | of items in last package (\bar{X} (SD)) | |
|---|--------------|----------------------------------|-------------------------------|------------|---|--|
| Bread, noodles, vermicelli, crackers | 84.3 | 5.9 (2.14) | 8.1 (3.01) | 0.0 | - | - |
| Commercial porridge | 66.8 | 4.2 (2.95) | 6.7 (2.82) | 81.8 | 2.6 (1.54) | Infants don't like Karapus brands or barley meal |
| Homemade porridge | 71.2 | 4.3 (2.71) | 8.9 (3.1) | 81.4 | 1.8 (0.50) | - |
| Cheese | 52.8 | 3.0 (2.55) | 7.9 (2.48) | 0.0 | - | - |
| Animal milk/ sour milk | 68.1 | 2.7 (2.7) | 8.6 (3.18) | 0.0 | - | - |
| Commercial baby fruit/ veg puree | 73.4 | 4.6 (2.60) | 6.3 (2.51) | 83.8 | 18.8 (4.05) | Expensive |
| Vegetables | 60.3 | - | - | 0.0 | - | Becoming expensive |
| Fruits | 74.2 | 4.7 (2.48) | 6.1 (2.11) | 0.0 | - | - |
| Eggs | 48.5 | 2.3 (2.08) | 8.1 (2.57) | 0.0 | - | Not fed so much since displaced |
| Potato | 61.6 | 3.6 (2.41) | 7.0 (2.36) | 0.0 | - | - |
| Peas and beans | 4.4 | 0.2 (1.01) | 12.7 (3.10) | 0.0 | - | - |
| Animal- source meat foods | 73.4 | 4.5 ^a (2.70) | 8.0 ^a (2.02) | 0.0 | - | Expensive |
| Commercial meat puree jars | 9.6 | - ^a | - ^a | 0.8 | 20.0 (n=1) | Expensive. Too salty, not tasty |
| Sugary foods | 16.2 | - | - | 0.0 | - | - |
| Tea or herbal tea | 60.3 | - | - | 0.0 | - | Given under 6- months for colic and other illness |
| Fruit/ veg juice | 59.8 | - | 5.8 (2.22) | 0.0 | - | Given to some mothers in donations |
| Other liquids (including soft drinks) | 4.4 | - | - | 0.0 | - | - |
| Commercial infant formula | 50.2 | 3.2 (3.33) | 4.2 (3.72) | 45.8 | 2.3 (1.72) | Malutka: not liked by all, allergenic; causes diarrhoea. |

^a7-day food frequency did not distinguish between commercial meat products and homemade meat products, the number displayed under homemade is for both categories.

Other donations specified by mothers in HHQs included sugar (n=1), wet wipes (n=1), diapers (n=2) and hygiene products (n=1).

Even though the majority of mothers fed baby purees when given to them for free, and HHQs confirm this practice is currently widespread, the majority of mothers expressed a preference for cooking food for their children. In Slovianske this appeared to happen whereas in Svitohirske this was often not possible. Svitohirske is unique in that there are no gas appliances, and therefore many mothers do not have electric pans to be able to cook. All mothers living in the Svitohirske monastery or collective centres reported having no access to cooking facilities and for this reason some donated foods (such as semolina) were thought to be inappropriate. The Svitohirske City Council representative expressed the need for blenders and multifunctional electric pans to allow mothers to cook purees and that in summer lack of refrigerators in dwellings is also a problem.

Advice and support services

Sources of advice

Mothers used doctors, nurses and other health care staff, the internet (social networks) and their mothers and friends or local communication networks as key sources of information on infant feeding. Some mothers also viewed commercial product packaging for advice on when to introduce foods. Even though a number of health care professionals in both Slovianske and Kramatorsk who participated in interviews reported providing hot-line numbers for advice from nurses and/or peer-mothers, mothers from FGDs in Slovianske and Kramatorsk were not aware of them. Participants proposed informational posters be displayed at distribution points (stating distribution schedules and key educational messages)

Health professionals found mothers were generally pro-active in asking questions on breastfeeding. FGD mothers exemplified this behaviour with one mother seeking advice when her infant was not gaining weight, and another seeking advice on her lack of breastmilk.

Information on NGOs in the area and donations seemed to be mainly received by telephone, sourced online and through word-of-mouth in Kramatorsk; in Slovianske advice was also sought from health professionals and volunteers. Some mothers had experienced misunderstandings about donations and queues being too long to wait in when they had children to care for.

Influential people

A birth clinic representative approximated that 70% of fathers were very active in the caretaking of a child from the first days and it appeared that across all locations fathers were welcome to attend almost all pre-natal visits and education sessions. The pre-natal clinic representative believed that fathers were the most influential figures in the household on breastfeeding practices and recommended that fathers and anyone else caring for the child be involved in the education. However, mothers in Kramatorsk felt that neither fathers nor grandmothers influenced their practices.

Fathers were often accompanying mothers to the Child Health Clinic in Slovianske however only an estimated 10% of grandmothers accompany mothers to the pre-natal Clinic and only some to education sessions.

Infant and young child feeding services

Pre-natal

The MoH protocol for pre-natal care, as reported by a pre-natal clinic neonatologist, is 9-11 visits during the period of her pregnancy, ideally with the first visit before 12 weeks. Attendance was good by most pregnant women although it had been observed that IDPs sometimes miss visits as they return to their homes in NGCAs.

In Slovianske and Kramatorsk clinics there are schools for pregnant women/ young mothers, with lectures and courses, including on breastfeeding practices. A number of mothers in the Kramatorsk FGD mentioned these schools, referring to them as a service available 'pre-conflict'. One mother understood that the schools

are still accessible through the ambulant and hospital clinics. The Kramatorsk neonatologist informed that a community-based 'Breastfeeding Support Group' operational pre-crisis, is no longer active.

Whilst the pre-natal clinic in Kramatorsk provides 1 to 2 sessions for pregnant mothers on breastfeeding, a FGD mother shared that she had not received any breastfeeding advice from the nurse during her prenatal home visit.

Birth Clinic

At the Kramatorsk and Slovianske birth clinics mothers are taught how to breastfeed, with support for early initiation, and fathers are taught how to support the mother in care giving.

However, FGD mothers reported mixed experiences at birth clinics. A number of mothers had been given advice by nurses, but not skilled support whereas one mother mentioned a 'milk nurse' who gave her specialised breastfeeding advice and support.

The Slovyanske birth clinic neonatologist had observed that IDPs were asking more questions about maintaining lactation, seeing continuing breastfeeding as more of a priority than the local population.

At the Kramatorsk birth clinic they stated that mothers should buy all the delivery medicines themselves as they do not have any.

Post-natal

Common post-natal services, which tend to be delivered through child policlinics and ambulant clinics, are two to three household visits during the month after birth by a doctor and/or nurse to measure the infants' weight and height and address any concerns. Breastfeeding education is also an integral part of these visits. Following this mothers are recommended to attend the policlinic monthly for check-ups.

Individual education sessions are provided by all post-natal facilities, whereas group education sessions are very limited; one clinic organised an opportunistic group session approximately once every 3-months for 3-4 mothers waiting to see the doctor whereas in other clinics these were more regularly facilitated, with 3-5 mothers per group. Both Kramatorsk Policlinic and Slovianske Ambulant Clinic provide a 'Room of the Healthy Child' where mothers can seek advice from a medical professional and view a video and printed information on exclusive breastfeeding and first foods.

Re-lactation support

At one clinic re-lactation support was only provided if a mother attended soon after stopping breastfeeding. In other clinics, there were defined steps to teach mothers re-lactation and assess the need for infant formula, with the majority of clinics having guidelines for how to assess infant feeding practices. Only one clinic recommended medicinal methods (EpiLac). If re-lactation was not possible after assessment, clinics provided infant formula. One clinic representative felt there was limited support provided for re-establishing or increasing breastfeeding. Even if provided with formula, mothers were encouraged to continue or pursue breastfeeding. During a FGD one mother shared *"I was supported with breastfeeding prior to being given infant formula when my infant was under 6-months old"*.

Considering support services, the local NGO, Slovianske Heart, had tried to provide group psychological support sessions for mothers in Svitohirske to reinitiate breastfeeding and in February 2015, following a large influx of IDPs, UNICEF had arranged an education session for IDP mothers on how to reinitiate breastfeeding.

Though generally non-medical services do not assess or provide support for breastfeeding practices, and as such are not doing so before distributing infant formula. The mother's word is taken for whether she is breastfeeding or not, and typically mothers are collecting infant formula even if they are breastfeeding and keep it for a later date. However, there were also mothers who were saying they did not need formula.

Health services nutrition capacity

Doctors and nurses receive refresher training every 5-years, previously from a regional hospital located in Donetsk City which has since moved to Kramatorsk. More regular training was delivered by heads of

departments/ chief paediatrician/ chief nurse. Training routines have been interrupted since the onset of the conflict, for example the MoH annual refresher training for pre-natal staff has not been delivered since 2013.

The Slovianske Polyclinic and Kramatorsk Ambulant Clinic are certified as Baby Friendly clinics; this requires all medical staff to receive training on IYCF. In Kramatorsk the training was delivered 1-2 times a year for resident staff and for all new staff. The Kramatorsk and Slovianske birth clinics reported working towards attaining Baby-friendly Hospital certification, however they have been unable to achieve this due to financial and bureaucratic constraints since the onset of the conflict.

Elsewhere, training on infant feeding seemed to vary in frequency and extend -one family doctor had completed a local 12-week training course for doctors and nurses on nutrition for young children whereas in other clinics infant feeding was included as part of a medical training package. The regional Chief Paediatrician in Slovianske delivered radio segments on breastfeeding and facilitated trainings for staff.

Representatives from baby-food companies occasionally present their products at clinics, which one family doctor found useful.

Materials and tools

All clinics were lacking, and emphasised the need for, printed information booklets and pamphlets for mothers. A number of mothers had received printed information prior to the conflict, including on age-related feeding, however mothers reported that since displacement these materials have not been available. The scarce printed information available was from baby food companies.

The Slovianske chief regional paediatrician emphasised the need for posters, as previous materials had been destroyed during the shelling at the polyclinic. One pre-natal clinic had educational booklets and pamphlets on breastfeeding made by the staff themselves, to give to registered patients; they did not have any for complementary feeding. Some clinics were also lacking in visual aids such as videos and models. The Kramatorsk pre-natal clinic also thought it would be useful to have models of the breast and of baby's mouths to show correct attachment.

Informational messaging topics thought to be needed included advantages of breastfeeding, when a mother should not breastfeed, scheduling breastfeeding and how to tell if a child is hungry.

There were no pamphlets included in the baby-food assistance parcels distributed. Slavyansk Heart NGO had been given some information booklets from UNICEF on breastfeeding and complementary feeding, to distribute, and emphasised a specific need for age-related feeding advice.

Caregiving support

Following requests from mothers, Slavyansk Heart in Svitohirske established a small room where mothers can leave their child for up to 4 hours a day. Caritas also provide this, managed by professionals to care for the children. FGDs revealed that these NGOs rooms were limited in size for the number of mothers wanting to use the service.

As well as using these spaces for childcare, FGD participants in Kramatorsk and Slovianske welcomed a place to socialise with other mothers. Considering organising group sessions for mothers, FGD caregivers indicated that they would prefer to stay with their children at a centre they would be keen to participate in an activity within the same building.

Water, sanitation and hygiene

Access

The majority of households had access to running water and facilities to boil water. For preparing drinks and food for infants the majority in Kramatorsk and Slovianske used bottled and tap water. Well use was more

common in Svitohirske than the other areas. (Table 11) FGD participants expressed the belief that bottled water was safe for babies as it was sterile.

Table 11: Percentage of household in HHQs (n=253) with access to running water, facilities to boil water and the sources of water used for preparing children’s food and drink

| | All | Region | | |
|---|------|-------------|------------|------------|
| | | Svitohirske | Kramatorsk | Slovianske |
| Access to running water | 97.6 | 97.1 | 97.5 | 98.1 |
| Facilities to boil water | 98.8 | 97.0 | 98.7 | 100.0 |
| Main source of water used for preparing drinks | | | | |
| <i>Bottled</i> | 56.5 | 32.4 | 68.4 | 63.2 |
| <i>Tap</i> | 30.0 | 38.2 | 22.8 | 30.2 |
| <i>Well</i> | 7.1 | 23.5 | 1.3 | 0.9 |
| <i>Water pump</i> | 0.4 | 1.5 | 0.0 | 0.0 |
| <i>Other^a</i> | 5.9 | 4.4 | 7.6 | 5.7 |
| Main source of water for preparing food | | | | |
| <i>Bottled</i> | 44.3 | 22.1 | 51.9 | 52.8 |
| <i>Tap</i> | 44.3 | 48.5 | 40.5 | 44.3 |
| <i>Well</i> | 7.9 | 25.0 | 3.8 | 0.0 |
| <i>Water pump</i> | 0.4 | 1.5 | 0.0 | 0.0 |
| <i>Other^b</i> | 3.2 | 2.9 | 3.8 | 2.8 |

^a Other: boiled, filtered, don't give; ^b Other: boiled, filtered, don't give

Soap use

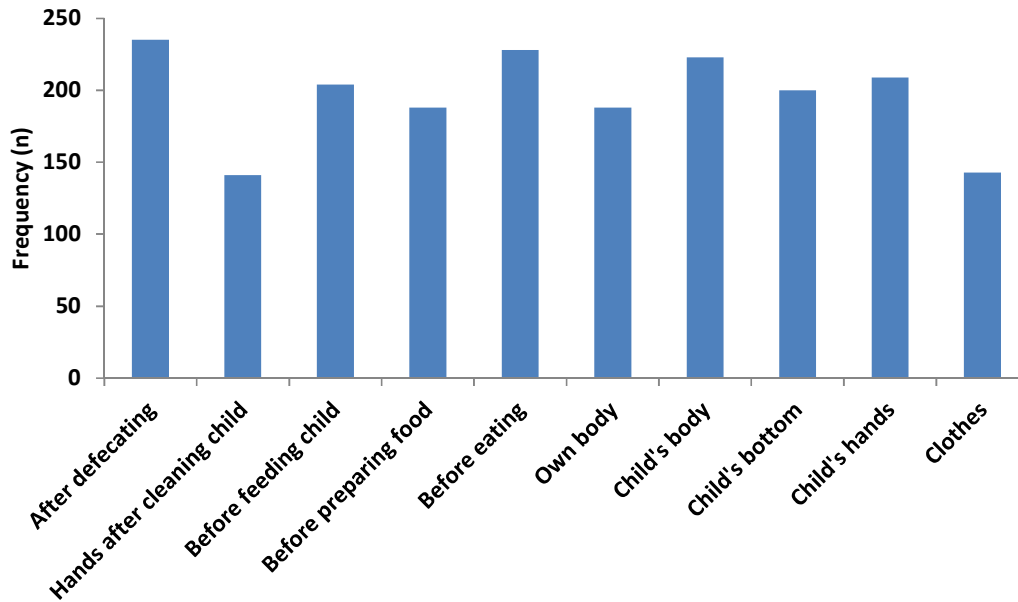
All HHQ participants had access to soap; the frequency of use is summarised in Table 12. Mothers from FGDs in Svitohirske once in 4 months had received a package from UNICEF containing soap with other hygiene and sanitation products, otherwise they had purchased soaps. In other locations mothers reported not having received soap and hygiene products since the previous summer. Mothers were also purchasing children’s laundry detergent, which had never been received in assistance.

There was an expressed need by both NGOs and mothers in all locations for baby hygiene products such as creams, detergent, shampoo, soap, and diapers.

Table 12: Frequency of soap use

| Soap use in the last 48 hours | All | Region | | |
|-------------------------------|------|-------------|------------|------------|
| | | Svitohirske | Kramatorsk | Slovianske |
| <i>0-4</i> | 1.6 | 1.5 | 0 | 2.9 |
| <i>5-10</i> | 22.7 | 26.5 | 16.5 | 25.0 |
| <i>>10</i> | 75.7 | 72.1 | 83.5 | 72.1 |

Figure 12: Frequency for different uses of soap in the last two days by 253 HHQ respondents



Acute malnutrition

Medical professionals who participated in interviews had also not seen any cases of malnutrition. There were no HHQ infants assessed as having acute malnutrition. All children aged 6 -23 months old had a normal MUAC⁸ (>125mm), ranging from 132 - 202mm with an average of 162.1mm (SD=12.25).

⁸ The prevalence of low MUAC, an independent indicator for acute malnutrition and a predictor of mortality, is measured for children 6 to <24 months of age, with the cut-offs of <115mm for severe acute malnutrition, and 115mm to <125mm for moderate acute malnutrition and >125cm considered normal. MUAC is currently not recommended for infants < 6 months.

