

Lessons Learned from Initiating Infant and Young Child Feeding in Emergencies Programming for the Ukraine Response in 2022

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Background

The Russian Federation's full-scale invasion of Ukraine in February 2022 resulted in the largest and fastest displacement of people in Europe since World War II. Most of those displaced were women and children.¹ As news reports depicted women birthing in bomb shelters, the destruction of electricity and water supply systems, widespread uncontrolled donations of commercial infant milks and foods, and stressed families carrying young children through rubble in sub-zero temperatures, the need for urgent infant and young child feeding in emergencies (IYCF-E) support was clear.

As described in this case study, the nature and scale of the crisis required innovative approaches by the humanitarian community, as the affected population had specific requirements that needed to be understood and respected. This case study outlines the early experiences of establishing and implementing IYCF-E interventions as part of the Ukraine Emergency Response. It highlights key technical reflections, aiming to provide insights that can inform the current crisis and future emergencies in similar contexts. Given the expanding scope of humanitarian crises and the likelihood of a growing number of comparable emergencies, the capturing of lessons learned was deemed important by the Global Nutrition Cluster (GNC) Technical Alliance².

Methodology

This case study draws upon the experiences of 35 individuals directly involved in the early response, where 69 per cent (n = 24) were Ukrainian nationals. The documentation process involved a desk review, key informant interviews (n = 15) and an online survey (n = 22), carried out between October 2022 and April 2023. A mostly qualitative survey was circulated in English and Ukrainian to 42 Ukrainian breastfeeding counsellors (response rate 52 per cent, and follow-up interviews were held with two survey respondents).³ Interviewees also included professionals from various United Nations (UN) agencies and international non-governmental organisations (NGOs) involved in IYCF-E.

Scope

This informal study focused on capturing technical lessons learned during preparedness and the initial six months of the response in Ukraine (February – August 2022), in particular exploring in-country perspectives of global and regional technical IYCF-E support. The study does not extend to the response in neighbouring countries.

While acknowledging the pressing and important need to address breastmilk substitutes (BMS) programming in contexts such as Ukraine, due to the complexity of this issue and existing initiatives already addressing it,⁴ limited attention was given to this topic during interviews to ensure coverage of other vital IYCF-E aspects.

Limitations

During the development of this case study, numerous limitations surfaced, which provided insights. Concerning the international humanitarian response, challenges emerged in obtaining data and reports at coordination and partner levels, hindering a comprehensive understanding of the IYCF-E services conducted. Difficulties were encountered in securing key informants for interviews, presumably due to high turnover, heavy workloads, the low number of implementing partners for IYCF-E and limited coordination in 2022. Some key individuals, such as the acting nutrition cluster coordinators that were in place for most of the early response, were unavailable for interview. This could be attributed changes in accountability following the handing over of nutrition coordination responsibilities to the WHO-led Health Cluster, as well as specific IYCF-E coordination challenges described later in this case study. Notably, international actors were unable to provide contact details for local actors due to the lack of formal partnerships and limited informal engagement at the time of their interviews, highlighting a significant finding.

¹ In July 2022, the International Organization for Migration (IOM) estimated that 5 per cent were infants (aged 0–11 months) and 4 per cent were pregnant or breastfeeding women.

² The GNC Technical Alliance is a mechanism that supports countries, agencies, and nutrition practitioners in humanitarian situations with technical assistance to meet the nutrition rights and needs of people affected by emergencies. ENN is part of the Alliance's leadership team and helps to facilitate learning based on identified learning gaps and needs. This case study was originally commissioned as part of work within the GNC Technical Alliance.

³ Breastfeeding counselling providers included health care professionals and paraprofessionals. Among the respondents were 18 lactation consultants (including one International Board Certified Lactation Consultant (IBCLC), two peer supporters, 14 doctors and nurses, one midwife, two psychologists and two doulas. A total of 2 follow-up interviews were conducted with the BFHI National Coordinator and Head of the Methodological Monitoring Centre of a national children's hospital, as well as with a lactation consultant, trainer and psychologist.

⁴ United Nations Children's Fund. *Case studies for the management of non-breastfed infants in emergencies*. UNICEF, New York, 2023

The effort required to identify and engage key Ukrainian informants, reduced the time remaining for primary data collection. Though there was a high level of interest and willingness to contribute among those who we were able to contact, translation needs coupled with subsequent time and budget constraints meant it was not possible to do a thorough desk review of tools and documents in Ukrainian or additional in-depth interviews and survey follow-ups in Ukrainian. Little recent data was located regarding complementary feeding practices and how they were impacted; the majority of key informants consulted for this case study were focused on supporting infant feeding rather than complementary feeding.

Context

The Ukrainian context was, in many ways, distinct from that of other recent humanitarian crises. As is typical for many European countries, pre-crisis information reveals low birth rates with most births occurring in health facilities, high education levels among women and good awareness of breastfeeding,⁵ yet prevalent mixed feeding with breastmilk and BMS. BMS was imported and expensive. Rates of wasting were low. Prior to the 2022 invasion, there were well-established infant feeding support services and networks and an adequate IYCF policy and national plan of action in place. Yet, from a preparedness perspective, inadequate IYCF-E policy and preparedness plans, and limited pre-existing in-country humanitarian mechanisms were noted. BMS marketing was pervasive and Code⁶ monitoring and enforcement measures were deemed weak in 2020.⁷ Although national legislation was updated in 2021 to meet European Union requirements and better reflect the Code, the COVID-19 pandemic hampered their implementation.

The responsibility for IYCF lay with the Ministry of Health, with the UNICEF-supported Baby-Friendly Hospital Initiative (BFHI)⁸ leading the way within Ukraine's well-developed health system. By 2021, 92 per cent of maternity hospitals, 66 per cent of children's hospitals and 6.5 per cent of primary health care centres were BFHI-accredited.⁹ However, Ukraine's health system had been put under strain by the COVID-19 pandemic and by ongoing conflict in eastern parts of the country.