Discussion

The cross-sectional purposive assessment on the feeding practices of infants and children under-two years of age among the IDP population was facilitated by Save the Children, with support from UNICEF, in the non-government controlled Donetsk oblast, eastern Ukraine, during the period of 05-13 June 2015.

The purpose of the assessment was to address the need for timely and reliable information on the status and practices amongst the most vulnerable groups and contribute to the evidence base for interventions directed at supporting, protecting, and promoting appropriate IYCF practices of children under two years of age.

Three cluster locations were selected for the assessment, Svitohirske, Slovianske and Kramatorsk, with locations agreed between the Save the Children and UNICEF.

Triangulation of household questionnaires (HHQs) with focus group discussions (FGDs)/community group discussion (CGD) and interviews with key informants (KIIs) was applied, to provide for diversity and plurality of information, which might not otherwise have been revealed through the HHQs alone, as well as to provide qualitative information.

This discussion provides a synthesis looking across the assessment's qualitative and quantitative findings from the various methods and participant groups, and provides clear recommendations for actions directed at protecting, promoting and support safe and appropriate IYCF within the current crisis context in Ukraine.

Limitations of the assessment

The assessment provides insight into the feeding practices of infants and young children under 24 months of age, but cannot be considered as representative of the feeding practices of the general IDP population of this age group in GCAs Donetsk Oblast for the following reasons: HHQ small sample size (children under 6 months n=29), sampling not proportional to population size, the sample being from an urban populations in three defined geographically easily accessible locations, and household lists having been accessed from a limited number of NGO databases of IDP household receiving humanitarian assistance and from polyclinics. Cited sources and types of HHQ assistance could be biased/weighted based on the NGO from which the household lists were accessed.

However there were differences between the characteristics of the clusters in each location, for example in terms of size, access, services and dwelling type. *(See Annex 2)*

Although stratification of sample size per cluster size was attempted, this was not possible due to the low response rate, challenges with securing household lists and lack of information on the total IDP population in the assessment locations. The low response rate was due to 59 households not being contactable, 36 households refused, and 92 households having had left the area -with a high 36.3% in Svitohirske. Enumerators reported weak mobile transmission coverage nearer the conflict line being the main reason households could not be contacted.

When considering the reporting by medical professionals, bias could be introduced due to the informants having been selected by their regional Head Paediatricians. In Slovyansk the polyclinic was registered as a Baby-friendly Hospital.

In total 258 household interviews, 4 Four FGD (45 individuals including 43 mothers and 3 fathers), 1 CGD (24 women and men) and 16 KIIs (10 health facility staff -birth, pre-natal and post-natal clinics-, 3 city administration representatives, 1 representative from a local NGO and 2 representatives from distribution centres).

Household demographics

Of the total 440 households randomly selected to participate in the HHQs, 253 primary caregivers were available to complete the interview, the number per cluster location being: Slovianske: 106; Kramatorsk: 79; Svitohirske: 68. This included 29 infants 0-5 months; 76 children 6-11 months; 66 children 12-15 months; 37 children 16-19 months; 50 children 20-23 months of age. There were 139 males and 119 females.

Note that where a selected primary caregiver had more than one child under 2 years of age, both children were included in the assessment, with a separate interview facilitated for each child.

Of the participating households, the mean household size was four, with one child under 2-years and 0.3 children between 2-5 years of age. The average age of the mother/primary caregiver was 30 years. Average displacement time for a household was 8.3 months (range 0-16 months). The majority (87.4%) of IDPs in Slovianske and Kramatorsk were living in rented accommodation, compared with Svitohirske where 41.2% were housed in rented accommodation and 41.2% in collective centres. Over all three locations only 9.7% lived with relatives. There was no significant difference between income level or education level of the mother/primary caregiver across the three clusters.

IYCF practices in the assessment locations

In accordance with the recommendations of the WHO, UNICEF and the MoH of Ukraine, infants should receive breast milk exclusively until the age of 6 months, followed by the introduction of soft, semi-solid and solid complementary foods, while continuing breast-feeding up to the age of two years or beyond.

The IYCF assessment indicates that since the onset of the crisis, based on comparison with 2012 data,⁹ there is suspicion of: an increase in early initiation of breastfeeding within 1 hour of birth; a decline in exclusive breastfeeding rates (infants under 6 months); decline in predominant breastfeeding (infants under 6 months); small decline in continued breastfeeding at 1 year; large decline in continued breastfeeding at 2 year; there is early introduction of solid, semi-solid and soft food; an increase in the proportion of children 6-23 months of age receiving the minimum meal frequency; an increase use of bottles by infants artificially fed.

The current state of IYCF practices within and between IDP populations, as based on the WHO key indicators^{10, 11} are discussed below.

*Early initiation of breastfeeding*¹² of the assessed children in the HHQ was 76.3% within 1 hour after birth and 16.2% within 24 hours after birth. Initiation within 1 hour after birth was higher than the 61.5% found for eastern Ukraine in the MICS 2012¹³

Health professionals reported that the small percentage of mothers who do not initiate breastfeeding are mainly mothers with HIV, TB or other medical reasons where breastfeeding is not recommended by the Ukraine MoH.

⁹ Ukraine Multiple Indicator Cluster Survey Final Report. 2012

¹⁰ WHO, 2002, Global Strategy on Infant and Young Child Feeding, <http://www.who.int/nutrition/publications/infantfeeding/9241562218/en/index.html>

¹¹ <https://www.humanitarianresponse.info/en/applications/ir/indicators/global-clusters/9?search=&page=3>

¹² This indicator defines the percentage of infants and young children <24 months who were put to the breast within one hour of birth, as based on historic recall

¹³ Ukraine Multiple Indicator Cluster Survey Final Report. 2012

Early initiation of breastfeeding has benefits to both mother and infant. Optimal practice, defined as putting the infant to the breast within one hour of delivery, ensures that the baby receives colostrum, the rich early breast milk produced by the mother during the first few days after delivery. Colostrum contains high concentrations of essential nutrients and antibodies that provide infants with immune protection from infection and it has been shown to reduce the risk of neonatal mortality. Breastfeeding immediately after delivery will facilitate expulsion of the placenta and promote stronger uterine contraction thereby reducing the risk of maternal postpartum haemorrhage and reducing neonatal hypothermia. When the infant remains with the mother and is put to the breast soon after delivery, production of the main breast milk is stimulated¹⁴ and milk flow established thereby helping to prevent breast engorgement. Mothers who initiate breastfeeding within one hour are likely to encounter fewer problems and maintain breastfeeding for a longer period. Breastfeeding soon after birth also facilitates emotional bonding of the mother and baby.

All newborns should ideally receive skilled care at birth (preferably in a health facility) and receive early and exclusive breastfeeding. They should be assessed for any problems, particularly breastfeeding difficulties.

Breastfeeding promotion activities targeted towards women during pregnancy are required, so they make the decision to breastfeed within 1 hour after birth.

*Exclusive breastfeeding rate for infants <6 months*¹⁵ (defined as infants under-6 months who are receiving only breast milk and no water, other liquids or solids¹⁶) of 13.8% was below the MICS 2012 rate of 21.3% for Eastern Ukraine.¹⁷ Rates were not significantly different considering gender, income or having a child older than 2 years of age. The low rates of exclusive breastfeeding are of concern, considering the immunological, nutritional, financial and protective benefits of exclusive breastfeeding and the risks of introducing other food and liquids too early, particularly with the current context in Ukraine increasing risk of infection. Reports of extended exclusive breast feeding, by three FGD participants, (one to 10-months of age) due to lack of affordability of food and cooking facilities is of concern, as extended exclusive breastfeeding increases risk of under-nutrition, illness and interruption to growth¹⁸

Exclusive breastfeeding for the first 6 months of life provides a range of benefits for infants' health, growth and immunity. Breast milk provides all the energy, nutrients and fluid required in the first six months of life and its composition is constantly adjusting to the child's needs, according to her/his age, appetite and the external temperature. Breast milk has special fats for brain development and important antibodies against common childhood illnesses and infections, including diarrhoea, respiratory and ear infections and allergies¹⁹ and which build a strong foundation against illness later in life. Protection through breastfeeding is greatest in younger infants. While some breast milk is seen as better than none, a number of studies have suggested that the immunity benefits for babies come only with exclusive breastfeeding; the risk of morbidity and mortality due to diarrhoea and other infections can increase many-fold in infants who are either partially breastfed, or not breastfed at all. Breast milk is clean, safe, at the right temperature and easily digestible. Breastfeeding is always considered safer than other feeding practices for young children, whose immune systems are still developing, as preparation, consumption and conservation of alternatives products require access to clean water and good hygiene and to be available and affordable. Beside its intrinsic benefits, breast milk does not require preparation, packaging, storage, transportation or refrigeration. Additionally, breastfeeding stimulates physical and emotional bonding between the mother and her child.

Breastfeeding also has positive influences on mothers' health, both in the short and long term. As well as aiding mother's recovery after birth, breastfeeding offers protection from iron deficiency anaemia, provides a natural method of delaying the return of fertility (the Lactational Amenorrhoea Method), and reduces the risk of breast and ovarian cancer and type 2 diabetes.

¹⁴ UNICEF. Improving child nutrition: the achievable imperative for global progress. 2013

¹⁵ WHO. Nutrient adequacy of exclusive breastfeeding for the term infant during the first 6 months of life. 2002

¹⁶ An infant may receive drops or syrups of "vitamins, mineral supplements, or medicines" and still be considered exclusively breastfed, however vitamins/medicines may *not* be diluted with water.

¹⁷ Ukraine Multiple Indicator Cluster Survey Final Report. 2012

¹⁸ WHO. Feeding and Nutrition of Infants and Young Children: Guidelines for the WHO European Region, with Emphasis on the Former Soviet Countries. WHO Regional Publications, European Series, No. 87. 2000

¹⁹ UNICEF. 2013. Improving child nutrition: the achievable imperative for global progress

The benefits of exclusive breastfeeding until 6 months of age, and the risks of introducing other foods and drinks at an earlier age, need to be widely communicated at community and health facility levels, supported by building the capacity for the provision of skilled support for women with breastfeeding difficulties.

The proportion of children born in the last 24 months who were ever breastfed is a reflection of the 'culture' of breastfeeding and of care practices around childbirth. Based on 24-hour historic recall, of children 0-23 months 85.8% were ever breastfed, which is lower than the 96.7% reported in eastern Ukraine in 2012.²⁰

Predominant breastfeeding of infants <6 months of age of 20.2% was much lower than 49.5% found in eastern Ukraine in the MICS 2012. Predominant breastfeeding showed no significant difference by sex ($p=0.79$), and income ($p=0.79$) but was significantly affected by having a child over 2-years ($p=0.019$). Previous generations promoted the use of water for infants exposed to hot ambient temperatures and herbal teas (commonly camomile and dill or fennel tea and dill water) as digestives and calmatives, and these practices are still seen.

Predominant breastfeeding is considered not 'exclusive' as it 'allows' ORS, vitamin and/or mineral supplements, ritual fluids, water and water based drinks, and fruit juice by a breastfed child. Other liquids, including non-human milks and food-based fluids, are not allowed, and no semi-solid or solid foods are allowed. Predominant breastfeeding has been shown to be associated with substantially lower risk of deaths compared with partial or no breastfeeding, however has been associated with an increased risk of illness from diarrhoea compared to children who are exclusively breastfed. This risk is heightened in contexts where safe water cannot be assured.

Considering the use of herbal teas, a practice encouraged by some health professionals, fennel is believed to stimulate digestion, through relaxing the gastrointestinal tract and getting rid of gas and thereby relieve colic pains; camomile to be a calmative and relaxant. However, herbal teas of dried or fresh flower heads can also contain bacteria and other contaminants, which increase the risk of a young child getting sick. Herbal teas may also have an inhibitory effect on non-haem iron absorption, as for other teas, therefore all types of tea - black, green and herbal- should be avoided until at least 24 months of age. Although there is a lack of scientific data on the safety of various herbs and herbal teas for infants, owing to their small size and rapid growth rate infants are potentially more vulnerable than adults to the pharmacological effects of some of the chemical substances present in herbal teas. Additionally, although fennel is known as a lactogen, excessive maternal consumption of herbal tea containing fennel has been shown to cause toxicity in newborns, consistent with the toxicity caused by the compound anethole found in fennel²¹

"Mothers sometimes give their sick children under 6-months berries with a lot of vitamins and honey"
(Paediatrician in Kramatorsk)

Caregivers and health professionals need to be aware of the risks of using herbal teas and be guided on other ways to reduce gas and calm babies, such as through massage. Messaging is required to inform caregivers that breastmilk contains all the water a baby needs, even in hot weather; the foremilk, found at the beginning of feeding, is particularly high in well absorbed water to satisfy baby's thirst.

Duration of breastfeeding, the average age of the child when s/he stopped breastfeeding, was 8.3 months. Continued breastfeeding at 1 year was 31.8% and at 2 years was 14.0%, lower than the MICS 2012 rates of 33.4% and 31.1% respectively.²² Similar trends are seen across assessment locations. This does not meet the Ukraine MoH, WHO and UNICEF recommendation to breastfeed for 2 years or beyond nor reflect FGD participants' range of opinions that breastfeeding should continue for 12 - 24 months, as expressed by the health professionals, except for one who said:

"I do not promote a duration as this is up to the mother to decide". (Health professional)

²⁰ Ukraine Multiple Indicator Cluster Survey Final Report. 2012

²¹ www.drugs.com

²² Ukraine Multiple Indicator Cluster Survey Final Report. 2012

The majority of HHQ respondents believe that breastfeeding should be continued to 12-18 months, showed similar trends across education levels; however for income, the higher income level (>4500UAH) were more likely to think breastfeeding should be continued until 6-11 months and less likely to have the opinion that breastfeeding should be continued until 12-18 months, compared other income levels.

"I kept breastfeeding for longer than 1-year with younger child due to stress and hard to cook for child. I don't know when to stop." (Mother, Svitohirske)

"For my elder child I breastfed for a long time. For my twins I stopped breastfeeding when they were 3 months. We changed places three times since we had to leave home."(Mother, Kramatorsk)

The main reason given for stopping breastfeeding reported in HHQs was stress due to the conflict (28.1%) followed by being out of milk (13.2%). In a minority of cases (6.1%) the reason was insufficient food for mother. "Milk drying up" was reported by FGD participants and health professionals to be a more common in IDP mothers. Duration of breastfeeding has also been adversely affected by the cold, due to full, sore breasts and cracked nipples during cold weather, and, since the onset of the conflict, also due to lack of hot water in some dwellings. A few mothers reported that they were separated from the infant due to the conflict and they had trouble to re-establish breastfeeding. A few health professionals had observed that IDPs were more stressed and asking more questions about maintaining lactation, seeing continuing breastfeeding as more of a priority than the local population.

Constraints on mother's caring capacity were also indicated by expressed: lack of time able to wait in distribution queues due to having other children to care for; lack of social connection with other mothers in locations of displacement; lack of privacy (in some collective centres); limited finances (and access to food preparation facilities for some) to enable provision of complementary foods of choice.

Breast milk continues to be an important source of energy and nutrients in children 6–23 months of age. It can provide one half or more of a child's energy needs between 6 and 12 months of age and one third of energy needs between 12 and 24 months.

The physical, psychological, emotional and social dimensions of a child and mother's health and well-being can have a considerable impact on IYCF practices. The particular needs of caregivers who are grandparents, single fathers or siblings must also be considered. In emergency contexts, social destruction, displacement and physical violence suffered by the population can impact on psychosocial wellbeing. Families in eastern Ukraine have experienced extreme stress, such as witnessing death, family separation, loss of possessions and shelter, limited income and access to financial resources, disrupted food and social support systems, and roles and responsibilities have been altered at family level, including an increased number of mothers being the sole caregivers in their location of displacement. Psychological trauma and stress can produce changes in behaviour and emotions and disrupt caring capacity, including stimulation and responsiveness supportive of optimal IYCF practices.

Stress may interfere with milk flow, through temporarily interrupting the milk let-down reflex, although milk production continues based on a hormone-controlled supply-demand basis. Frequent suckling by baby at the breast promotes milk flow and produces hormones that calm mother and baby.

Mothers may require psychosocial and lactation counselling to support continuing, or re-establishing, breastfeeding. Participation in social activities (such as peer support groups and action-oriented groups) can also play an important role in reducing stress and supporting optimal breastfeeding practices.

Age appropriate breastfeeding (0-23 months), a summary measure of the proportion of children <2 years who are appropriately breastfed and who receive complementary foods when needed, was 33.4% for HHQ infants and young children <24 months.