At the war's onset, the United Nations Population Fund estimated that 256,000 women were pregnant, with 80,000 expected to give birth within three months.¹⁰ In areas with active fighting, women resorted to birthing at home, in bomb shelters or makeshift maternity wards in hospital basements staffed by committed health workers and breastfeeding counsellors who moved on-site for the first few months of the war. By August 2022, six months into the war, 6.6 million people were internally displaced, and even more sought refuge outside of Ukraine.¹¹

Other important contextual factors included the risk of nuclear accidents and other warfare threats; the frequently urban setting of the response; the sub-zero temperatures during the winter-time invasion, and subsequent disruption of electric, heating, phone and internet systems in some areas; and a strong culture of volunteering and charitable giving.¹² The wartime situation and humanitarian access varied throughout the country, which included: areas with active hostilities, including air strikes, areas at risk of missile strikes, to conflict-free areas receiving internally displaced persons. The high profile of the crisis attracted ample funding and attention, presenting a rare opportunity to raise global awareness on IYCF-E and deliver comprehensive IYCF-E programming. The response was locally led by the Ukrainian government and civil society,¹³ driven by national unity, with limited international presence.¹⁴

Some of these factors and complexities likely contributed to a slower start by the international humanitarian IYCF-E community, as comprehension and ways of working needed to be adjusted.¹⁵ It is also worth noting that lessons¹⁶ specific to IYCF-E were already available from the humanitarian response to conflict and displacement in eastern Ukraine in 2014 and 2015.

5 Kovtiukh, Tetiana. "Breastfeeding: Current State Of The Problem." ГРААЛЬ НАВКИ 6 (2021): 379-380.

6 The International Code of Marketing of Breastmilk Substitutes subsequent relevant World Health Assembly (WHA) resolutions (collectively referred to as "the Code"). In emergency situations, the Code is particularly important for controlling donations and distribution of breastmilk substitutes, feeding bottles and teats. The Code protects infants who are artificially fed by ensuring that product labels carry the necessary warnings and instructions, and products are provided in an appropriate manner only to those who need them. More details on the Code can be found here: <https://apps.who.int/iris/bitstream/handle/10665/254911/WHO-NMH-NHD-17.1-eng.pdf>

7 Marketing of breast-milk substitutes: national implementation of the international code, status report 2020. Geneva: World Health Organization; 2020.

8 For more information on the BFHI, see <<https://www.unicef.org/documents/baby-friendly-hospital-initiative>>.

9 Romanenko, Lidiia, Olha Shlemkevych, and Maryse Arendt. "The Current State of Breastfeeding in Ukraine: An Interview With Lidiia Romanenko and Olha Shlemkevych." *Journal of Human Lactation* (2023): 08903344221136477.

10 <https://ukraine.unfpa.org/en/tyl4q5>

11 UNHCR (2022) Ukraine Situation Flash Update #27 - August.

12 World Giving Index 2022. https://www.cafonline.org/docs/default-source/about-us-research/caf_world_giving_index_2022_210922-final.pdf

13 Many local groups were newly and rapidly formed to provide assistance (1,700 in the first 6 weeks), adding to Ukraine's pre-existing civil society. (Source: Humanitarian Outcomes, 2022).

14 Stoddard, A., Harvey, P., Timmins, N., Pakhomenko, V., Breckenridge, M.-J., & Czwarno, M. (2022, June 10). Enabling the local response: Emerging humanitarian priorities in Ukraine March–May 2022. Humanitarian Outcomes. Retrieved from https://www.humanitarianoutcomes.org/sites/default/files/publications/ukraine_review_2022.pdf

15 While progress was particularly slow for IYCF-E, the start-up and scale-up of the international humanitarian response was slow in general, across most sectors, due to lack of preparedness and contingency planning and the highly challenging operational context, among other reasons. For further information, see: Stoddard, A., Harvey, P., Timmins, N., Pakhomenko, V., Breckenridge, M.-J., & Czwarno, M. (2022, June 10). Enabling the local response: Emerging humanitarian priorities in Ukraine March–May 2022. Humanitarian Outcomes. Retrieved from https://www.humanitarianoutcomes.org/sites/default/files/publications/ukraine_review_2022.pdf.

16 Ukraine summary of lessons learned and essential documents on Infant and Young Child Feeding in Emergencies (IYCF-E)- 2015. www.enonline.net/ukrainesummaryofflessionslearnediycfe

Findings: Planning, Coordination and Assessment

De-prioritisation of IYCF-E within the international response

At the start of the war, IYCF-E as a vital component of the response was strongly advocated for at the global level by UNICEF nutrition specialists, the GNC and other Infant Feeding in Emergencies (IFE) Core Group¹⁷ members. A widely endorsed *Joint Statement on Protecting IYCF Practices in the Ukraine Conflict and Refugee Crisis* was released.¹⁸ Ukrainian breastfeeding counsellors issued a plea for support.¹⁹ INGO technical staff working in Ukraine invested significant efforts in internal and external advocacy and sensitisation on IYCF-E, including attempts to engage the Ministry of Health. However, these efforts did not result in IYCF-E being prioritised by decision-makers in Ukraine.

This deprioritisation may partially be attributed to the inclusion of IYCF-E within the emergency nutrition sector, which was deprioritised overall to focus on other sectors. As reported previously during the 2015 response,²⁰ this reluctance to strengthen nutrition emergency actions seemed to be based on the belief that Ukraine did not face food shortages and the lack of evidence of wasting presumed that any additional nutrition needs would be addressed by initiatives in the health or food systems.

Despite funding availability and advocacy efforts, little traction was gained with UNICEF Ukraine and the UNICEF Regional Office, with whom prioritisation decisions for the international response lay. Those interviewed flagged that, although no formal communication took place, IYCF-E specifically was seemingly deprioritised for reasons which remained unclear to them. As described in this case study, this directly and significantly impacted the establishment of an adequate IYCF-E response by the international community.

Gaps in the coordination of IYCF-E

The GNC intensively supported nutrition coordination, including through the provision of a dedicated Cluster Coordinator and Information Management Officer, from March until May 2022.²¹ At this point, UNICEF Ukraine, acting as Nutrition Cluster Lead Agency (CLA) indicated that coordination responsibilities would be covered by UNICEF National staff until the recruitment of a dedicated Cluster Coordinator, while the GNC would provide only remote support. The subsequent coordination mechanism was

reported to be inadequately resourced and understaffed. As a result of this limited human capacity, partners continued to reach out to the GNC for information and support. Some INGOs had proactively incorporated IYCF-E coordination responsibilities into role descriptions, indicating readiness to fill coordination gaps. Confusion and varied understandings of the nutrition coordination mechanism, and its status, among those interviewed are indicative of both a lack of leadership and a lack of clear communication.

The Ukraine Nutrition Cluster held regular (bi-weekly, subsequently monthly) online meetings from March to October 2022 (and in January 2023 the accountabilities for coordinating nutrition were transferred to the Health Cluster.) Throughout this time, often INGO and United Nations staff based outside of Ukraine attended in the absence of in-country counterparts. Attendance by Ukrainian actors was low, including minimal involvement by the Ministry of Health,²² and further declined over time, reportedly due to language barriers, limited awareness, and negative perceptions regarding the bureaucratic nature and usefulness of the mechanism. Following this period, alternative coordination approaches were used.²³

The national breastfeeding coordinator for the multi-sectoral National Breastfeeding Committee, active under the BFHI, attended international nutrition coordination meetings in the first few months. However, there were missed opportunities for engagement and information sharing between national coordination bodies and the international nutrition response due to a lack of pre-crisis support in strengthening national IYCF-E coordination capacity, including lack of designation of a national focal point for IYCF-E coordination and advocacy in preparedness.

Building on existing networks, Ukrainian breastfeeding counsellors took matters into their own hands and used Facebook²⁴ and Telegram to enhance access to breastfeeding support, coordinate themselves and map their locations to support referrals, including being able to track whether breastfeeding counsellors were among recently displaced groups, and were able to assist families. A Ukrainian lactation consultant interviewed for this case study noted that strategic coordination support from international organisations was wanted to alleviate reliance on volunteers and enhance planning and direction.

¹⁷ The IFE Core Group is the Global Thematic Working Group on IYCF-E as part of the Global Nutrition Cluster Technical Alliance. At the start of the crisis, the group established a programmatic working group as well as an advocacy and communication working group to support the IYCF-E response. <https://www.enonline.net/ife>

¹⁸ Joint Statement Version 2 - Protecting Maternal and Child Nutrition in the Ukraine Conflict and Refugee Crisis. www.enonline.net/jointstatementiycfenukraine

¹⁹ <https://www.gifa.org/en/what-do-mothers-in-ukraine-need/>

²⁰ Anna Ziolkovska (2016). Nutrition coordination in Ukraine: Experiences as a sub-cluster of health. *Field Exchange* 52, June 2016. p76. www.enonline.net/fe/52/nutritioncoordinationukraine

²¹ The formal cluster coordination mechanism for the overall response was officially activated in March 2022.

²² This contrasted with experiences from clusters such as the Food Security and Livelihoods cluster, which reported good engagement by government agency representatives. This may be attributable to the fact that the Food Security cluster was maintained after the 2015 response, while nutrition coordination was not.

²³ Although this occurred at a time beyond the scope of this case study, it is important to note that an ad-hoc Nutrition Technical Working Group (TWG) was set up in October 2022 and supported by the Technical Support Team of the Alliance to fill the technical support gap created by the suspension of the nutrition cluster. In January 2023, a Nutrition TWG was created under the Health Cluster (led by WHO). This decision is reminiscent of that taken during the 2015 Ukraine response to shift nutrition coordination from the Food Security and Nutrition Cluster to the Health Cluster, given existing national systems and the availability of global nutrition expertise and donor presence within the Health Cluster membership. (Ziolkovska, 2016)

²⁴ 'Breastfeeding Consultants in Ukraine' was created in December 2015 and is accessible at: www.facebook.com/groups/1683622991924542/permalink/3240840936202732/?app=fbl

While the GNC Technical Alliance Technical Support Team (TST²⁵) had proposed to support the development of an IYCF-E Strategy, this offer did not reach the local actors who expressed their need for such assistance. This highlights the need to reconsider how remote support can successfully reach and engage local actors in the absence of a robust coordination mechanism in-country.

Gaps in needs assessments for IYCF-E

There were IYCF-E alerts present early on, which, as per global guidance, indicate further investigation is needed.²⁶ Save the Children advocated to the United Nations Office for the Coordination of Humanitarian Affairs for IYCF-E to be integrated within early assessments and proposed standard questions. However, nutrition sector findings were not included in Multisector Rapid Needs Assessment Reports published in April 2022, nor was IYCF-E mentioned under Health or Food Security and Livelihoods sector findings.²⁷ The *provision of baby products or food* was one of the top 10 priorities cited by key informants in each subnational needs assessment report.²⁸ Additionally, agencies that were seizing opportunities to conduct rapid assessments at collective shelters and other gathering points reported difficulties in locating mothers – as most preferred to shelter with family, friends or in private accommodation if the option was available to them – and thus relied on consultation with limited numbers of particularly vulnerable mothers with greater exposure to BMS donations. Therefore, the assessment findings used to inform decision-making may not have accurately represented infant feeding needs and practices within the wider displaced population. Requests for technical support and contextualised guidance on needs assessments and IYCF indicator selection were made.