Of those children 0-23 months ever breastfed, 19.4% of infants were breastfed on a schedule. Breastfeeding on demand, whenever the baby wants to breastfeed rather than on a schedule, is recommended for healthy babies who can suck effectively. Breastfeeding on demand has many benefits, including helping to regulate maternal milk production and infants intake and prevent engorgement of mothers breasts and in the first few days post-delivery breastfeeding on demand promotes the earlier

passage of meconium, helps establish breast milk flow, and reduce jaundice.^{23,24}

Considering the use of infant formula, feeding of infant formula alone for infants under-6 months is not a common practice at only 13.8% of infants in HHQs and limited self-reports in FGDs and mixed feeding of infant formula and breast milk is practised by 24.1%.

However for children 6-23 months 50.2% had consumed infant formula in the 24 hours before the interview. Predominant infant formula brands used are the Ukrainian brands Malutka and Malysh, as they are the brands being provided in humanitarian assistance, and the cheapest at 57-200UAH for one packet -which lasts three days. Malutka was commonly reported as being not liked, allergenic and to cause diarrhoea.

Breast milk substitutes (BMS),²⁵ including infant formula, otherwise termed 'artificial milk', lack breast milk's precise infant-specific balance of nutrients and appropriate temperature and do not contain antibodies to protect against illness. Babies who receive BMSs have increased risk of infection, compared to exclusively breastfed babies under 6-months of age, via bacteria and parasites that can contaminate water supplies, infant formula and feeding equipment during preparation and use. BMSs may also be incorrectly prepared and are more difficult to digest. Additionally, a child who is not breastfed may receive less attention from and stimulation by his/her mother.

Mothers should be supported to exclusively breastfeed infants under 6 months, and continue breastfeeding until their children are 2 years of age. Infant formula for infants under 6 months of age should only be used for medical reasons, based on assessment and ongoing growth support by a health professional. Those infants under 6 months who are mixed fed (given both breastmilk and infant formula) should be supported to move to exclusive breastfeeding, as breastmilk production works on a supply-demand basis, therefore when not exclusively breastfeeding mothers will make less breastmilk. Where the need for artificial feeding is indicated, mothers and caregivers need assured access to adequate amounts of an appropriate infant formula for as long as is necessary (until infants are at least 6 months old) as well as to the associated essential supports, including cups, safe water, fuel, storage facilities, growth monitoring, medical care, time.

Bottle feeding is very common with 72.5% of HHQ infants fed from a bottle with a teat the previous day, consistent across all assessment areas. This is higher than the MICS 2012 report of bottle feeding at <6 months of 59.2% and at 6-23 months 66.6%.²⁶

Even though a spoon is provided with Malysh and Malutka infant formula the majority of FGD participants fed infant formula from a bottle. Slavyansk Heart in Svitohirske had been given bottles to distribute, but the organisation accessed cups with covers for one distribution, aware of the concerns regarding use of bottles.

Feeding bottles and teats should not be used. Bottles and teats need to be thoroughly cleaned with a brush and then boiled to sterilize them, which requires adequate fuel, time and hygienic conditions, or the risk of babies getting diarrhoea is increased; these are often constrained in emergency contexts. Feeding an infant from a bottle with a teat may also make it more difficult for the baby to learn to attach well at the breast due to "nipple confusion" and has been associated with compromised breastfeeding frequency, intensity and duration, as well as increased risk of dental disease and otitis media²⁷. Bottle feeding also increases the risk that the infant will receive inadequate stimulation and attention during feeds.

If an infant cannot feed directly from the breast, or the mother is unable to breastfeed, use of a cup rather than a bottle is recommended. Cups are safer than bottles because they are easier to clean with soap and water and are less likely than bottles to be carried around for a long time, thereby giving bacteria the opportunity to multiply. Use of cups prevents nipple confusion. Cup feeding also requires the mother or

²³ <http://www.tensteps.org/step-8-successful-breastfeeding.shtml>

²⁴ <http://www.lli.org/nb/nbjulaug03p126.html>

²⁵ A breastmilk substitute (BMS) includes any food being marketed or otherwise presented as a partial or total replacement for breastmilk, whether or not suitable for that purpose. Note: In practical terms, foods may be considered a BMS depending on how they are marketed or represented. These include infant formula, other milk products, therapeutic milk and bottle-fed complementary foods marketed for children of up to two years of age and complementary foods, juices and teas marketed for infants under six months.

²⁶ Ukraine Multiple Indicator Cluster Survey Final Report. 2012

²⁷ WHO. Feeding and Nutrition of Infants and Young Children: Guidelines for the WHO European Region, with Emphasis on the Former Soviet Countries. WHO Regional Publications, European Series, No. 87. 2000

other caregiver to hold and have more contact with the infant, thus providing more psychosocial stimulation than with bottle feeding.

When infant formula is provided, it should be accompanied by provision of cups, information on the risks of using bottles and teats and guidance on feeding with cups.

Introduction of soft, semi-solid and solid food (6-8 months) was common before the recommended age of 6 months in the sampled population. The majority (83.3%) of HHQ children aged 5-months were receiving food, and 33.3% of 4-month olds. Age of introduction was not significantly associated with education status ($p=0.12$), job status ($p=0.84$), household income ($p=0.46$) or accommodation type ($p=0.76$). Differences were not tested for other variables due to consistent results and/or small sample sizes.

A common concern mothers of infants under-6 months report to health professionals is that their breast milk does not have enough fat and their child is hungry. Some mothers in FGDs reported introducing foods and liquids at 3 to 4 months as the packets of commercial baby food give this advice. That some infant food packages and baby food companies' leaflets promote the introduction of foods before 6 months of age does not conform to the health professionals reported advice, nor the MoH and WHO recommendations, to introduce complementary foods at 6 months of age. Introducing foods later than the recommended ages is also of concern, as found with three HHQ infants given food at 9-12 months-old, and FGD mothers citing introduction at 8-months and 10-months.

"Some mothers feed their 1-month old babies because their mothers believe their milk was is enough."
(Paediatrician and Neonatologist, Slovianske Child Health Clinic)

Timely introduction of appropriate complementary foods promotes good health, nutritional status and growth of infants and young children during a period of rapid growth. The target range for complementary feeding is 6-23 months. Around the age of 6 months, an infant's need for energy and nutrients starts to exceed what is provided by breast milk and nutritionally adequate safe and appropriate complementary foods, in addition to breast milk, are necessary to meet energy and nutrient requirements. At about 6 months of age, an infant is also developmentally ready for other foods. Breastfeeding remains important until the age of 2 years, so to ensure breast-milk volume is maintained mothers should continue to breastfeed their infants frequently during the period of complementary feeding²⁸

Too early an introduction of complementary foods and fluids increases the risk of infection and reduces the benefit of exclusive breastfeeding. Too late an introduction can result in interruption of growth, under-nutrition and an increased risk of illness²⁹

Rates of malnutrition among children usually peak during the time of complementary feeding. Growth faltering is most evident between 6-12 months, when foods of low nutrient density begin to replace breast milk and rates of diarrheal illness due to food contamination are at their highest.³⁰

Optimal complementary feeding is a process of introducing foods with an increasing variety of texture, flavour, aroma and appearance.

In the assessment, commonly given first foods were commercial fruit/ vegetable purees (potato, pumpkin, zucchini, and cauliflower) and porridges, and homemade semolina. Additionally to these health professionals recommended curds and fruit juice, with introduction of egg yolk at 7-8 months (as introduced for 40% of HHQ infants), meat and poultry around 7-8 months, fish at 9 months, cow's milk for drinking at 10-12 months.

In the 7 days prior to the HHQ assessment, of infants aged 6-8 months: over 90% had consumed commercial fruit/ vegetable purees; over 80% commercial porridges; 27% homemade porridges (rice, oat-wheat, wheat); 58% had consumed fresh fruits; 54% fresh vegetables, though dark green vegetables are not widely available

²⁸ WHO. Feeding and Nutrition of Infants and Young Children: Guidelines for the WHO European Region, with Emphasis on the Former Soviet Countries. WHO Regional Publications, European Series, No. 87. 2000

²⁹ WHO. Feeding and Nutrition of Infants and Young Children: Guidelines for the WHO European Region, with Emphasis on the Former Soviet Countries. WHO Regional Publications, European Series, No. 87. 2000

³⁰ Save the Children. Nutrition in the first 1,000 days: State of the world's mothers. 2012

or consumed, due to their high cost); 30% cottage cheese; 50% were receiving homemade meat -this increased to 80% in infants older than 12-months.

Soups eg 'borsch' are also given. Just over 50% of children 19-23 months had eaten eggs in the 24 hours prior to the HHQ, which is lower than pre-crisis consumption of 94.2% for children up to 3-years,³¹ reportedly due to the high price (24UAH for 10 eggs)³². Mothers reported preferring to make home-made purees, due to commercial products being expensive, and to not adding fat and sugar to porridge.

"I prepare porridge with a mixture of rice, oat-wheat, wheat, adding a special milk for children and fruit, like apple, banana or strawberries" (Mother in Slovianske)

"I suggest oat wheat, corn or buckwheat for first cereals, 50% milk and 50% water, with no/little added sugar and olive oil if needed" (Health professional)

"Previously they practiced to introduce juice and soft food since 1 month. Now strongly recommended not to give earlier than 6 months –though sometimes there are individuals who seek and follow doctor's advice and other mothers who consider they otherwise know the best."(Paediatrician and Neonatologist, Slovianske Child Health Clinic)

The too-early introduction of unmodified cow's milk and milk products is an important nutritional risk factor for the development of iron deficiency anaemia and gastrointestinal bleeding³³ Unmodified cow's milk should not therefore be introduced as a drink until the age of 9 months and thereafter can be increased gradually; it can however be used in small quantities, 50% water/50% milk, in the preparation of complementary foods from 6-9 months of age. Reduced fat cow's milk should not be given before the age of about 2 years, because of the low energy density but also because protein constitutes a considerably higher proportion of the energy.

Egg proteins contain amino acids, providing a valuable means of improving the intake of animal protein important to growth and development. Egg protein has been associated with allergic reactions and should therefore not be introduced before the age of 6 months. Eggs are often thought of as a good source of iron, however, though their iron content is relatively high the iron is bound to phosphoprotein and albumin and is therefore not very bioavailable.

Fruit juices are a good source of vitamin C, and if given as part of a meal will improve the bioavailability of non-haem iron present in plant foods. It is nevertheless important to limit the volume given to avoid interfering with the intake of breast-milk and with the diversification of the diet. Furthermore, fruit juices contain sugars which, due to their acidity, can cause dental caries and erosion of the teeth.³⁴

³¹ S. Nyankovskyy et al., Dietary habits and nutritional status of children from Ukraine during the first 3 years of life, *pediatriapolska* 89 (2014) 395 -40

³² S. Nyankovskyy et al., Dietary habits and nutritional status of children from Ukraine during the first 3 years of life, *pediatriapolska* 89 (2014) 395-40

³³ WHO. Feeding and Nutrition of Infants and Young Children: Guidelines for the WHO European Region, with Emphasis on the Former Soviet Countries. WHO Regional Publications, European Series, No. 87. 2000

³⁴ WHO. Feeding and Nutrition of Infants and Young Children: Guidelines for the WHO European Region, with Emphasis on the Former Soviet Countries. WHO Regional Publications, European Series, No. 87. 2000

Consumption of iron-rich or iron-fortified foods (6–23 months) can reduce the risk of anaemia. The HHQ iron-rich food category was limited to ‘meat’ intake. Of young children, 73.4% ate meat the previous day, and 9.6% commercial meat puree. The average frequency of consumption was 4.5 times in the past 7 days, ranging from 0 to 7 times. FGD participants believed meat was good for their young child, but amount per serving and frequency of consumption was constrained by affordability. Given that some infants are receiving no meat and others very small amounts, that green leafy vegetables are rare in Ukraine and consumption of peas/beans consumed by only a minority of infants (<10%), their diets may well be deficient in iron.

Optimal iron stores at birth are important for the prevention of iron deficiency in the infant and young child. Anaemia lowers resistance to disease and weakens a child’s learning ability and physical stamina. To help ensure good infant iron stores, the mother should eat an iron-rich diet during pregnancy. Studies suggest that pregnant women who take iron and folate supplements not only lower their risk of dying in childbirth, they protect maternal stores and breast milk content and thereby enhance the intellectual development of their babies. A full-term infant should have iron stores to last 6 months. Of note, 50% of iron in breast milk is absorbed (due to lactoferrin “milk iron”) compared with 7% of iron from infant formula.

When complementary foods are introduced at about 6 months of age, it is important that iron-rich foods such as liver, meat, fish and pulses or iron-fortified complementary foods are included. Even small amounts of lean meat can have positive effects on young children’s growth. Lean meat contains substantial amounts of protein of high biological value, and is an important source of highly bioavailable minerals such as iron and zinc. Meat used in complementary foods should be minced, chopped or puréed.

The assessment key informant health professionals did not have available data on current anaemia rates of young children but suggested that they were between 18% and 20% for their service areas, with no differences in anaemia rates between IDPs and locals. These rates are below the MoH target of 21%.³⁵ The protocol at health clinics for testing for anaemia in infants is to test at 9 months, unless symptoms are present, and diagnosed anaemia treated with liquid iron supplements and dietary advice including not giving whole milk but to give fruit juice and to include vegetables, fruit and meat in the child’s food, and to stop giving tea after food.

Women are recommended to take iron and folate tablets when planning a pregnancy or starting from the first term of pregnancy. These must be purchased out-of-pocket and FGD participants reported that due to their high price they were not being purchased. Maternal anaemia rates were thought to be high, with 30% estimated by one health professional key informant. The protocol for testing for anaemia during pregnancy is to test during the first visit to the doctor, and at 30 weeks, unless women report feeling ill. Treatment of anaemia is recommended through diet (including not drinking tea with meals) and ferrum supplements for 2nd or 3rd level anaemia.

“If the mother is breastfeeding I would not suspect anaemia and that if the child was growing well they would not consider nutrition.” (Kramatorsk Paediatrician)

Monitoring of anaemia rates in Ukraine is required. Support for maternal purchase of iron-folic acid supplements and distribution of point-of-use micronutrient powders for children 6-23 months need to be considered.

Dietary diversity (children 6-23 months) is a proxy for the adequate micronutrient-density of foods.

Dietary diversity for HHQ children, based on 24-hour recall and scored based on six groups³⁶, comprising grains, dairy, fruit and vegetables, peas/beans, eggs and meat sources, was reached by 77.7%. Fewer children reached the minimum dietary diversity in the younger age groups, in ‘other’ accommodation type and collective centres.

³⁵ <http://data.worldbank.org/indicator/SH.ANM.CHLD.ZS>

³⁶ Minimum Dietary Diversity (MDD) (≥4 food groups in the last 24 hours) is typically calculated based on the WHO food groups, however this was not possible due to limitation in the food group categories in the household questionnaire 24-hour recall and 7-day recall. Scoring was instead based on the following groups: grains (porridges, breads, noodles, vermicelli, crackers); dairy (infant formula, animal milk, cheese); fruit and vegetables (including potatoes); peas/beans; eggs; meat sources (red meat, poultry, fish, offal). ‘Vitamin-A rich fruit and vegetables’ and ‘Legumes and Nuts’ were not included.

Minimum meal frequency (6-23 months), defined as the percentage of children receiving the minimum number of meals in the last 24 hours, at 94.7% was high across all assessment areas (slightly lower in those children not breastfed), higher than the 67.2% reported in MICS 2012.³⁷

The number of meals an infant or young child requires in a day depends on how much energy the child needs (and, if the child is breastfed, the amount of energy needs not met by breast milk), the amount that a child can eat at each meal, and the energy density of the food offered. When energy density of the meals are between 0.8–1 kcal/g, among children who are breastfed, the recommended minimum meal frequency with solid, semi-solid or soft food is two times or more per day for children aged 6-8 months of age, and at least three times for those aged 9-23 months. For non-breastfed children aged 6-23 months, the recommended minimum meal frequency, defined as solid, semi-solid or soft food and milk feeds, is at least four times per day³⁸.

Based on dietary diversity and minimum meal frequency the consumption of soft, semi-soft and solid foods of young children 6-23 months of age appears adequate. However, during winter and spring months dietary diversity may be compromised due to seasonal impacts on food availability and price. To gain a more comprehensive understanding of intake, future assessments should include assessment of the consumption of vitamin A rich vegetables, dark green leafy vegetables, and nuts and legumes food groups.

Acute malnutrition

All HHQ children aged 6 -23 months had a normal MUAC (range 132 - 202mm) and medical professionals who participated in interviews reported not having seen any cases of malnutrition.

However, considering the poor IYCF practices, and the associated underlying and basic causes of malnutrition³⁹, there is risk of under-nutrition amongst this vulnerable population, especially with the prolonged duration and effects of the conflict.