Without a comprehensive assessment of needs and capacity, it cannot be definitively stated that humanitarian assistance on IYCF-E was needed or wanted as a priority by the emergency-affected population, and in what form. However, as mentioned, Ukrainian breastfeeding counsellors consulted for this case study reported that specific assistance from international organisations was desired.

Response planning based on outdated data

In the absence of needs assessment data, IYCF-E response planning initially relied on the results of a 2012 Multiple Indicator Cluster Survey (MICS) and reports from the 2015 response in eastern Ukraine.²⁹ The MICS statistic that 66.6 per cent of children under 2 years of age were bottle-fed and just 19.7 per cent of infants under 6 months of age were exclusively breastfed³⁰ raised alarm bells, with initial estimations³¹ indicating an unprecedented need to support more than 200,000 infants with BMS.

Local experts expressed frustration that recent statistics were available but not used and that the older data used did not accurately reflect current practices. Statistical surveillance data on infant feeding is collected by the BFHI National Methodological and Monitoring Centre and shared with UNICEF Ukraine annually. As reported by all³² health care institutions in Ukraine in 2021, 56.06 per cent of infants were exclusively breastfed for the first 6 months of life and 25 per cent were still breastfed at one year of age.³³

A lack of consensus on infant feeding response needs

Early analyses of infant feeding needs focused on exclusive breastfeeding rates. It is noteworthy that the 2012 MICS data also indicated that 51.6 per cent of infants under 6 months of age were *predominantly* breastfed. These infants and their breastfeeding mothers can be viewed as candidates for transitioning to exclusive breastfeeding with skilled support. Surveys conducted among internally displaced persons in 2015 found that while exclusive breastfeeding was low, most non-exclusively breastfed infants were classified as such because they received water or tea in addition to breastmilk, rather than infant formula.³⁴ Just 14.8 per cent of infants were exclusively formula fed.³⁵

In contrast to the views of most interviewed international responders, Ukrainian breastfeeding counsellors stressed that “breastfeeding is the *norm* in Ukraine”.³⁶ While BMS support was undoubtedly needed as a lifesaving intervention at a far larger scale than for other recent humanitarian crises, the counsellors questioned the high initial planning figures for BMS support based on outdated exclusive breastfeeding statistics.

²⁵ A mechanism within the GNC Technical Alliance

²⁶ As listed in OG-IFE (2017) 4.10, including reports of infant and maternal deaths, orphaned infants, artificial feeding practiced pre-emergency, low exclusive breastfeeding prevalence pre-emergency, mothers reporting difficulties breastfeeding, low continued breastfeeding prevalence at one year, reports of non-breastfed infants under 6 months of age, requests for infant formula, reports of BMS donations and untargeted distributions of BMS, amongst other factors.

²⁷ REACH (April 2022) Rapid Needs Assessments

²⁸ Recommendations for nutrition/IYCF-E assessment were subsequently made. A qualitative study to understand the impact of the crisis and subsequent response on infant feeding was undertaken in Ukraine and Poland by FHI 360 in September 2022. Results are due to be published in 2023. Further assessments (by the The Centers for Disease Control and Prevention (CDC) and International Medical Corps (IMC)) were in the pipeline for 2023 at the time of interview towards the end of 2022.

²⁹ Ukraine Nutrition Cluster. Data and Assessment. Accessed on 3 Jan 2023 at <https://response.reliefweb.int/ukraine/nutrition>

³⁰ MICS (2014) Ukraine Multiple Indicator Cluster Survey – 2012

³¹ Assumption: 70 per cent of infants 0–11 months of age in need of BMS (i.e., around 200,700 – 233,600 infants).

³² Including those that were not BFHI-accredited. BFHI-accredited facilities reported even higher exclusive breastfeeding rates of 75.6 per cent in 2021.

³³ Romanenko, L. (2022) Analysis report on the extended BFHI in Ukraine for 2022 (Аналіз розвитку Розширеної Ініціативи «Лікарня, доброзичлива до дитини» в Україні за 2022 рік) Accessed at https://kdm-idd.org.ua/wp-content/uploads/ANALIZ_RI_Likarnia-dobrozichlyva-do-dytny_2022.pdf on 8 May 2023.

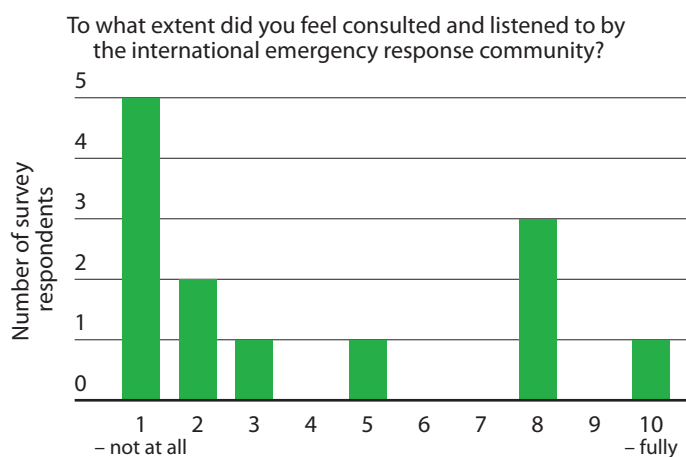
³⁴ Summers, Aimee, and Oleg O. Bilukha. “Suboptimal infant and young child feeding practices among internally displaced persons during conflict in eastern Ukraine.” *Public health nutrition* 21, no. 5 (2018): 917–926; Presentation: IYCF Survey – Donetsk City, Makiivka, Horlivka, Shartask, Khartzisk – 2015.

³⁵ Presentation: IYCF Survey – Donetsk City, Makiivka, Horlivka, Shartask, Khartzisk – 2015.

³⁶ Key Informant Interview and Ksenya Solovey (2022) A Plea from Ukrainian Breastfeeding Consultants.

Noting an increased appreciation for breastfeeding by mothers following the full-scale invasion, skilled breastfeeding support was identified as a top IYCF-E priority by 100 per cent (n=16) of survey respondents due to barriers faced by breastfeeding mothers. Freezing temperatures impacted the comfort and accessibility of breastfeeding, requiring context-specific guidance and support. Barriers included variable breastfeeding knowledge among mothers and health care providers,³⁷ disrupted health and breastfeeding support services and difficulties accessing them, high exposure to stress and trauma (including increased sexual and gender-based violence), pervasive BMS marketing and donations, and cultural beliefs (including breastfeeding beliefs around stress,³⁸ poor diet and birthing under stressful conditions, as well as the misconception that BMS is safer than breastmilk provided by another woman.

Educating parents, health care workers, and volunteers on IYCF-E was considered crucial by all survey respondents. Support for accessing BMS (13 per cent top priority, 47 per cent lower priority, 33 per cent not a priority) and provision of guidance on hygienic BMS usage in emergency conditions (40 per cent top priority, 33 per cent lower priority, 27 per cent not a priority) were lesser priorities for respondents.³⁹ Ukrainian breastfeeding counsellors interviewed felt that the international community's initial focus on BMS support detracted from ensuring mothers received skilled breastfeeding support as a lifesaving measure. As shown in Figure 1 most (62 per cent, n = 13) of national breastfeeding counsellors surveyed did not feel listened to by the international response community.



FINDINGS: THE RESPONSE

IYCF-E activities

The 2022 Humanitarian Response Plan, published just prior to the large-scale invasion, included nutrition education and promotion in two Health Cluster activities but did not specify IYCF-E. While the startup was slow, a handful of agencies gradually introduced IYCF-E interventions in 2022, including training, counselling, messaging, education and supportive spaces (i.e., Mother Baby Areas). UNICEF collaborated with a local breastfeeding support organisation to create and distribute a video course on breastfeeding. UNICEF also supported procurement and programming for BMS-dependent infants, while the World Food Programme (WFP) supported maternal nutrition and complementary feeding. Many Ukrainian breastfeeding counsellors continued with their services, adapting as necessary. Local volunteer organisations concentrated on food distribution, including cooked meals. More detailed information and technical reflections are available in the subsequent sections of this case study.

Capacity strengthening and technical support

Prior to the invasion, United Nations agencies and INGOs had limited in-country IYCF-E capacity. Most agencies implementing IYCF-E in 2015 had either exited the country or turned their attention to non-emergency programming in sectors other than nutrition. A lack of partner readiness, reluctance to prioritise IYCF-E, and European Union employment restrictions resulted in limited in-country capacity and disproportionate remote involvement by individuals working at the international level.⁴⁰

IYCF-E training delivered during the 2015 response does not appear to have had a sustained impact on national IYCF-E capacity. INGOs recruiting IYCF-E staff for the 2022 response identified a lack of competencies related to complementary feeding and emergency-specific infant feeding needs. Pre-service training covering Code compliance and infant feeding, and educational materials and clinical protocols were available.⁴¹ However, BFHI personnel reported varying levels of knowledge of this among health workers, with susceptibility to BMS industry influences, and identified a pressing need to educate leaders and decision-makers on the Code.

³⁷ Recent health system changes had expanded the scope of infant care to include specialists with less lactation education; previously, infant feeding support was only the remit of paediatricians and neonatologists.

³⁸ Well documented during the 2015 crisis in Ukraine

³⁹ Most respondents reported that counselling on artificial feeding was part of their role.

⁴⁰ For example, the acting nutrition coordination mechanism coordinator developed a workplan of what was needed at country level and reached out to the Alliance (TST and IFE Core Group) for support, as the usual IYCF-E partners were not adequately in place within the country.

⁴¹ Ministry of Health (2002) Modern Management of Lactation and Breastfeeding Manual

At the war's onset, various remote initiatives⁴² were implemented to provide rapid orientation on IYCF-E issues and resources. Safely Fed Canada applied a strengths-based training approach, which first acknowledged existing expertise and aimed to build confidence; this was reportedly well received, resulting in participants' improved understanding of how their skills could be useful and of risks that they needed to mitigate. Within Ukraine, local trainers resumed online trainings for breastfeeding consultants and made an existing training on lactation medicine freely available to health workers. International Medical Corps successfully collaborated with academics and hospitals to train health workers, noting high motivation and rapid learning. Additionally, Save the Children, in partnership with the TST and UNICEF HQ, delivered an IYCF-E training over the course of five half-days and noted that although pre-training test scores were high (75 per cent), all participants said some (30 per cent) or most (70 per cent) of the information was new to them.⁴³ On the other hand, one Ukrainian trainer interviewed observed that training offered by international agencies tended to underestimate local capacity.

Ukraine-specific Mother Baby Area guidance was developed internationally and translated into Ukrainian, based on UNICEF's early plans to integrate IYCF-E into Blue Dot Hubs.⁴⁴ The TST provided support for specific technical outputs, such as costing guidance for complementary feeding baskets, the establishment of an IYCF-E TWG and the development of Standard Operating Procedures for BMS programming. Breastfeeding counsellors surveyed in Ukraine reported relying on colleagues, professional associations, and networks, such as national NGO Milky Rivers Ukraine, the Academy of Breastfeeding Medicine, the European Lactation Consultants Alliance and the Institute for Breastfeeding and Lactation Education, for technical support. Knowing assistance was available and receiving expressions of support from international colleagues reportedly played a vital role in raising morale for breastfeeding counsellors.