Structures and services to support safe and appropriate IYCF practices

Registration to access support

Registration of households as being displaced and receiving assistance enables families to be visible, so that they can access targeted support services. Registration of births with civil authorities, by caregivers, has reportedly continued in GCAs since the beginning of the crisis, as it enables families to receive child social services benefits.⁴⁰

Of the 258 children < 2 years of age included in the HHQs, 98.8% were registered at a polyclinic. Health key informants reported access to be available equitably to the IDP and local populations, and no-one would be refused care if they did not have the requested documents. A few health professional key informants reported that IDPs showed an increase in health seeking behaviour, as they attended the clinics to receive humanitarian assistance provided clinics by charitable organizations and volunteers; for this reason some social groups were registered who would have been less likely to register before the conflict.

Registration for displacement and registration for assistance, as self-reported in HHQs, was high at 97.2% and 90.5% respectively. Of these 99.2% were registered as displaced with the Ministry of Social Policy and 96.2% registered for assistance with humanitarian organisations, with registration for assistance typically completed within one month of application.

Baby food aid for children under 2 years of age

³⁷ Ukraine Multiple Indicator Cluster Survey Final Report. 2012

³⁸ Ukraine Multiple Indicator Cluster Survey Final Report. 2012

³⁹ <http://www.unicef.org/nutrition/training/2.5/4.html>

⁴⁰ Ukraine Multiple Indicator Cluster Survey Final Report. 2012

Links with food security programmes are essential to support complementary feeding in emergency contexts. Food security responses should aim to meet short-term needs, 'do no harm', reduce the need for the affected population to adopt potentially damaging coping strategies, and contribute to restoring longer-term food security. Understanding the market capacity and the appropriate modality for delivery (eg food baskets, cash or voucher transfers or grants) is critical to designing food security interventions. For food distributions, the target beneficiaries nutrient needs, digestive and physical capacities, and social and traditional preferences as well as the ability to store, prepare and cook food should be considered in informing the choice of commodity.

The IYCF Assessment provided information on the availability, acceptability, and appropriateness of complementary food items and distribution methods.

Since January 2014 cash/vouchers, food, non-food or baby food assistance had been received by 87.4%, 86.2%, 71.2% and 88.9% of households, infrequently, although baby food assistance had been received by HHQ respondents a month ago on average. Standard food baskets for children under 3 years of age consist of fruit/ vegetable purees and porridges. Monthly baby food aid was reported to last 1-2 weeks. The main providers of the main providers of baby-food assistance among the surveyed population were Slavyansk heart, Pomozhem and the Rinat Akhmetov Foundation.

Those in rented accommodation appear to receive baby-food assistance less frequently than those in collective centres; the higher frequency of distributions received by those in collective centres could be due to collective centres being more visible, the households receiving more awareness of distributions, or being targeted by humanitarian organizations due to considering they are in greatest need (Previous reports have cited that those in collective centres are likely receiving lower incomes, however this was not indicated by the IYCF assessment).

"The food aid is not enough for them. We also buy ourselves some cereals for young children.... we ourselves bought for mothers in October jars of meat and vegetables combined –but it was too little for them. " (Representative, local Sviatohirst NGO)

Infants up to 1-year also receive infant formula, including those exclusively breastfed; children 1 to 3-years of age also receive cereals. Infant formula had been received by 78.3% of HHQ infants under 1-year and 19.6% of infants 12-23 months. Provision of infant formula is not based on a breastfeeding assessment and support for re-lactation and supplies are not provided with guarantee the child will have access to infant formula until 6 months of age, in accordance with the recommendations in the IYCF Operational Guidance.

"Children up to 1 year if they are not breastfeeding suffer from lack of infant formula, 2 packets is not enough for them." (Representative of the City Council, Sviatohirst)

"Even those mothers who don't seem to have low income they come for the assistance in very expensive cars and they insist on being given infant formula." (Representative, Local Sviatohirst NGO)

Meat puree was received from aid agencies by only 0.8% of households (n=1) but consumed by 9.6%, therefore even though a number of FGD mothers expressed the opinion that meat in tins/meat puree was not tasty and too salty it appears that they would be utilised if provided.

No foods received freely were considered by FGD participants to not be priority items, however FGDs mothers reported that many infants did not like the taste of the commercial porridges (eg 'Karipus' brand) which could be the reason consumption did not appear to match availability, as shown by 80% of households receiving commercial porridges but only 66.8% of infants having consumed these in the last 24 hours.

Provision of semolina was considered inappropriate by mothers living in collective centres with no cooking facilities.

Foods reported in HHQs as being consumed frequently but not received in baby-food assistance were as follows: bread/ noodles/ vermicelli/ crackers and fresh fruit and vegetables. Foods eaten less frequently, but still in large numbers of infants were dairy products: cheese, animal milk/ sour milk, and potatoes. The inference would be that these are the products which families are purchasing (therefore 'affordable' and which are thought to be important foods for children of under 2-years.

Dairy products (butter, cottage cheese, keffir, ingredients to make yoghurt), as well as fresh vegetables, meat products, bottled water, sunflower oil, salt, sugar and tea, were also considered by FGD and key informant interview participants as being priority items for children 6-23 months but not included in food baskets.

Baby-food assistance parcels have not included information on breastfeeding, complementary feeding or hygiene, except for one distribution of UNICEF booklets made by Slovianske Heart to mothers in Sviatohisrk.

The majority of mothers expressed a preference for cooking food for their children, however some dwellings didn't have gas appliances and households didn't have electric pans therefore mothers were unable to cook. The Svitohirske City Council representative expressed the need for blenders and multifunctional electric pans to allow mothers to cook purees. Lack of refrigerators in dwellings also constrained safe home storage of food during warm weather.

Mothers have received information on humanitarian aid/distributions available via the telephone, online searches, from health professionals or NGO volunteers. Some mothers had experienced misunderstandings about donations, regarding eligibility and distribution point locations and scheduling, and reported that due to some distribution queues being long they were unable to wait due to having children to care for.

"..as prices have increased for foods, for all layers of the population it has affected food choices. The IDPs are often unemployed and do not have as much money. Local resident populations may have their own gardens."(Family Doctor, Ambulant Clinic, Slovianske)

The population is currently not food-aid dependent but financial constraints and unstable access to food, through both assistance and markets, limit their ability to provide the choice of foods desired for their children, although during the summer (the period of the current assessment) a greater variety of fresh fruits and vegetables are available compared to winter months.

The untargeted distribution of infant formula to children under 12 months of age is of concern, and does not conform to globally agreed recommendations as conveyed in 'The Code' and 'The Operational Guidance'. Advocacy for appropriate food basket distribution is required for distributing agencies, including education on safe and appropriate IYCF for distribution point staff, and referral pathways for caregivers to receive breastfeeding counselling. Breastfeeding and complementary feeding education for caregivers could be provided at distribution points and information leaflets be provided in food baskets on safe handling and optimum use of the food provided, and the benefits of exclusive breastfeeding to 6 months of age and continued breastfeeding for 2 years complementing the introduction of age-appropriate soft, semi-soft and hard foods from 6 months.

Improved communication about distributions is indicated, through IDPs being informed of their entitlements, the nutritional quality, quantity and type of ration to be distributed and the distribution plan. This could be facilitated through a dedicated website (or social forum) or social services centres and at distributions points.

Coordination of distributions with child-minding services or child-friendly spaces could facilitate access of caregivers to distributions and their exposure to information on IYCF.

Health services support and capacity for IYCF

Pre-natal clinic attendance by mothers at the recommended frequency of 9-11 visits during the period of pregnancy (and ideally with the first visit before 12 weeks) is reportedly high, although IDPs sometimes miss visits when they return to their homes in NGCAs.

Pre-natal schools are held at the Kramatorsk and Slovianske clinics with lectures and courses that include breastfeeding practices, however they are not well known by mothers.

Birth clinics were reported by health professionals to have skilled personnel are present at every birth, provision of breastfeeding support, and hotline contact details provided prior to discharge, with discharge being on average three days post-delivery. However, FGD mothers reported mixed experiences at birth

clinics pre- and post-crisis regarding the quality of support they had received, varying from not receiving skilled support to receiving specialised advice and support from a 'milk nurse' and were not aware of the hotline support available.

Post-natal services, currently include home visits by a family doctor and/or nurse during the first month during which breastfeeding advice and support are provided, and following this mothers are recommended to attend the polyclinic monthly for check-ups, which includes growth measurement and advice on breastfeeding. Specific counselling services are available at the 'Room of the Healthy Child'

Group education sessions, however, are very infrequent, adhoc and untargeted (provided occasionally for mothers waiting to see the doctor) and comprise few participants (3-4 mothers). Peer support groups are not facilitated.

Infant formula is provided to mothers who report not having enough breastmilk, while encouraging them to pursue or continue breastfeeding, and infant formula or 'EpiLac' is recommended for mothers who cannot re-lactate. The assessment indicates that although breastfeeding is promoted, skilled support for re-lactation and moving mothers away from mixed feeding to exclusive breastfeeding (and associated combined psychosocial and lactation support) is lacking, as is education on complementary feeding.

Financial and bureaucratic constraints associated with the crisis have reportedly impacted on health services through interrupting routine training procedures, constraining the Kramatorsk and Slovianske birth clinics ability to achieve 'Baby-friendly Hospital' certification, and stopping the provision to health facilities of printed information leaflets, pamphlets and booklets on maternal nutrition, breastfeeding and complementary feeding.

As well as seeking advice on infant and young child feeding from doctors, nurses and other health care staff; the internet, grandmothers and friends are also key sources of information; commercial product packaging is viewed by some for advice on when to introduce foods.

There appear to have been no community based breastfeeding support activities other than education sessions on how to reinitiate breastfeeding, held by UNICEF in February 2015 for IDP mothers in Svitohirske, and a few group psychological support sessions for mothers to reinitiate breastfeeding provided by the local Sviatohirst NGO Slavyansk Heart. Community-based breastfeeding peer support groups that existed in the assessment location pre-crisis are seemingly no longer functional.

Everyone has the right to health, as enshrined in a number of international instruments. The contribution of the health sector is to provide essential health services, including preventive and promotion interventions that are effective in reducing health risks. Implementation of essential health services must be supported by actions to strengthen the health system.

Since the onset of the crisis, health services have been generally limited by their capacity (available skilled human resources, educational materials, funding) to support safe and appropriate IYCF, in relation to the increased (IDP) population to be served.

The capacity of health facilities to appropriately and adequately support optimal infant and young child feeding needs to be supported, through increased availability of skilled staff, staff trainings (with an emphasis on re-lactation and psychosocial counselling), and informational materials, and this be supported by strong endorsement of The Code, at policy and health facility levels. At community level, information on available hotline services provided by health facilities needs to be widely communicated, and peer support and action-oriented groups established to support appropriate infant and young child feeding, with their schedules and venues coordinated with child care/child friendly spaces services

[The water and hygiene environment](#)

Ukraine contains some of the most polluted landscapes in Eastern Europe. A heavily industrialised area, surface and ground water in many areas in eastern Ukraine are contaminated by heavy metals and

chemicals, and do not comply with the Ukrainian limits for drinking water supply.^{41, 42} Pre-crisis much of the population were used to bottled water for drinking.⁴³ Additionally water supplies in some areas have been damaged due to the conflict⁴⁴.

The majority of households who participated in the HHQ had access to running water (97.6%) and facilities to boil water (98.8%). For preparing food and drinks for infants, the majority of primary caregivers in Kramatorsk and Slovianske use bottled or tap water; in Sviatohirst well use is more common. There was the expressed, erroneous, belief that bottled water is safe for babies because it is sterile.

All HHQ participants had access to soap, which 22.7% of primary caregivers used 5-10 times and 75.7% used >10 times in the past 48 hours before the assessment, for a variety of uses. Mothers indicated that they are informed on the importance of hygiene and soap use, and purchase soap and laundry detergent as finances enabled. Mothers from FGDs in Svitohirske had received a package containing soap with other hygiene and sanitation products once in 4 months from UNICEF; in other locations mothers reported not having received soap and hygiene products since the previous summer. Children's laundry detergent had never been received in assistance. There was an expressed need by both NGOs and mothers in all locations for hygienic products including diapers, baby creams, shampoo, wet wipes and teething gel as well as soap and children's laundry detergent.

Safe food, clean water and good hygiene are essential to prevent diarrhoea and food- and water-borne diseases, which are a major cause of poor nutrition, stunting and recurrent illness in children under 2 years of age. Use of soap in hand washing helps to reduce diarrhoeal transmission. The expressed priority hygiene items need to be considered for inclusion in hygiene kits, to support the prevention of illness among young child and to promote their optimal food intake. Leaflets on safe and appropriate IYCF could also be included in hygiene kits, using standardised messaging, coordinated with the Nutrition Sub-sector.

Recommendations

A multi-pronged approach, utilising IYCF-specific actions complemented by broader IYCF-sensitive actions targeted at individual, household, community, health system and policy and coordination levels, is required to protect, promote and support appropriate IYCF practices within the current context in Ukraine. The assessment findings indicate that the response needs to be weighted towards protecting and promoting safe and appropriate IYCF through integration of activities into multi-sectoral programming and strengthening the health system to support optimal IYCF practices.

Recommendation 1:

Provide targeted, clear, context-specific and evidence-based communication on IYCF through a variety of delivery channels

- **Develop a maximum of ten priority key positive messages** targeted for primary caregivers of infants and young children <24 months of age, to be consistently disseminated by key stakeholders in the humanitarian response. Ensure coordinated messaging on IYCF, nutrition, health, and hygiene across the clusters. Target the messages to primary caregivers as well as to their peers, the fathers and grandmothers as they are consulted for advice on feeding practices.

Sample messages:

1. Breastfeeding gives babies the best start in life, providing strong protection for your baby's health and nutrition. Breast milk provides all the food and water your baby needs and should have during the first 6 months. It is made to perfectly meet each individual baby's nutrient, fat and water needs and to help protect against infection.

⁴¹ Save the Children Ukraine Humanitarian Response Strategy 2015

⁴² Vystavna Y & Diadin D. Water scarcity and contamination in eastern Ukraine. Hydrological Sciences and Water Security: Past, Present and Future. (Proceedings of the 11th Kovacs Colloquium, Paris, France, June 2014). IAHS Publ. 366, 2015

⁴³ Save the Children Ukraine Humanitarian Response Strategy 2015

⁴⁴ Save the Children Ukraine. OPS Field Report CGAs Donetsk March 2015

There is no substitute that can replicate it.

2. Put baby to the breast within one hour after birth. This milk (colostrum) is baby's first "immunization" providing concentrated antibodies to build protection from illness. No infant formula or water should be given. Mother's supply of breastmilk is sufficient
3. Breast milk contains enough water for the baby's needs. During the first 6 months baby does not need any other liquids, such as water, juice or tea -even during hot and cold weather- as this may cause baby to drink less breastmilk and to get sick from diarrhoea and other infections
4. Use of bottle and teats reduces how often baby suckles at the breast and as a result mother makes less breastmilk, causes nipple confusion and increases risk of diarrhea and other infections. Do not use bottles and teats; use cups instead
5. Stress or inadequate nutrition of mother does not make the milk dry or stop milk production but may temporarily interrupt milk flow. Frequent suckling by baby at the breast promotes milk flow and produces hormones that calm both mother and baby. Babies can get fussy or upset for many reasons; if concerned, keep breastfeeding and seek medical assistance to identify the cause.
6. Breastfeed as often as baby demands milk, allowing baby to feed until satisfied. Babies can regulate the amount of breastmilk they need to meet their thirst and nutrient needs. The more baby suckles the more milk mother supplies
7. Infant formula should only be used for medical reasons based on assessment by a health professional, and given by teaspoon or cup
8. At 6 months, introduce other foods in addition to breastmilk. Give a variety of nutritious foods, including meats, fruits and vegetables. Feeding non-breastmilk foods and liquids before 6 months can cause baby to get sick and reduce the intake of nutritious breastmilk. Starting foods too late can cause baby's growth to falter.
9. Continue breastfeeding up to 2 years, or beyond. Breastmilk continues to provide older babies with nutrients and energy important for their healthy growth and development

- [Develop/Provide targeted IYCF informational materials \(pamphlets and brochures\) in baby food baskets, hygiene kits and with pregnancy care kits/vouchers](#), including the following topics: best practices guidelines -eg optimal age-appropriate breastfeeding and complementary feeding; guidance on optimal nutritional use of the baby-food commodities; requirements for safe handling and preparation of the foods and fluids; caring practices- and contact details for accessing support services
- [Develop a website, or online social forum providing IYCF guidance](#): guidelines described; key messaging; questions & answers on IYCF; details of humanitarian aid available, health facility and aid agencies hotlines, and linkages to other recommended websites. Widely promote the website/forum through multi-cluster contact points and health facilities
- [Investigate the feasibility and support for establishing and managing a central/Ukraine IYCF-specific hot-line service](#)
- [Widely disseminate guidance documents](#) to agencies supporting the humanitarian response, to promote adherence to nationally and globally recognised standards for the protection, promotion and support of optimal IYCF, including "The Code" (collectively, the International Code of Marketing of Breast milk Substitutes and subsequent relevant World Health Assembly (WHA) resolutions and The Operational Guidance on infant feeding in emergencies)

Recommendation 2:

[Strengthen the capacity of primary health care services](#) to provide appropriate training and support to caregivers on safe and appropriate breastfeeding and complementary feeding in prenatal, perinatal and postnatal periods:

- [Provide trainings and educational resources and tools for healthcare worker \(facility and mobile\)](#). Trainings should highlight exclusive breastfeeding; support for breastfeeding difficulties (re-lactation and psychosocial counseling); risks of mixed feeding and use of teas and water; feeding on demand; age-appropriate introduction of complementary foods; facilitating action-oriented and peer support group sessions

- Promote adherence to the International Code of Marketing of Breastmilk Substitutes at health facilities through incorporating The Code in trainings and monitoring of certified Baby-friendly Hospitals, UNICEF as the lead agency to follow up on reported violations.

Recommendation 3:

Build and enhance community-based support for safe and appropriate IYCF

- Identify and train a pool of mobile community-based breastfeeding-psychological first aid counselors to provide peer support group education at health facility and community levels and to facilitate home visits for mothers requiring one-to-one skilled support
- Develop guidance protocols and establish community-based referral systems for caregivers to access support, including referral of primary caregivers of children <2 years with indicated mental health issues, stress or depression to appropriate psychosocial services; infants dependent on infant formula)
- Support the revitalization of breastfeeding support groups existing pre-crisis, with provision of trainings and educational tools/materials on IYCF. Develop communication linkages with health services/facilities and websites.

Recommendation 4:

Build the capacity of humanitarian agencies for IYCF-E

- Provide orientation sessions to relevant agencies/clusters staff (including Health, WASH, Food Security, Child Protection, Education, Shelter, Coordination, Logistics, NGO Forum) on safe and appropriate IYCF-E within the current context, the linkages with their cluster and guidance on potential modalities for integration of IYCF-specific and -sensitive actions into their sectoral programmes
- Advocate for agencies to endorse or develop a policy on IYCF-E, according to the Operational Guidance and the Nutrition Sub-Cluster standard operating procedures (SOP), directed at no agencies facilitating indiscriminate distributions of infant formula and any distributions of infant formula are targeted and supported according to the defined protocols.
Establish systems for monitoring violations of The Code by humanitarian agencies; UNICEF as the lead agency to follow up on reported violations
- Integrate specific IYCF messages into the Health Cluster disease outbreak plans/interventions. Provide IYCF messaging and support counselors during immunization campaigns
- Advocate to and support food distribution agencies to implement appropriate and acceptable complementary food distribution activities
 - Provide IYCF-E orientations for staff of agencies distributing baby food (incl health and social service facilities), highlighting adherence to The Code
 - Provide priority messaging information pamphlets in food baskets
 - Provide group IYCF education at distribution points, where feasible, including food demonstrations on age-appropriate use of commodities. Schedule distribution times and locations in coordination with IYCF point-of-distribution education activities and child-care/child-friendly space activities
 - Design food basket/voucher commodities considering inclusion of priority requested foods: mixtures of cereals, fruit and vegetable puree, fresh vegetables, meat products, sunflower oil. Omit Karapus brand cereal and barley meal from food baskets
 - Ensure risk mitigation for diversion of baby food for children 6-23 months to younger age groups through point of distribution eligibility targeting, group education and informational materials
 - Clearly communicate information about food distributions, including details on eligibility criteria and rationale for receipt of baby food assistance; entitlements (quantity and type of baby food ration); the distribution plan (schedules; locations). Disseminate at point of distribution, and through selected websites, text messaging, and notices at public venues, as appropriate
 - Ensure the distribution efficiency, to reduce caregiver waiting time for collection, eg provide phased collection schedules or increase the number of locations for distribution points. Ensure availability of appropriate areas for women to breastfeed women or establish priority queues
- Advocate for, needs-based, provision of non-food items to support safe and appropriate IYCF
 - Multi-cookers to enable home preparation of complementary foods in collective centres

- Hygiene products: diapers, teething gels, baby creams, children's laundry detergent, shampoo, soap, and wet wipes
- Provide cups with infant formula packages distributed for the non-breastfed child, along with guidelines for minimizing the risks of use and preparation; concurrently provide breastfeeding mothers with goods of equal or greater value, directed at minimizing the harm to breastfeeding.

Recommendation 5:

Support the prevention and treatment of iron deficiency anaemia

- Strengthen anaemia systematic monitoring of pregnant women and children 6-23 months at health facility level
- Conduct feasibility study on use of micronutrient powders for young children 6-23 months of age. Provide sensitization and distribution as appropriate
- Investigate modalities to support the micronutrient intake of pregnant and lactating women, including conditional vouchers for accessing iron and folic acid supplements

Insights for moving forward

- Number of FGD participants (10-11 per focus group as per the PCA, was too many for well capturing all participants dialogue. Limit size to 7-9 participants
- Sample selection should be accessed from a wide variety of sources, to reduce bias
- A diverse range of key informants should be consulted and involved in future IYCF assessments. Key national and local government representatives (including local authorities and the MoH), sector leads, and aid distribution staff should be consulted from the planning phase, their inclusion as key informants and in analyzing the results and formulating recommendations, in order to better formulate the assessment questionnaires/guides, have 'shared ownership', get their 'buy-in' and support for implementing the recommendations
- Innovation is required when conducting assessments and working in urban contexts and middle-income countries. Technology should be utilized when feasible and appropriate (eg telephone interviews for future assessments on feeding practices) as should the local diverse skills base within the public and private sector
- A Post-winter IYCF assessment be facilitated, and with the additionally inclusion of vitamin A rich vegetables, dark green leafy vegetables, and nuts and legumes food groups

PART TWO: BACKGROUND INFORMATION

Infant and Young Child Feeding in Emergencies (IYCF-E)

Children who get the right nutrition in the critical window from birth until 2 years of age have an increased chance of child survival and optimal growth and development; a foundation that lasts their entire lives^{45, 46, 47}

Optimal feeding practices that maximise survival and reduce morbidity in children under two years include: early initiation of breastfeeding (within an hour from birth); exclusive breastfeeding for the first 6 months of life; continued breastfeeding for 24 months or beyond, combined with adequate, age-appropriate and safe complementary foods starting at 6 months^{48, 49}. These constitute the infant and young child feeding practices recommended by the WHO⁵⁰ as reflected in the globally recognised standard indicators related to recommended IYCF practices⁵¹

- Early initiation of breastfeeding (within one hour of birth)
- Exclusive breastfeeding rate (<6 months)
- Predominant breastfeeding (<6 months)
- Continued breastfeeding rate (at 1 year and at 2 years)
- Duration of breastfeeding
- Age-appropriate breastfeeding (0–23 months)
- Timely introduction of solid, semi-solid and soft food (6–8 months)
- Minimum dietary diversity (6–23 months)
- Minimum meal frequency (6–23 months)
- Milk feeding for non-breastfeeding children (6–23 months)
- Consumption of iron-rich foods (6–23 months)
- Bottle feeding (0–23 months)

For the vast majority of infants, emphasis should be on protecting, promoting and supporting breastfeeding and ensuring timely, safe and appropriate complementary feeding -however there are a few exceptions when breastfeeding may not be advised, for example according to the Ukraine Ministry of Health positive HIV/AIDS is a contraindication^{52, 53, 54}

IYCF-E concerns the protection and support of appropriate, adequate and safe feeding for infants and young children under the age of 24 months in emergency situations, with the goal of safeguarding their survival, health and growth.

Infants and young children under the age of two years are among the most vulnerable victims of natural or human-induced emergencies due to their age-specific nutrition needs, risk of infection and their complete dependency on others for their care. Sub-optimal infant and young child feeding practices increase vulnerability to under-nutrition, illness and death.

Conditions that arise during emergencies can greatly affect the appropriate and safe feeding of infants and young children; with the impact of sub-optimal IYCF practices exemplified.

⁴⁵ Save the Children. Nutrition in the first 1,000 days: State of the world's mothers. 2012

⁴⁶ UNICEF. Improving child nutrition: the achievable imperative for global progress

⁴⁷ IBFAN, What Scientific Research Says?, <http://www.ibfan.org/issue-scientific-breastfeeding.html>

⁴⁸ <http://www.who.int/topics/breastfeeding/en/>

⁴⁹ IBFAN, What Scientific Research Says?, <http://www.ibfan.org/issue-scientific-breastfeeding.html>

⁵⁰ WHO, 2002, Global Strategy on Infant and Young Child Feeding,

<http://www.who.int/nutrition/publications/infantfeeding/9241562218/en/index.html>

⁵¹ <https://www.humanitarianresponse.info/en/applications/ir/indicators/global-clusters/9?search=&page=3>

⁵² 2010 WHO Guidelines on HIV and infant feeding: http://whqlibdoc.who.int/publications/2010/9789241599535_eng.pdf

⁵³ WHO. Guidelines on HIV and infant feeding. 2010

⁵⁴ Standard operating procedures on donations, distribution and procurement of infant formula and infant feeding equipment as agreed by the Nutrition Sub-Cluster of the Health and Nutrition Cluster on the 13 May 2015

These conditions include inadequate shelter, lack of privacy, overcrowding, time and psychosocial constraints on caring capacity, compromised water quality and availability, breakdown of health structures and availability of quality services, nutrition and health services, disrupted food supplies, effects on markets and loss of livelihoods limiting income and thereby ability to afford and access services and food/liquids and non-food commodities.

Appropriate and timely support of IYCF-E saves lives. IYCF-E should be considered at all stages of programming humanitarian assistance: needs assessment, response analysis and programme design, implementation, monitoring and evaluation, considering nutrition specific and nutrition sensitive actions.

Several international instruments make a strong case for protecting, promoting and supporting appropriate infant and young child feeding, and stipulate the right of every human being, man, woman and child, to optimal health, to the elimination of hunger and malnutrition, and to proper nutrition. These include the International Covenant on Economic, Social and Cultural Rights (CESCR), the Convention on the Rights of the Child (CRC), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)⁵⁵

The Operational Guidance on Infant and Young Child Feeding in Emergencies⁵⁶ and Sphere Minimum Standards in Humanitarian Response⁵⁷ provide concise practical guidance on how to best protect and support IYCF in emergency contexts. The International Code of Marketing of Breast milk Substitutes, with subsequent World Health Assembly Resolutions⁵⁸ (collectively known as 'The Code') apply in all emergencies in all countries and need to be adhered to as a minimum requirement. The Code is embedded in the Operational Guidance (*See Annex 4*)

Artificial feeding should only be initiated according to the Operational Guidance, following a needs assessment by a qualified health/nutrition staff trained in breastfeeding and infant feeding issues, in accordance with the International Code of Marketing of Breast milk Substitutes and where the use of artificial milk is acceptable, feasible, affordable, sustainable and safe. This requires ensuring safe water quality and availability, feeding equipment, cooking facilities, storage and formula preparation and supporting breastfeeding in order to avoid any 'spill-over' of artificial feeding into the breastfeeding population, that may lead to early and unnecessary cessation of breastfeeding. Inappropriate distribution of infant formula or milk powder during emergencies can have negative effects on breastfeeding rates (through leading to early and unnecessary cessation of breastfeeding) and infant mortality (through contamination and reduced immunological protection provided from breast milk). Careful consideration is needed in procuring, targeting, distributing and monitoring BMS in order to ensure safe artificial feeding in emergency contexts, in accordance with the International Code of Marketing of Breast-milk Substitutes⁵⁹ and the Infant and Young Child feeding in Emergencies Operational Guidance⁶⁰

Humanitarian accountability to affected populations requires that the prevention of malnutrition should be the primary aim rather than waiting for a deterioration and then treating.

All of those involved in an emergency response - from policy makers to national governments, donors to agency technical and operational staff – are responsible for the protection and support for the appropriate feeding of infants and young children in emergencies, to ensure strong policy, coordination, advocacy, technical guidance and capacity building (resources and training) at all levels.

⁵⁵ IBFAN. Report on the situation of infant and young child feeding in Ukraine. The committee on economic, social and cultural rights. 2013

⁵⁶ IFE Core Group, Operational Guidance on Infant and Young Child Feeding in Emergencies (for emergency relief staff and programme managers), version 2.1, February 2007

⁵⁷ The Sphere Project. Humanitarian Charter and Minimum Standards in Humanitarian response. 2011 edition

⁵⁸ WHO. The international Code of Marketing of Breastmilk Substitutes. 1981

⁵⁹ WHO. The International Code of Marketing of Breast milk Substitutes, with WHA resolutions.1981

⁶⁰ The IFE Core Group (WHO). The Infant and Young Child Feeding in Emergencies Operational Guidance for Emergency Relief Staff and Programme Managers Version 2.1. 2007

Ukraine Pre-crisis context

Pre-crisis IYCF

Pre-crisis practices

According to the Multiple Indicator Cluster Survey (MICS) 2012 report, based on self-reported recall by mothers/primary caregivers in eastern Ukraine, only 61.5% of mothers initiated breastfeeding within one hour of birth and 83% within 24 hours after delivery; 18.5% received a pre-lacteal feed. Of children under 6 months of age only 21.3% were exclusively breastfed, whereas 47.5% were predominantly breastfed. Newborns in the rural areas were more likely to be exclusively breastfed during the first 6 months of their lives compared to children in urban communities, 29.0% and 16.0% respectively. By the time infants were age 12–15 months 33.4% were still breastfed, and by age 20–23 months-old 31.1% still breastfed.⁶¹ The median duration of breastfeeding was 0.4 months for exclusive and 2.4 months for predominant breastfeeding. Feeding with a bottle and teat was common, at 51.1% of children aged 0–23 months. Considering age appropriate complementary feeding, 22.6% of children 6-23 months were breastfeeding and receiving soft, semi-solid and solid foods; 31.2% with the minimum meal frequency (defined as two times or more per day for children 6-8 months; 3 or more times per day for children 9-23 months of age). Of those not breastfeeding 89.3% were receiving solid, semi-solid and soft food or milk feeds the recommended 4 times or more per day. However, of note, on average for all regions in Ukraine, of breastfed infants aged 6-8 months and 9-11 months only 8.9% and 10.3%, respectively, received the minimum number of meals.⁶²

The 2007 DHS⁶³ reported that, of children 0-5 months who were breastfed non-exclusively (81.8%): 21.9% were given other milk, 19.5% water, 18% complementary foods and 2.7% non-milk liquids. At 6-8 months 38% were no longer breastfed, and at 12-15 months 74% were no longer breastfed. Of children 6-23 months receiving complementary foods, 75.5% of breastfed infants received food made from grains and 26.2% fortified baby foods; of non-breastfed infants, 90.1% received food made from grains and 32.6% fortified baby foods. Some commercially available baby foods are targeted at 4+, 5+ months of age, as written on the package labels.

A study of the diet of Ukrainian children aged 9-months to 3-years in 2014 found that young children, although being fed an adequate diet, were not being fed a balanced diet. Diets tended to be too high in energy and protein and had a lack of micronutrients. Previous sources have reported low iron levels in 40-50% of children, low vitamin-C levels in 80-90% of children, low B-vitamin levels in 40-80% of children and low iodine levels in 35% of children.⁶⁴

In 2002, the CRC Committee made recommendations on IYCF.