Recruitment

INGO recruitment of national IYCF-E personnel was challenging, initially due to displacement and the need to focus on personal survival. Later barriers included poor understanding by international responders of breastfeeding support cadres (profiles) and locally available services and the lack of recognition by potential candidates that they were qualified for advertised roles. Once technical jargon (IYCF-E) was replaced with familiar terminology like "breastfeeding support" and "complementary feeding" in job advertisements, and orientation workshops were held, applications increased.

The IFE Core Group supported the remote mapping of 70 breastfeeding counsellors, which some INGOs successfully used for recruitment. Some counsellors reportedly found it challenging to provide the mapping details requested due to the stress of the early days, while others were not reached due to limited support for the process from in-country actors with connections to and knowledge of local breastfeeding networks and actors. Attempts to recruit staff from existing local services, instead of supporting those services, were criticised by some interviewees.

Complementary feeding and maternal nutrition

In April 2022, a WFP survey revealed that one-third of households in Ukraine experienced food insecurity.⁴⁵ Meeting the specific nutritional needs of pregnant and breastfeeding women and young children was a particular concern. Women's confidence in their ability to breastfeed was impacted, indicating a need to address misconceptions around breastfeeding and diet. Technical issues regarding gluten and lactose intolerance as well as iron-deficiency anaemia in women were also raised.

Those involved in very early IYCF-E coordination reported having to make difficult decisions with regards to the large quantities of commercial complementary foods that had been donated. Concerned that rejecting all products would cause harm, and challenged by a lack of control, human resources and information, they accepted donations to be sent to besieged areas following the rapid screening of product labels to verify shelf life, language and nutritional content.

Caregivers demonstrated specific care and attention to young child nutrition, reportedly preferring the use of commercial (and to a lesser degree, organic) complementary food products. International key informants identified a need for emergency guidance on acceptable compromises and adaptations with regard to the use of commercial complementary foods, given pre-crisis practices, widespread donations, and food preparation difficulties reported by caregivers in some areas.

In May 2022, guidance on supporting complementary feeding in Ukraine was remotely developed, containing contextual considerations for food assistance and a decision tree for choosing the type of modality to implement.^{46,47} WFP conducted a market analysis to identify the availability of some of the food commodities preferred by the community. Following a reportedly complex online costing exercise, a further contextualised guidance note was issued by the Ukraine Nutrition Cluster in July 2022, advising cash-based

⁴² Such as: global calls co-led by the IFE Core Group and UNICEF, Safely Fed Canada online training provided at the request of European Lactation Consultants Association, Trauma Informed Care Webinar provided by Vakbad Vroeg and IMH Netherlands.

⁴³ Save the Children. Ukraine IYCF-E Training Report 2022.

⁴⁴ Multi-sectoral safe space, protection and support hubs. Plans to integrate IYCF-E were not executed, presumably due to its de-prioritisation.

⁴⁵ WFP (May 2022) Ukraine Food Security Report

⁴⁶ Ukraine Nutrition Cluster (July 2022) Guidance note on the operational implementation of complementary food assistance packages for the feeding of children aged 6 months to 2 years in the context of the Ukraine crisis (July 2022) Accessed on 3 May 2022 at: <https://reliefweb.int/report/ukraine/guidance-organisations-supporting-feeding-children-aged-6-months-2-years-context-ukraine-crisis-may-2022>

⁴⁷ Options to support complementary feeding included cash, distribution of ready-to-eat foods and provision of uncooked foods suitable for preparation of age-appropriate meals.

assistance and in-kind assistance (in the form of a costed, monthly food basket of mostly jarred foods).⁴⁸ To what extent the provided guidance was implemented in 2022 could not be confirmed for this case study.⁴⁹

Mothers and young children were primarily reached through general food distribution and cash programming. To convince local partners who wanted to focus on mass food distribution on the importance of prioritising pregnant and breastfeeding women and disseminating IYCF-E messages, significant sensitisation was reportedly needed. People on the move received rapid response packages consisting of a five-day ration of 17 kgs of ready-to-eat foods. In parallel, local volunteer groups played a significant role in conducting large-scale on-site feeding (wet rations).

Support for the early initiation of breastfeeding

Reported barriers to exclusively breastfeeding newborns after the full-scale invasion included increased childbirth interventions, higher numbers of premature and low birth weight infants,⁵⁰ poor maternal mental health, and the donation of excessive amounts of BMS to maternity services. Early breastfeeding initiation, delayed weighing and bathing, two-hours of skin-to-skin contact and non-separation were the norm in Ukraine prior to the war,⁵¹ and these practices reportedly remained largely unchanged by the war.⁵² High levels of BFHI-accreditation (92 per cent) among maternity hospitals appear to have contributed significantly to resilience. Requests by pregnant women for support with preparing for successful breastfeeding increased, and BFHI-accredited facilities continued to offer anticipatory antenatal counselling and education as much as possible.

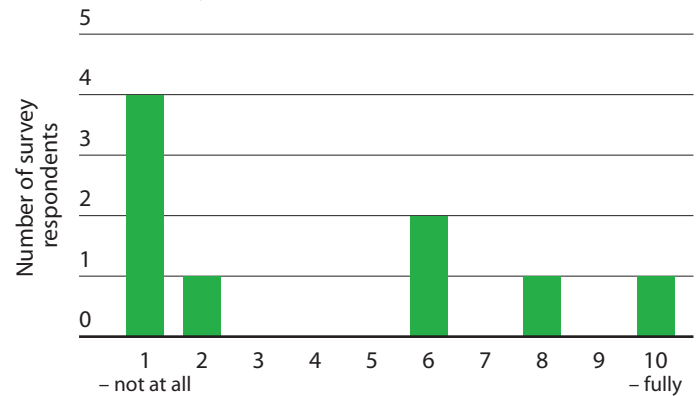
Skilled breastfeeding support

Prior to the war, breastfeeding counselling was provided by a few International Board Certified Lactation Consultants⁵³ and hundreds of locally certified breastfeeding consultants⁵⁴ and peer counsellors through health facilities,⁵⁵ regional breastfeeding support centres, private clinics, select NGOs⁵⁶ and a strong network of mother-to-mother support groups. Many of these services had moved their services online during the COVID-19 pandemic and provided information and educational materials through affiliated websites⁵⁷ and social media platforms.⁵⁸ Some of these counselling cadres and services were unfamiliar to key informants

whose previous experiences were limited to low-income country emergency contexts.