These recommendations (Paragraph 50) addressed the needs to: (a) “Ensure that all children, especially the most vulnerable groups, have access to primary health care; (b) Develop a national policy in order to ensure an integrated and multidimensional approach to early childhood development, with a focus on health and nutrition; (c) Continue to operate with and seek assistance from...UNICEF and WHO”⁶⁵

Policy

The most relevant laws and regulations in Ukraine relevant to protecting and promoting IYCF include:

- Order/ Nakaz № 149 (2008) of the Ministry of Health (MoH) “Clinical protocol on health care of the healthy child till 3 years of age”, a progressive national policy with an integrated and multidimensional

⁶¹ Ukraine Multiple Indicator Cluster Survey Final Report. 2012

⁶² Ukraine Multiple Indicator Cluster Survey Final Report. 2012

⁶³ Ukrainian DHS, 2007

⁶⁴ S. Nyankovskyy et al., Dietary habits and nutritional status of children from Ukraine during the first 3 years of life, *pediatriapolska* 89 (2014) 395 -40

⁶⁵ IBFAN-Sumy group. The Convention on the Rights of the Child. Report on the situation of infant and young child feeding in Ukraine. Session 56 January 2011

approach to early childhood development with focus on health and nutrition: plus other Nakazes (more than 20), which include many provisions of current WHO recommendations in relation to early childhood health and nutrition

- MOH Order 152 on medical care for healthy newborn baby
- The law on "The Protection of Childhood"
- The law on "Health", Article 57: "Promotion of Motherhood"
- The Resolution of the Ministers of Cabinet of Ukraine (2002), № 1914 on the approval of the cross-integrated programme "Nation's Health for 2002-2011"
- The Resolution of the Ministers of Cabinet of Ukraine (2006), № 1849 on the approval of the State programme
- The Labour Code, which entitles paid maternity leave in relation to pregnancy, childbirth and baby care and breaks for breastfeeding (article 183)
- "Reproductive Health, 2006-2015"; which affirms the necessity to increase to 60% the percentage of children who are exclusively breastfed for six months
- Other laws relevant to IYCF include those related to: "Child protection", "The safety and quality of food", "Milk and dairy products"^{66, 67, 68, 69}

Support services for IYCF

A government sectoral programme "Support of breastfeeding in Ukraine, 2006-2010", which focused only on breastfeeding, was adopted some years ago but no comprehensive nutrition programme was set up. One of its objectives was to attract NGOs to promote breastfeeding but IBFAN reported that there was little interest to develop cooperation with NGOs and no encouragement due to fears that NGOs are non-specialists and the perception that NGOs are competitors in the ministries "own" hospital area.

A few mother-to-mother support groups have existed in Ukraine, but they have found it difficult to sustain themselves, and their work has generally been separated from public health facilities.⁷⁰

In early 2000 UNICEF and the MOH provided a series of training courses on breastfeeding (including HIV/breastfeeding management) for health workers with the aim of building breastfeeding national trainers and counsellors. In January 2010 there were 188 professional national and regional Baby-friendly Hospital Initiative (BFHI) trainers, 176 BFHI evaluation experts, and 29 BFHI re-evaluation experts⁷¹

In 2004, national training textbook on breastfeeding management was produced, printed and 2000 copies distributed⁷²

Obstacles to the protection, promotion and support of optimal IYCF practices in Ukraine have been reported to include: systemic weaknesses in the availability, collection, analysis and reliability of data, and harmonization of different data sources related to breastfeeding; low funding for public awareness on infant feeding issues; weak IYCF policies. For example, the International Code of Marketing of Breast milk Substitutes⁷³ is perceived as a recommendation and not a requirement, it lacks enforcement, implementation of the basic principles is very weak, there is lack of systematic monitoring on violations, existing legislation does not include any sanctions for violations, a draft Order regulating observance of The Code has been drafted but not signed, and medical professionals and families lack knowledge of The Code. The extended Baby-friendly Hospital Initiative (initiated in Ukraine in 1996) lacks degree of implementation – it has not been included in training programmes for doctors and specialists, nurses and midwives at regional or national levels, medical staff lack attention to the essential elements in provision of mother-and family-friendly services and efforts of medical staff to support BFHI are not compensated financially⁷⁴. A National

⁶⁶ Global Nutrition Cluster. Report of the Global Nutrition Cluster Scoping Mission to Ukraine. February 2015

⁶⁷ IBFAN. Report on the situation of infant and young child feeding in Ukraine. The committee on economic, social and cultural rights. 2013

⁶⁸ IBFAN. Report on the situation of IYCF in Ukraine. Session 56. January 2011

⁶⁹ Nyankovskyy S et al. Dietary habits and nutritional status of children from Ukraine during the first 3 years of life. *Pediatrics Polska* 889: 395-405. 2014

⁷⁰ IBFAN. Report on the situation of infant and young child feeding in Ukraine. The committee on economic, social and cultural rights. 2013

⁷¹ IBFAN. Report on the situation of infant and young child feeding in Ukraine. The committee on economic, social and cultural rights. 2013

⁷² IBFAN. Report on the situation of infant and young child feeding in Ukraine. The committee on economic, social and cultural rights. 2013

⁷³ WHO. The international code of marketing of breast milk substitutes. 1981

⁷⁴ IBFAN. Report on the situation of infant and young child feeding in Ukraine. The committee on economic, social and cultural rights. 2013

Methodical Monitoring Centre for monitoring implementation of the renewed and extended BFHI has been created, with regional methodical and organizational monitoring centres, referred to as centres for breastfeeding support⁷⁵

Malnutrition prevalence

The last survey available with data on wasting is the MICS Survey in 2000⁷⁶ which reported 1.3% of children under five to be wasted, far below WHO's acceptable prevalence of 5%.

Other related sectors

Health

The total fertility rate in 2014 was 1.3 children born per woman (MICS est). In eastern Ukraine the median age at first birth among women aged 25–49 years, was 21.7 years in 2012,⁷⁷ with women in urban areas generally having a higher median age at first birth (22.3 years) than women in rural areas. Based on 2012 data relating to the two years preceding the survey, 78.8% of women had at least 4 antenatal visits, with antenatal care typically provided by doctors (in 97.4% of cases); in rare cases (1.2%) pregnant women are observed by nurses or midwives.

Virtually all births in Ukraine in the two years preceding MICS were delivered by a skilled health professional (99.4%), with most deliveries (almost 92%) attended by a doctor, with nurses/midwives attending only 7% of births, and in very rare cases (about 1%) by another person; 11.7% were delivered by C-section. The majority of deliveries (99%) were institutional deliveries. Of all births, 97.2% were weighed at birth and approximately 3.1% of infants weighed less than 2,500 grams.

All women who gave birth in a health facility stayed there for 12 or more hours following delivery and almost all women stayed there for 3 and more days.

The infant mortality rate in rural areas was higher than in urban areas, due to exogenous factors - they die twice as often from respiratory diseases, 2.1 times more frequently from infectious diseases and 2.5 times more often from external actions^{78, 79, 80}

According to the Ukrainian legislation, any person can access any health facility in order to get primary health care,⁸¹ covered by 3.54 physicians per 1000 population in 2012⁸²

However, Ukraine's health system was weak before the crisis, with the structure of service delivery, (including human resources) not matching the health needs of the population.

The Ukrainian health system is decentralised, with health facilities sub-ordinate to the Ministry of Health but financially answerable to the regional and local self-government, which has constrained the implementation of healthy policy and fragmented financing⁸³

Despite the considerable network of medical institutions that provide medical care to children, unbalances in the health system make it difficult to provide equal access to health care for rural and urban children. It has been reported that there is a serious lack of financial possibilities for families living in rural areas, a lack of

⁷⁵ IBFAN. Report on the situation of infant and young child feeding in Ukraine. The committee on economic, social and cultural rights. 2013

⁷⁶ Ukraine Multiple Indicator Cluster Survey Final Report. 2000

⁷⁷ Ukraine Multiple Indicator Cluster Survey Final Report. 2012

⁷⁸ UNICEF State of the World's Children in numbers. 2014

⁷⁹ Ukraine Multiple Indicator Cluster Survey Final Report. 2012

⁸⁰ IBFAN. Report on the situation of infant and young child feeding in Ukraine. The committee on economic, social and cultural rights. 2013

⁸¹ IBFAN. Report on the situation of infant and young child feeding in Ukraine. The committee on economic, social and cultural rights. 2013

⁸² <https://www.cia.gov/library/publications/the-world-factbook/geos/up.html>

⁸³ Lekhan V et al. Ukraine Health system review. European Observatory on Health Systems and Policy. 2010

social awareness of parents regarding their health and their children's health, as well as limited access to health care.⁸⁴

A 'Health Systems Assessment' conducted in 2011 by the USAID-funded 'Health Systems 20/20 Project', found that although Ukraine had significantly improved the delivery of maternal and child health care and family planning/reproductive health services, capacity and resource constraints, limited managerial autonomy and Government spending on health care were low overall, as was the share of resources dedicated to primary health care (PHC) services and there was insufficient investment in preventative services. There was a shortage of family doctors, the personnel remuneration system did not provide incentives for health workers to improve the quality, efficiency, or quantity of their work and there was no strategic national plan for human resource development in the health sector.

While quality of care has improved in some priority areas since 2011, through the state reform introduction of area coverage allocation of family doctors, most Ukrainians pay for their drugs and medical supplies out-of-pocket and the overall the content and nature of clinical practice in Ukraine requires further standardisation and modernization⁸⁵

According to the Ukraine MoH order 417, all pregnant women must have their Hb level tested and iron tablets are prescribed if Hb <110 g/L, as are folic acid tablets, for out-of-pocket purchase. The health care providers report data on anaemia prevalence in pregnant women to national authorities once a year.

In 2011 the prevalence of anaemia in children under 5 was 27% (based on percentage of children under 5 whose haemoglobin level is less than 110 grams per litre at sea level). These levels do not meet the MoH target of 21%.⁸⁶ Ukraine has no policy on distribution of micronutrient supplements and there is therefore no distribution of micronutrient activities such as Vitamin A or multiple micronutrient supplementation for children.

For protection against communicable diseases, UNICEF and WHO provide support to the Government of Ukraine in provision of vaccinations⁸⁷

In 2013 the adult HIV/AIDS prevalence rate was estimated to be 0.83.

Water and Hygiene

Most urban areas access the soviet era centralised water supply system. Although pipeline breaks were frequent and resources for their repair limited, in 2012 it was reported that access to improved drinking water source in eastern Ukraine was good, at 97.6%^{88, 89}, with 78% of the population having water piped on premises⁹⁰. However in and around highly industrialised regions the ground water is contaminated by heavy metals and chemicals⁹¹. Local production of bottled water was a successful business prior to the conflict. An educated population, they have good knowledge of hygiene practices.

Child protection

In 2012 99.5% of children under 5 years of age in eastern Ukraine had their birth registered with civil authorities⁹². An incentive for timely birth registration (no later than three months after birth) is the payment of a lump-sum child birth grant by the government; the amount depends on the succession of a live birth (whether this is the first, the second, etc., child). In addition to these payments, mothers/primary caregivers receive monthly childcare benefits for children under three years of age.

⁸⁴ IBFAN-Sumy group. The Convention on the Rights of the Child. Report on the situation of infant and young child feeding in Ukraine. Session 56 January 2011

⁸⁵ USAID. Ukraine health system assessment: Health systems 20/20. 2011

⁸⁶ <http://data.worldbank.org/indicator/SH.ANM.CHLD.ZS>

⁸⁷ UNICEF. Ukraine. http://www.unicef.org/ukraine/activities_11390.html

⁸⁸ Ukraine Multiple Indicator Cluster Survey 2012

⁸⁹ <https://www.cia.gov/library/publications/the-world-factbook/geos/up.html>

⁹⁰ Global Nutrition Report. 2014 Nutrition Country Profile. Ukraine. 2014

⁹¹ Save the Children Ukraine Humanitarian Response Strategy 2015

⁹² Ukraine Multiple Indicator Cluster Survey Final Report. 2012

Communication

In eastern Ukraine the 2012 MICS found that the main sources of information on health-related issues for women aged 15–49 years were health workers (88.4%), friends and relatives (45.2%) and television (40.4%). Over one-third of women (32.5%) aged 15–49 years searched for information on health related issues on the Internet⁹³

Regarding the most trusted sources of information on issues related to their health and health of their families, they were found to be health workers (87.3%), friends and relatives (24.3%), followed by recommendations from pharmacies (20.8%), internet (6.7%), television (6.7%), magazines (2.7%), newspapers (1.4%), radio (0.3%).

The 2012 MICS reported that 90.2% of women 15-24 years of age had used the internet within the past year, with 83.1% having used the internet at least once a week during the past month; those in poorer households had used it less than those from the higher wealth households. Use of newspaper, radio and television at least once per week was 55.8%, 49.2% and 94.6% respectively.

A somewhat larger share of women with higher education were exposed to all indicated media (newspaper, radio, television) at least once a week, as compared with women with secondary education.

⁹³ Ukraine Multiple Indicator Cluster Survey. Final Report. 2012

Background to the crisis

In April 2014, Russia annexed Crimea, which then voted to detach itself from Ukraine as an Autonomous Republic; this triggered a wave of internal displacement within Ukraine. The political crisis deteriorated into a localised military conflict due to mounting tensions between pro-Russian separatist groups and pro-Ukrainian groups in Donetsk and Luhansk, which together form the 'Donbas' region of the east of Ukraine. Direct military engagement between the Ukrainian Armed Force and pro-Russian separatist armed groups ensued, with open conflict in densely-populated urban areas. Parts of Donetsk and Luhansk are no longer under the control of the Government of Ukraine and have been declared, by non-government forces, as the 'Donetsk (or Luhansk) People's Republic', despite the 'anti-terrorist operation' by the Government of Ukraine. However, the Minsk agreement and the Government of Ukraine recognize the Ukraine Government's enduring state sovereignty over the DPR.

Since hostilities began an increasingly complex humanitarian crisis has developed across eastern Ukraine, with a steady increase in insecurity and displacement.

As at end of June 2015, the humanitarian crisis had affected more than 5.2 million people, the estimated pre-crisis population in conflict-affected areas in eastern Ukraine. More than 2.2 million Ukrainians had been uprooted by conflict, with 1,357,778 people registered by the Ministry of Social Policy (MoSP) as being internally displaced and an additional 900,000 Ukrainians having sought asylum, residence permits or other forms of legal stay in neighbouring countries⁹⁴. This figure does not include either internally displaced people (IDPs) living in NGCAs, IDPs whose registrations have been cancelled⁹⁵ or those who have not registered as IDPs. IDPs include those who are unable or unwilling to return to their original dwellings or area in NGCAs. According to the 'All-Ukrainian Charitable Foundation's Right to Protection' monitoring teams, people are in no rush to register as IDPs. In some cases, IDPs fear sharing their personal data to government officials, others are young men who worry about being drafted into the military, while still others are being refused registration because their IDs have been lost, forgotten at home or destroyed at checkpoints.⁹⁶

Although the number of IDPs increases as hostilities intensify, the introduction in February 2015, by Ukraine's State Security Service Anti-Terrorist Centre, of a security policy requiring special passes to cross the border into the Donbas made fleeing war zones difficult, and obtaining the pass has been reported to take up to 3 months⁹⁷.

IDPs report that they left home due to security concerns (shooting, shelling) and/or the humanitarian impact of the conflict (lack of water, food, medicine); they left with few personal belongings⁹⁸. Many of the women fled from their homes with heavy responsibilities, caring for their children, and often also elderly relatives; some crowded in homes with relatives or friends or temporarily staying in collective centres, in deprived conditions, and with an uncertain future for themselves and their families; all of which generate inter-personal tensions and stress⁹⁹.

The majority of IDPs are geographically located in the areas close to their homes, in particular residing in the GCAs within Donetsk and Luhansk oblasts eg Svitohirske, Slovianske, Kramatorisk and Krasny Liman, and neighbouring Dnipropetrovsk, Kharkiv and Zaporizhzhia oblasts. The most vulnerable IDPs have started to return back home or are based in collective centres; better off families are moving towards Kiev, Dnipropetrovsk, Zaporizhzhia and Kharkiv¹⁰⁰.

⁹⁴ OCHA. Ukraine Situation Update No. 5. 26 June 2015

⁹⁵ Atlantaic Council. Ukraine's IDP crisis worsens as local attitudes harden. 27 July 2015

⁹⁶ HIAS. Ukraine displacement crisis worsens as local attitudes harden. <http://www.hias.org/ukraine-displacement-crisis-worsens-local-attitudes-harden>. July 2015

⁹⁷ HIAS. Ukraine displacement crisis worsens as local attitudes harden. <http://www.hias.org/ukraine-displacement-crisis-worsens-local-attitudes-harden>. July 2015

⁹⁸ UNHCR. Profiling and Needs Assessment of IDPs. 17 October 2014)

⁹⁹ UNHCR. Profiling and Needs Assessment of IDPs. 17 October 2014

¹⁰⁰ UNHCR. Profiling and Needs Assessment of IDPs. 17 October 2014)

The protracted nature of the crisis has had profound social and economic implications. Livelihood opportunities for IDPs are very restricted due to the difficult economic situation facing Ukraine and discrimination by employers. In 2014, the Ukraine GDP fell by 14.8% and inflation reached 36%. The Ukrainian Hryvnya (UAH) devalued by 50%, while interest rates soared in 2014 there was a concurrent nationwide food price increase of 25 per cent, with even higher figures reported in some conflict areas, which contributed to a reduction in households' purchasing power^{101,102}. In the conflict-affected areas of Donbas basic life-saving services and availability of supplies have been disrupted. There are severely limited functioning financial services in the non-government controlled areas, social payments have reduced or stopped, and economic activity has been negatively impacted¹⁰³



Humanitarian response and operational environment

Stakeholders to the conflict include the Ukrainian government and their National Guard, Ministry of Internal Affairs, and the Security Service of Ukraine; non-state armed groups (DPR – Donetsk People’s Republic; LPR – Luhansk People’s Republic; other miscellaneous groups); the Russian state; the International Community, particularly EU Member States in the role of facilitating ceasefire negotiations; other international State actors exploring supplying resources to Ukraine (US, UK), and the international humanitarian community including the UN and local and international NGOs.

The Government of Ukraine coordinates its response to the IDP emergency in the GCAs, through an inter-agency coordination council led by the State Emergency Services under the supervision of the Deputy Prime Minister. Regional governors and mayors have led in facilitating the reception of IDPs, often using their own understanding of priority issues, supported by civil society driving the assistance effort¹⁰⁴.

In the case of emergencies, States should facilitate safe and unimpeded access for international assistance. Humanitarian laws, the Geneva Conventions, and additional protocols, include the right to access to food in situations of armed conflict and occupation. States should make every effort to ensure that refugees and IDPs have access at all times to adequate food (The Sphere Handbook. 2011¹⁰⁵)

¹⁰¹ <http://www.unocha.org/top-stories/all-stories/ukraine-10-things-you-need-know>

¹⁰² ACAPs. The Conflict in Eastern Ukraine, Briefing report. 10 March 2015

¹⁰³ <http://www.unocha.org/top-stories/all-stories/ukraine-10-things-you-need-know>

¹⁰⁴ UNHCR. Profiling and Needs Assessment of IDPs. 17 October 2014

¹⁰⁵ The Sphere Project. Humanitarian Charter and Minimum Standards in Humanitarian Response. 2011

A steady deterioration of the humanitarian situation following the failure of a September ceasefire attempt led to the activation of a selection of IASC clusters on the 23rd of December 2014, including the Food Security and Nutrition Cluster. UNICEF is the UN agency responsible for IYCF in the field. As well as provision of aid from formal aid organisations, aid is also being provided by wealthy Ukrainians and, in the NGCAs, from Russia.¹⁰⁶

The operational context provides a challenging environment for humanitarian agencies in Ukraine.

- In areas of frequent fighting along the confrontation line, humanitarian access to the affected population has been limited access due to security constraints.
- There are several types of actors: national and international NGOs, groups of volunteers, local foundations, religious structures, United Nations agencies, state entities.
- Operational actors have different approaches, international agencies undertaking needs assessment and beneficiaries' identification prior to programmes' implementation, on the other hand national organisations providing direct assistance with poor, when any, records of the activities carried out
- Population movements linked with the intensity of fighting and shelling, which hinders a fully accurate assessment, planning, monitoring and impact evaluation
- Additionally, the majority of IDPs are living amongst the host community, challenging to the ability to identify and access them
- A challenging legislative and taxation system in Ukraine, for humanitarian aid at beneficiary and organizational levels, are taxable unless a long project registration process is followed.
- Complex administrative, legislative and taxation, procedures for humanitarian aid slows down the implementation of activities.

Positive factors about the operational context include the fact that Ukraine is a middle-income country with a functioning sovereign government, a well-educated and literate (99.8% adults) population and a growing civil society movement.

Relief operations have demonstrated that working with and through local organisations is an effective option to reach those most in need; however it is also important to ensure aid is destined for civilians and not for political and military gain.^{107, 108}

Humanitarian needs have been reported to be highest in and around the front lines in Donetsk and Luhansk. The 'Assessment Capacities Project' (ACAPS) in March 2015 estimated that 1.2m people in rebel-held areas are in need of food, water, shelter and health care, compared to 430,000 in government-held areas¹⁰⁹ Those that have remained in the NGCAs of Donetsk are mostly the elderly, the sick and women and children, who are not easily evacuated or who have elected to stay to keep their families intact¹¹⁰

Key humanitarian issues have been defined as being continued displacement, protection of affected populations, humanitarian access, emergency shelter and non-food items, access to food, WASH, health and other life-saving services, ongoing insecurity¹¹¹ The Multi-Sector Needs Assessment in March 2015 found a lack of household resources appeared to be the main reason household needs were not able to be met, namely financial resources. In NGCAs this was linked to lack of administration, reduced employment opportunities, absence of pensions and social benefit payments and closure of banks, creating forced movement of people into government controlled areas. In GCAs employment opportunities for IDPs are limited and delays in financial assistance and social benefits have been reported, and as of January 2015 cessation of social welfare benefit payments to IDPs^{112, 113, 114}

¹⁰⁶ The Conflict in Eastern Ukraine, ACAPS briefing report, 10 March 2015

¹⁰⁷ OCHA. Ukraine Humanitarian Response Plan (revised) January to December 2015. February 2015

¹⁰⁸ The Conflict in Eastern Ukraine, ACAPS briefing report, 10 March 2015

¹⁰⁹ The Conflict in Eastern Ukraine, ACAPS briefing report, 10 March 2015

¹¹⁰ The Conflict in Eastern Ukraine, ACAPS briefing report, 10 March 2015

¹¹¹ OCHA Ukraine Humanitarian Snapshot. 02 July 2015

¹¹² Report of the Global Nutrition Cluster scoping mission to Ukraine, February 2015

¹¹³ UNHCR Participatory Assessment Kharkiv and Northern Donetsk, Ukraine, April 2015

¹¹⁴ Ukraine NGO forum. Ukraine multi-sector needs assessment (MSNA) report. March 2015

The crisis in Ukraine is a highly political context and there is a need for a principled (impartial, neutral, and independent) humanitarian approach to ensure access across both sides of the conflict line¹¹⁵

Post-crisis infant and young child feeding and other sectors

Infant and young child feeding

Infants, toddlers and children under 5 years have been identified as the second most vulnerable group overall in GCAs and the most vulnerable in NGCAs.¹¹⁶ For nutrition, their vulnerability is linked to their reliance on others for their care, specific nutritional requirements and the sub-optimal pre-crisis feeding practices.

Of people officially registered as at 17th April 2015, the Nutrition Sub-Cluster estimated that, of children under 2 years of age in need, more than 63,000 children are living in NGCAs of Donetska and Luhanska Oblast and about 9,000 IDP children in government controlled Donetsk oblast¹¹⁷

Generally, in conflict-affected NGCAs and GCAs, self-reports inform of difficulty providing food according the age-specific dietary requirements, with concerns expressed about the limited availability of food in the markets (particularly in NGCAs), price rises and lack of resources to purchase food. Foods most often requested by affected populations have been reported to be commercial baby foods and infant formula^{118, 119, 120}

A report on a scoping mission by the Global Nutrition Cluster in February 2015¹²¹ outlined several areas of concern, both in the immediate food security context as well as entrenched caring practices and code violations with the provision of breast-milk substitutes.

Key informant interviews with health care providers and focus groups discussions with affected population conducted in Donetska, Luhanska and Kharkivska Oblasts in April 2014 reported pre-crisis sub-optimal feeding practices had deteriorated post-crisis, with mothers complaining that they lost breast-milk supply because of inadequate food consumption or stress. It was also found that most violations of the WHO/UNICEF recommendations on IYCF and MOH order 149 were in delivery places, known as "roddoms"¹²²

Pre-crisis many powdered milks were imported from Europe, however 'Malysh' and 'Malutka' were produced locally including in Donetsk and in Russia. A 'Rapid assessment for Market' in GCAs in 2015 found that many wholesalers of powdered milk who were based in Donetsk have moved to GCAs meaning specialised baby food and powdered milk are no longer being produced in NGCAs. Prices of the locally available baby formula Malysh by 46% and Malutka by 37%. Imported brands Babi, Nestogen and Nan have increased by 98%, 186% and 83%, respectively.

Early in the humanitarian response, Nutrition partners had informed of their distribution of infant formula, bottles and teats and expressed concern about the lack of infant formula for distribution, in many cases not aware of the MoH orders on IYCF. This raised concerns about well-meant but ill-advised donations and distributions by local small civil society and volunteer organisations¹²³

¹¹⁵ Save the Children Ukraine Response Strategy 2015

¹¹⁶ Ukraine ACAPS/NGO forum. Ukraine multi-sector needs assessment (MSNA) report. March 2015

¹¹⁷ Ukraine Nutrition Sub-Cluster Response Plan. May-December 2015. May 2015

¹¹⁸ Kiev International Institute of Sociology. November 2014

¹¹⁹ Ukraine ACAPS/NGO forum. Ukraine multi-sector needs assessment (MSNA) report. March 2015

¹²⁰ Ukraine Nutrition Sub-Cluster Response Plan. May-December 2015. May 2015

¹²¹ Global Nutrition Cluster. Report of the Global Nutrition Cluster scoping mission to Ukraine. February 2015

¹²² Ukraine Nutrition Sub-Cluster Response Plan. May-December 2015. May 2015

¹²³ Ukraine Nutrition Sub-Cluster Response Plan. May-December 2015. May 2015

According to the Operational Guidance, the decision to accept, procure, use or distribute infant formula in an emergency must be made by informed, technical personnel in consultation with the coordinating agency, lead technical agencies and governed by strict criteria. Breast milk substitutes, other milk products, bottles and teats must never be included in a general ration distribution. Breast milk substitutes and other milk products must only be distributed according to recognized strict criteria and only provided to mothers or caregivers for those infants who need them. The use of bottles and teats in emergency contexts should be actively avoided¹²⁴

The 2015 Rapid assessment for Market (RAM) in GCAs found that although all sourcing of buckwheat, pasta, sugar, flour and fruits and vegetables from NGCAs had ceased, markets had sufficient supply as they had little reliance on the NGCAs.

The Multi-Sector Needs Assessment in March 2015 found the top self-reported priorities of surveyed households in GCAs and NGCAs of Donetsk and Luhansk to be: livelihoods as an overall first priority; food as first priority in the NGCAs and second in GCAs; health, particularly in Donetsk and Luhansk oblasts; shelter for IDPs outside the conflict zone in the “DKZ” oblasts; protection, safety and dignity as priorities for those in NGCAs.¹²⁵

Based on focus group discussion and key informant interviews, micronutrient deficiencies, particularly anaemia prevalence, are of concern in the crisis affected population, considering the pre-crisis prevalence; however no post-crisis data exists.

Nutrition Sub-Cluster

The Food Security and Nutrition Cluster, led by WFP, was created in Ukraine at the end of December 2014 following the conflict in Donbas region and population displacement.

Following recommendations from a Global Nutrition Cluster scoping mission to Ukraine in February 2015 a Nutrition Sub-Cluster, led by UNICEF, was positioned under the Health and Nutrition Cluster. As at end June 2015, the Nutrition Cluster had five partners listed in their 5Ws Activities database. Many of the Nutrition Sub-Cluster partners are also partners of the Food Security Cluster.

The primary goal of the Nutrition Sub-Cluster is to contribute to the prevention of death and the reduction of acute/chronic under-nutrition and associated micronutrient deficiency disorders among vulnerable conflict-affected populations inside Ukraine. Children under five, and especially under-two, years of age and pregnant and lactating women are included among the most vulnerable in terms of nutrition.

The Nutrition sub-Cluster strategic objectives relevant to IYCF reflect the Health Cluster objectives 2 and 4.

- Provide reliable health and nutrition information for evidence-based emergency response, monitoring and policy decision-making
- Contribute to prevention of excessive nutrition-related morbidity and mortality of vulnerable groups

The Nutrition Sub-cluster response plan for May-December 2015 (an update on the February 2015 Ukraine Humanitarian Response Plan) focuses on preventative activities, namely the support, protection and promotion of breastfeeding and appropriate complementary feeding in NGCAs and the contact line of the two Oblasts (Donetska and Luhanska) that have been directly affected by the conflict.

The most critical issues identified by partners as requiring immediate interventions included: advocacy to regulate donations and indiscriminate distribution of breast-milk substitutes to breastfed infants, capacity building of nutrition partners and humanitarian community in IYCF and nutrition in emergencies, counselling services on nutrition to pregnant and lactating women and caretakers of boys and girls aged 0-23 months in selected GCAs, and provision and distribution of complementary food for boys and girls 6-23 months in NGCAs.

IYCF activities of the Nutrition Sub-Cluster achieved as at mid-July 2015¹²⁶ included:

¹²⁴ IFE Core Group, Operational Guidance on Infant and Young Child Feeding in Emergencies (for emergency relief staff and programme managers), version 2.1, February 2007

¹²⁵ Ukraine Multi-Sector Needs Assessment Report 30th March 2015

¹²⁶ Ukraine Nutrition Sub-Cluster Response Plan May-December 2015. May 2015

- IYCF Joint Statement developed (directed at promoting, protecting and supporting breastfeeding and appropriate complementary feeding, while addressing needs of BMS-dependent infants), currently pending endorsement by the Minister of Health
- Standard operating procedure (SOP) criteria for targeting and use of infant formula in each programming context established and agreed upon by partners (*See Annex 5*)
- Complementary food basket for children 6-23 month developed in collaboration with the Food Security Cluster¹²⁷
- Advocacy toolkit developed
- Contingency plan developed
- IFE Operational Guidance translated in Russian
- Multiple micronutrient powder distribution, for home food fortification, proposed for IDP children 6-23 months in 5 priority GCAs, including Donetsk Oblast

As at end-June 2015, IYCF relevant activities by partners specified in the 5Ws in assessment coverage areas of included:

- *Completed:* UNICEF funded two IYCF assessments covering four of five priority oblasts (Donetska, Kharkivska, Zaporizhska, Dnipropetrovska) and in GCAs of Donetsk trained volunteers in 16 collective centers to provide IYCF counselling to caretakers of children 6-23 months and developed IYCF promotional materials
- *Ongoing:* Akhmetov Foundation is delivering about 39,000 complementary food baskets per month for children 0-23 months, 33,000 in NGCAs and 6,000 in GCAs, including Donetsk City, Makiivka, Yenakiieve, Slovianske, Kramatorsk). This includes distribution of infant formula to all children under 1 year of age (about 40% of all children).^{128, 129}

Nutrition programmes are implemented in collaboration with the MoH and relevant health programmes. For example breastfeeding and appropriate complementary feeding promotion is delivered as a part of the 'Maternal and Child Health' programmes in Ukraine, and in accordance with MoH and WHO protocols.

Other sectors

Health

The already weak pre-crisis Ukrainian health system has been extremely strained, particularly in conflict affected regions with the highest IDP and returnee caseloads.

Health service delivery in the conflict areas has been affected due to discontinuation of State support in December 2014, which affected the supply of medicine, and insufficient medical staffing due to displacement¹³⁰

In GCAs, no extra-budgetary resources have been allocated for IDP health services, therefore where there are displaced people the health system is overstretched. Additionally, in many locations and supplies are not available to replenish stocks.

Hospitals and health care facilities are totally relying on voluntary donations and supplies provided by Health Cluster partners, WHO, UNICEF, ICRC, MSF/B, private/voluntary donations or through Russian convoys.

While IDPs have free access to the public health system, this system does not cover the cost of medications. According to the HRP (revised in February 2015), WHO estimates that around 2.2 million conflict-affected people (IDPs, host communities, returnees and residents of conflict zones) are in need of assistance as they are unable to purchase out-of-pocket health services^{131, 132}

¹²⁷ Ukraine Nutrition Sub-Cluster Response Plan 2015. May 2015

¹²⁸ Ukraine Nutrition Sub-Cluster 5Ws. June 2015

¹²⁹ Ukraine Nutrition Sub-Cluster meeting, 16 July 2015

¹³⁰ Humanitarian System Monitoring Report. December 2014

The latest available data (MoH statistics, 2014) for anaemia prevalence in pregnant women reported 24.1% nationwide with substantial variation between oblasts; 29.0% in GCAs of Donetsk Oblast, however there is no distinction between the IDP and host population.¹³³

Donetsk and Luhansk Oblast are home to some 31,076 people living with HIV, of which an estimated 13,449 were under ARV treatment in 2015, and 4,653 TB patients, of which 1,078 are considered Multi-drug Resistant Tuberculosis (MDR-TB) patients¹³⁴.

Given the large population displacement and the lowest vaccination rates in Europe, with the Government is challenged with procuring vaccines. In July 2015 barely 50% of the 7.9 million children were reportedly fully vaccinated.¹³⁵ Low vaccination rates heighten the risk of outbreaks of vaccine-preventable diseases, especially among children. Donetsk and Luhansk oblasts are at particularly high risk of communicable-disease outbreaks due to a lack of safe drinking water and inadequate waste removal. The HSM data indicated an increase in respiratory infections, anemia, chronic malnutrition, psychological trauma and mental health issues^{136, 137, 138, 139}

Food security

In eastern areas, the high levels of inflation in Ukraine, increased fuel cost, market breakdown, restricted physical access for people and supplies due to front-line movement restrictions, a weak labour market, and decreased purchasing power among conflict-affected populations has impacted on deterioration in food security.