In a statement circulated among international breastfeeding networks in March 2022, Ukrainian breastfeeding consultant Ksenia Solovey stated: “There are MANY trained breastfeeding consultants in Ukraine. We are ALREADY helping mothers in Ukraine.”⁵⁹ The recruitment and rapid training of new counsellors by INGOs, as well as international offers for remote counselling supported by translators, was therefore deemed unnecessary by some key informants, including a local trainer. In addition, five out of nine Ukrainian survey respondents felt their expertise had not been recognised or leveraged by international organisations (see Figure 2).

To what extent do you feel that your expertise was recognised, valued and used by international organisations providing trainings?



Breastfeeding counsellors swiftly adapted to the disruptions caused by the war to continue their support efforts. Most requests were for support with milk stagnation, breast refusal, breastmilk production concerns, initiating breastfeeding after birth, transitioning from mixed to exclusive breastfeeding, and relactation. A breastfeeding consultant and obstetrician noted a four- to five-fold rise in subacute mastitis cases, which may be attributable to the reduction in breastfeeding frequency often reported during emergencies.

The main changes in the counsellors’ practice included shifting from paid to free or donation-based services (supported by financial donations) and conducting more online classes and consultations.⁶⁰ As it was uncertain whether a caregiver could be counselled more than once,

⁴⁸ Nutrition Cluster and UNICEF. Guidance note on the operational implementation of complementary food assistance packages for the feeding of children aged 6 months to 2 years in the context of the Ukraine crisis (July 2022). <https://reliefweb.int/report/ukraine/guidance-note-operational-implementation-complementary-food-assistance-packages-feeding-children-aged-6-months-2-years-context-ukraine-crisis-july-2022>

⁴⁹ Ukraine Nutrition Cluster (July 2022) Guidance note on the operational implementation of complementary food assistance packages for the feeding of children aged 6 months to 2 years in the context of the Ukraine crisis (July 2022) Accessed at <https://reliefweb.int/report/ukraine/guidance-note-operational-implementation-complementary-food-assistance-packages-feeding-children-aged-6-months-2-years-context-ukraine-crisis-july-2022> on 15 May 2023.

⁵⁰ 7.6 per cent in 2022 compared to 6.46 per cent in 2021; this figure is likely under-reported due to the exclusion of temporarily occupied territories with ongoing or recent active hostilities.

⁵¹ Romanenko, Lidiia, Olha Shlemkevych, and Maryse Arendt. “The Current State of Breastfeeding in Ukraine: An Interview With Lidiia Romanenko and Olha Shlemkevych.” *Journal of Human Lactation* (2023): 08903344221136477.

⁵² 93.9 per cent of new mothers initiated breastfeeding within one hour of birth according to 2022 BFHI statistics.

⁵³ The number of International Board Certified Lactation Consultants in Ukraine is low due to the prohibitively high cost of certification and the English language barrier.

⁵⁴ For example, between 2007 and 2022, NGO Milky Rivers trained 450 lactation consultants.

⁵⁵ In accordance with the requirements of the regulatory documents of the Ministry of Health of Ukraine for health care institutions providing services to mothers and children. Many maternity hospitals had lactation consultants on staff; all BFHI-accredited facilities had health workers trained to provide skilled breastfeeding support.

⁵⁶ Such as the breastfeeding support organisation “Milky Rivers Ukraine” www.breastfeeding.org.ua

⁵⁷ <https://lactation.com.ua/> is an example of a popular website and blog

⁵⁸ Romanenko, L. and Shlemkevych, O., (2022) Presentation. “Breastfeeding in Ukraine. Experiences from War Zone.”

⁵⁹ <https://www.gifa.org/en/what-do-mothers-in-ukraine-need/>

⁶⁰ There was less interest in phone/hotline consultations

the counselling approach shifted from multiple consultations to ensuring the most urgent and important information was shared during the first consultation, noting that often a lot of attention had to first be given to dispelling mothers' fears. Sharing personal success stories from other mothers proved effective in inspiring and building confidence among women. The use of equipment, such as breast pumps and nipple shields, remained relatively unchanged, as survey respondents already worked minimally with such tools.

Online support

Remote support played a crucial role in providing assistance. For example, in February 2022, two free-of-charge Telegram chat groups were established by local actors to address the specific needs and concerns of pregnant and breastfeeding women during the crisis. General advice was shared, and women could also receive individual support through private chats. By 2023, they had reached over 7,000 women.

The breastfeeding support group was supported by a team of 17, including two paediatric specialists with a background in lactation and 15 breastfeeding consultants, five of whom had a background in psychology. It is important to note that all the support provided was voluntary⁶¹ and driven by a collective desire among Ukrainians to help by pooling their skills. The safety and well-being of team members spread across different locations was a primary concern in the face of warfare and intermittent ability to communicate. To accommodate poor internet connections, the volunteer team transitioned from video and audio consultations to text-based support and learned to anticipate a surge in requests for support once connectivity was restored. Although the provision of 24/7 support was taxing, volunteers' sleep was already disrupted by shelling, electricity interruptions and breastfeeding their own infants. They found it supportive to their own well-being to be able to help others during these disruptions and adjusted their approach after recognising that non-breastfeeding volunteers had greater difficulty offering round-the-clock support. Despite the challenges, the provision of remote support proved successful, and breastfeeding continued even in the face of adversity, highlighting the resilience and dedication of the volunteers and breastfeeding mothers.