This is compounded by IDPs having difficulties finding employment, fewer employment opportunities being available in regions where housing costs are low and reported accessing bank accounts and receiving social benefits.

UNHCR's humanitarian severity monitoring network has identified widespread use of coping strategies including switching to less preferable foods and high reliance on in-kind humanitarian food distributions.

In Ukraine home gardens are a major source of food for much of the population; from autumn disappearance of kitchen gardens will further constrain food security.

Water, Sanitation and Hygiene

The crisis in Donetsk Oblast has significantly increased the vulnerability of the water, sanitation and power infrastructure, posing a serious threat to the health and wellbeing of the people. The soviet era water supply system is centralised. The main water supply lines cross and/or run along the conflict zone, and water supply and sanitation utilities lack sufficient resources for timely necessary maintenance and repairs of infrastructure damaged by the conflict¹⁴⁰ The 2015 Humanitarian Response Plan highlighted that 1.3 million people were in need of WASH support, in the conflict-affected areas of eastern Ukraine. In GCAs, sanitary and hygiene product retailers no longer supply the cheap products previously sourced from Donetsk^{141, 142, 143, 144} A Save the Children assessment in GCAs of Donetsk reported the requested need for hygiene kits and baby kits for collective centres.

¹³¹ Ukraine Health Cluster Response Plan. February 2015

¹³² UNHCR. Profiling and Needs Assessment of IDPs. 17 October 2014

¹³³ Ukraine Nutrition Sub-Cluster Response Plan May–December 2015. May 2015

¹³⁴ OCHA. 2015 Humanitarian Response Plan Ukraine (revised) January – December 2015. . February 2015

¹³⁵ UNICEF. [http://www.unicef.org/ukraine/donor_briefs_17.07.2015\(1\)_health.pdf](http://www.unicef.org/ukraine/donor_briefs_17.07.2015(1)_health.pdf). July 2015

¹³⁶ http://apps.who.int/immunization_monitoring/globalsummary/countries?countrycriteria%5Bcountry%5D%5B%5D=UKR&commit=OK

¹³⁷ http://www.who.int/immunization/monitoring_surveillance/data/ukr.pdf

¹³⁸ <http://www.pharmaceutical-journal.com/news-and-analysis/news/who-says-ukraine-is-at-risk-of-polio-outbreak-as-vaccine-stockpiles-dry-up/20066444.article>

¹³⁹ Ukraine Nutrition Sub-Cluster Response Plan 2015. May 2015

¹⁴⁰ Save the Children Ukraine Humanitarian Response Strategy 2015

¹⁴¹ Rapid Assessment for Market (RAM) Report, March 2015

¹⁴² OCHA. Ukraine Humanitarian Response Plan. 2015

¹⁴³ Ukraine NGO forum. Ukraine multi-sector needs assessment (MSNA) report. March 2015

¹⁴⁴ Save the Children Ukraine Humanitarian Response Strategy 2015

Child Protection

The Nutrition Sub-Cluster has identified that numerous reports have highlighted the impact that the conflict, in terms of psychosocial trauma, is having on women and caretakers, impacting on their capacity to care and feeding practices for infants and young children¹⁴⁵

Shelter and Non-food items

It is estimated that approximately 80% of IDPs live in the private sector ie stay with relatives, friends, other host families, or in rented apartments, with the rest living in a variety of collective centres, some of which were created spontaneously by religious or civic groups, individuals or organised by the regional or municipal authorities using both public and private premises.¹⁴⁶

Svitohirske, Slovianske, and Kramatorsk serve as a transit point, as well as a place for temporary relocation for many IDPs fleeing the active conflict zones. The majority stay in rented apartments or live in private houses with relatives, however in Svithirske (a remote area where there is less availability of services, transport links are poor, and employment options scarce) some vulnerable categories of IDPs are accommodated at collective centres/summer camps.¹⁴⁷

The MSNA identified that among the different IDP living arrangements, those in collective centres reported higher concerns in terms of food, health and children showing signs of stress.¹⁴⁸

Collective centres are often overcrowded, with issues of lack of privacy and tension due to sharing of rooms and coexistence of people with different political views, and some with poor access to and conditions of washing and food preparation facilities. Collective centres also appeared to be the main target for assistance. It needs to be considered that those living in collective centres are more visible than those in private accommodations^{149, 150}

IDPs living in the private sectors also report multiple challenges. Not wanting to trespass for too long on the hospitality of their hosts, they sometimes move frequently among friends and relatives, which complicates their efforts to re-establish a sense of stability. Household conflicts are common. Rent and utility prices have dramatically increased¹⁵¹

¹⁴⁵ Ukraine Nutrition Sub-Cluster Response Plan 2015. May 2015

¹⁴⁶ UNHCR. Profiling and Needs Assessment of IDPs. 17 October 2014

¹⁴⁷ UNHCR. Profiling and Needs Assessment of IDPs. 17 October 2014

¹⁴⁸ Ukraine ACAPS/NGO forum. Ukraine multi-sector needs assessment (MSNA) report. March 2015

¹⁴⁹ Global Nutrition Cluster scoping mission report. February 2015

¹⁵⁰ Ukraine ACAPS/NGO forum. Ukraine multi-sector needs assessment (MSNA) report. March 2015

¹⁵¹ Global Nutrition Cluster scoping mission report. February 2015

PART THREE

ANNEX

Annex 1: Assessment timeline

| Result | Activities | Timeline | | | | | |
|---------------------|--|-------------|--------------|---------------|---------------|------------|------------|
| | | 2-4 June | 5-13 June | 14-24 June | 25-27 June | 15 July | 31 July |
| Preparatory phase | Finalise Assessment Tools | X | | | | | |
| | Enumerator Training | X | | | | | |
| Data collection | Data Collection and entry | | X | | | | |
| Data analysis | Data analysis | | | X | X | | |
| Preliminary results | Presentation of ppt to Nutrition Sub-Cluster | | | | | X | |
| Report submission | Draft report submitted to Save the Children | | | | | | X |

Annex 2: Characteristics of the assessment locations

Svitohirske is a forested tourist destination, 30 kilometers (19 mi) from the city of Sloviansk. The 2013 population was estimated at 4,654.¹⁵² In June 2015 an estimated 6.5-8,000¹⁵³ IDPs resided in Svitohirske, many in collective centres.

Kramatorsk is located at the northern portion of Donetsk Oblast, in eastern Ukraine. Since October 11, 2014 Kramatorsk has been the provisional capital of Donetsk Oblast, following the events surrounding the conflict in Donbass. In 2013 there was an estimated population of 164,283. In June 2015 an estimated 41,151 IDPs were resident.

Sloviansk is a city that serves as the administrative center of the Sloviansk Raion (district) though it does not belong to the raion. The city was one of the focal points in the early stages of the 2014 pro-Russian conflict in Ukraine, but was retaken by Ukrainian forces in July 2014. In 2013 there was an estimated population of 117,445. In June 2015 an estimated 29,183 IDPs resided there.

¹⁵² State Statistics Service of Ukraine. Retrieved 21 January 2015

¹⁵³ Department of Social Protection statistics

Annex 3: Training of enumerators/interviewers schedule and content

| Time | Section | Content |
|---------------|--|--|
| Day 1 | | |
| 9.00 - 9.15 | Welcome tea | |
| 9.15 | Welcome and Introductions | |
| | Training overview | Schedule. Methodology. Ways of working. Times and days |
| | Assessment overview | - Background to the assessment: Assessment context. IYCF-E. Assessment development and purpose. How information will be used. - Assessment schedule: HHQs; FGDs; KIs. Data analysis. Report. - Daily schedule: Start-finish. Pre- and end of day briefing meetings |
| | Team members roles and responsibilities | Principles and Code of Conduct Communication in the field |
| 10.00 -10.15 | Morning break | |
| | Understanding the questionnaire | Reviewing understanding the terminology and components of the questionnaire |
| | Review of questionnaire | Language clarity. Cultural/social appropriateness. Ease of administration |
| | Interview techniques | Techniques conducting the interview |
| 12.30-13.30 | Lunch | |
| | MUAC assessment | Training on assessing MUAC |
| 15.00 – 15.15 | Afternoon tea | |
| | Sample selection | Household selection methods. Daily house-to-house visitation planning |
| | Conducting home visits | Protocol |
| | Using the questionnaire | Role play using various household scenarios |
| | Questions and Answers | Answering potential questions |
| Day 2 | | |
| 9.00 - 9.15 | Welcome tea | |
| | Starting the day exercise | What is the truth? |
| | Administration | Forms to complete daily. Cluster control form. Diapers distribution. Petrol reimbursement. Mobile top-up |
| | MUAC standardization test | Standardization test performed on 10 children aged 6-23 months |
| 10.00-10.15 | Morning tea | |
| | MUAC standardization test | Continuation of MUAC standardization test |
| 12.30-13.30 | Lunch | |
| | Data entry | Entering data on the tablets |
| 15.00 – 15.15 | Afternoon tea | |
| | Role play | Household visits, questionnaire administration and data entry |
| Day 3 | | |
| 9.00 - 9.15 | Welcome tea | |
| | Practicum: Field practice | Pre-testing facilitating the household questionnaire interviews with: 1. Known family. 2. Unknown family (Enumerator pairs each assess MUAC, concealing results, then share to determine if assessed same measure) |
| 12.30-13.30 | Lunch | |
| 13.30 | Review of practicum | Troubleshooting, questions, review of performance |
| 15.00 – 15.15 | Afternoon tea | |
| | Finalizing the training | Final questions, answers, comments |
| | Planning for commencing data collection | Allocation of location and households |

Annex 4: International instruments for protecting, promoting and supporting breastfeeding

The Operational Guidance on Infant and Young Child Feeding in Emergencies v2.1. 2007¹⁵⁴

'Operational Guidance for Emergency Relief Staff and Programme Managers on infant and young child feeding in emergencies', which includes the protection, promotion and support for optimal breastfeeding, and the need to minimize the risks of artificial feeding, by ensuring that any required breast-milk substitutes are purchased, distributed and used according to strict criteria

Key Points:

1. Appropriate and timely support of infant and young child feeding in emergencies (IFE) saves lives.
2. Every agency should endorse or develop a policy on IYCF-E. The policy should be widely disseminated to all staff, with agency procedures adapted accordingly and policy implementation enforced.
3. Agencies should ensure the training and orientation of their technical and non-technical staff in IYCF-E, using available training materials.
4. Within the United Nations Inter-agency Standing Committee (IASC) cluster approach to humanitarian response, UNICEF will likely be the UN agency responsible for coordination of IYCF-E in the field. Other United Nations agencies and NGOs do, nonetheless, have key roles to play in close collaboration with the government.
5. Key information on infant and young child feeding needs to be integrated into routine rapid assessment procedures. If necessary, more systematic assessment using recommended methodologies could be conducted.
6. Simple measures should be put in place to ensure that the needs of mothers, infants and young children are addressed in the early stages of an emergency. Support for other caregivers and those with special needs, e.g., orphans and unaccompanied children, must also be established at the outset.
7. Breastfeeding and infant and young child feeding support should be integrated into other services for mothers, infants and young children.
8. Foods suitable to meet the nutrient needs of older infants and young children must be included in the general ration for food-aid dependent populations.
9. Donated (free) or subsidized supplies of breastmilk substitutes (e.g., infant formula) should be avoided. Donations of bottles and teats should be refused in emergency situations. Any well-meant but ill-advised donations of breastmilk substitutes, bottles and teats should be placed under the control of a single designated agency.
10. The decision to accept, procure, use or distribute infant formula in an emergency must be made by informed, technical personnel in consultation with the coordinating agency, lead technical agencies and governed by strict criteria
11. Breastmilk substitutes, other milk products, bottles and teats must never be included in a general ration distribution. Breastmilk substitutes and other milk products must only be distributed according to recognized strict criteria and only provided to mothers or caregivers for those infants who need them. The use of bottles and teats in emergency contexts should be actively avoided.

The International Code of Marketing of Breast milk Substitutes ('The Code') is an international health policy framework for breastfeeding promotion, adopted by the World Health Assembly (WHA), of the World Health Organization (WHO) in 1981, and supported by subsequent WHA resolutions. It provides a minimum global standard aiming to protect appropriate infant and young child feeding by requiring States to regulate the marketing activities of enterprises producing and distributing breastmilk substitutes. The Code provides recommendations on the restrictions on marketing of breastmilk substitutes, to ensure that mothers are not discouraged from breastfeeding and that substitutes are used safely if needed. The Code also covers ethical considerations and regulations for the marketing of feeding bottles and teats. Some of the provisions in the Code include:

- No advertising to the public of any product within the scope of the Code;
- No free samples to pregnant women and mothers;
- No promotion of products through healthcare systems;
- No gifts to healthcare providers;
- No words or pictures idealizing artificial feeding or pictures of infants on labels of formula cans, feeding bottles, etc
- Mothers should be informed on the risks of artificial feeding^{155, 156, 157}

¹⁵⁴ IFE Core Group, Operational Guidance on Infant and Young Child Feeding in Emergencies (for emergency relief staff and programme managers), version 2.1, February 2007

¹⁵⁵ WHO. The international code of marketing of breast milk substitutes. 1981

¹⁵⁶ http://www.unicef.org/ukraine/ukr/7_Code_on_Breastfeeding_substitutes.pdf

¹⁵⁷ WHA Resolution text 2010 http://apps.who.int/gb/ebwha/pdf_files/WHA63-REC1/WHA63_REC1-P2-en.pdf

WHA: Resolution 63.23 (May, 2010)¹⁵⁸ Urges Member States:
“to ensure that national and international preparedness plans and emergency responses follow the evidence-based”

Human rights treaties¹⁵⁹

These endorse that States have the obligation to create a protective and enabling environment for women to breastfeed, through protecting, promoting and supporting breastfeeding

- International Covenant on Economic, Social and Cultural Rights (CESCR), especially *article 12 on the right to health*, including sexual and reproductive health, *article 11 on the right to food* and *articles 6, 7 and 10 on the right to work*
- Convention on the Rights of the Child (CRC), especially *article 24 on the child’s right to health*
- Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), in particular *articles 1 and 5 on gender discrimination on the basis of the reproduction status* (pregnancy and lactation), *article 12 on women’s right to health* and *article 16 on marriage and family life*

Annex 5: Acceptable reasons for the use of breast milk substitutes¹⁶⁰

Infants’ conditions: Infants who should not receive breast milk or any other milk except specialised formula

- Infants with classic galactosemia: a special galactose-free formula is needed
- Infants with maple syrup urine disease: a special formula free of leucine, isoleucine and valine is needed
- Infants with phenylketonuria: a special phenylalanine-free formula is needed (some breastfeeding is possible, under careful monitoring)

Maternal condition: Maternal conditions that may justify permanent avoidance of breastfeeding

- if replacement feeding is acceptable, feasible, affordable, sustainable and safe

Maternal condition: Maternal conditions that may justify temporary avoidance of breastfeeding

- Severe illness that prevents a mother from caring for her infant, for example sepsis
- Herpes simplex virus type 1 (HSV-1): direct contact between lesions on the mother’s breasts and the infant’s mouth should be avoided until all active lesions have resolved
- Maternal medication:
 - Sedating psychotherapeutic drugs, anti-epileptic drugs and opioids and their combinations may cause side effects such as drowsiness and respiratory depression and are better avoided if a safer alternative is available
 - Radioactive iodine-131 is better avoided given that safer alternatives are available – a mother can resume breastfeeding about two months after receiving this substance
 - Excessive use of topical iodine or iodophors (e.g., povidone-iodine), especially on open wounds or mucous membranes, can result in thyroid suppression or electrolyte abnormalities in the breastfed infant and should be avoided
 - Cytotoxic chemotherapy requires that a mother stops breastfeeding during therapy

Other:

- Absent or dead mother, infant rejected by mother
- Re-lactating mother until lactation is re-established
- Mother who was artificially feeding her infant prior to the emergency (note: if the child was mixed fed, i.e. fed with breast-milk and infant formula, this should be actively discouraged, no supply of the infant formula should be provided to such child).

¹⁵⁸ WHA Resolution text 2010 http://apps.who.int/gb/ebwha/pdf_files/WHA63-REC1/WHA63_REC1-P2-en.pdf

¹⁵⁹ IBFAN. Report on the situation of infant and young child feeding in Ukraine. The committee on economic, social and cultural rights. 2013

¹⁶⁰ Standard operating procedures on donations, distribution and procurement of infant formula and infant feeding equipment as agreed by the Nutrition Sub-Cluster of the Health and Nutrition Cluster on the 13 May 2015