Donations

Code violations were rampant during the 2015 response.⁶² Dishearteningly, history repeated itself at an even greater scale during this crisis. Despite advocacy and awareness-raising efforts, including the dissemination of a Joint Statement by UNICEF, the United Nations High Commissioner for Refugees, the GNC, the IFE Core Group, and partners⁶³ advising against donations, and the countering of

widespread calls on social media for donations by concerned experts, an "avalanche"⁶⁴ of donated BMS flooded accessible areas of Ukraine. It was reported that BMS were distributed in an uncoordinated and untargeted manner by a broad range of actors, including BMS producers. Those consulted regarded the supply-driven donations as a major distraction, a misuse of financial resources, and harmful. They highlighted storage challenges and the expiry or repurposing of BMS, such as in cooking.

Maternity settings, despite high levels of BFHI-accreditation, received excessive amounts of BMS,⁶⁵ leading breastfeeding counsellors to link breastfeeding difficulties among new mothers to the blanket "just in case" provision of BMS upon discharge, in contravention of BFHI standards. Issues were also reported with donations of vast quantities of unfamiliar commercial baby foods labelled in foreign languages. Factors contributing to the provision and distribution of these harmful and excessive donations include weak monitoring and enforcement of the Code, stress and variable awareness among health workers and health facility administrators, and strong reluctance of volunteers to withhold food products (an action reminiscent of Holodomor). The significance of decision-makers' awareness is illustrated by the example of the Lviv region, where BFHI regional representatives and health facility managers prohibited BMS donations. Subsequently, no decline in IYCF practices, such as early initiation of breastfeeding, were reported by the region to BFHI. Lack of engagement by international responders with Ukraine's Coordination Headquarters for Humanitarian Affairs,⁶⁶ whose remit included coordination with commercial enterprises, foreign governments, authorities and international organisations, may have been a missed opportunity to prevent and manage inappropriate donations at national level.

Both local and international responders desired urgent technical expertise, guidance and action to address the issue. Questions arose regarding the condemnation of BMS donations in the face of inadequate BMS support and real need, despite the fact that donations are usually not accompanied by the instructions, support, or supplies required to minimise risks. UNICEF HQ provided guidance on managing donated BMS to mitigate risk, including methods for identifying recalled products. Information on preventing and managing donations was of particular interest to participants in various trainings provided by international agencies.⁶⁷ The First Lady of Ukraine contacted UNICEF for technical advice regarding a BMS donation offered by Nestle. An online form was shared to report Code violations to the nutrition coordination team early in the response, but it remains unknown how many reports were received and how

⁶¹ Supported by donors outside the formal humanitarian system. A UN Women Survey conducted in March 2022 revealed that many of such women's groups were formed or started providing new services in response to the emergency; the main challenge faced by most survey respondents was a lack of funding.

⁶² Anna Ziolkovska (). Nutrition coordination in Ukraine: Experiences as a sub-cluster of health. Field Exchange 52, June 2016. p76. www.enonline.net/fe/52/nutritioncoordinationukraine

⁶³ Joint Statement Version 2 - Protecting Maternal and Child Nutrition in the Ukraine Conflict and Refugee Crisis. www.enonline.net/jointstatementiyfceinukraine

⁶⁴ Quote from an interviewed IBCLC

⁶⁵ only 4 – 5 % of newborns are not breastfed at discharge

⁶⁶ Established by Ukraine's president in March 2022

⁶⁷ As reported by Save the Children and Safely Fed Canada

they were actioned, including whether reported donations were intercepted and appropriately managed.⁶⁸

Of special note, a call for donations of specialised infant formulas for infants with rare metabolic disorders⁶⁹ was made to international organisations and baby food manufacturers as part of a widespread social media campaign. BFHI Ukraine responded strongly, stating that alleged connections to Ukraine's children's hospitals had not been verified, referring to the Joint Statement, calling out violations of law and conflicts of interest, and emphasising that the appropriate provision of BMS was already handled by UNICEF. The GNC and UNICEF promptly advised against the campaign and urged its termination. Requests for further information on the number of infants in need and the specific types of formulas required to better understand the perceived need went unanswered. Had the need been confirmed, what would constitute an appropriate intervention remains undefined. This experience underscores the complexities that may be encountered with donations in high- and middle-income settings with elevated artificial feeding rates.

Support for BMS-dependent infants

Given disruptions to markets, health care, electricity, safe water and humanitarian access in many parts of the country, as well as high numbers of institutionalised children⁷⁰ and the high prevalence of artificial feeding, BMS-dependent infants were a highly vulnerable group of particular concern to government institutions, civil society organisations and international responders. Nevertheless, it was extremely challenging to reach consensus on an appropriate approach. While the targeted distribution of BMS through the national health system remained viable, assuring individual assessment, targeted provision and adequate monitoring through inexperienced partners was a concern. Caregiver awareness on general hygienic BMS preparation and usage in non-emergency settings was reportedly good; however, guidance on adapting practices to mitigate the elevated risks of feeding BMS in the changed context was needed. Communicating the nutritional needs of BMS-dependent infants was challenging in the face of controversy and concerns about undermining breastfeeding.

UNICEF encountered difficulties in accurately calculating BMS supply needs given the population dynamics and access issues in active conflict zones. Following intensive consultations with WHO and WFP, as well as discussions with government agencies to better understand their network for distribution and monitoring, a decision was made to initially aim to reach 10 per cent of BMS-dependent infants, prioritising the most vulnerable. An emergency nutrition agreement framework for BMS distribution and reporting was established between the Ministry of Health and UNICEF. The coordination mechanism also approached the Ministries

of Health and Social Policy to use their distribution channels for reaching orphanages and health facilities. In addition to BMS, UNICEF also supported counselling and training on the hygienic preparation of artificial feeds. Additional equipment and services to enable hygienic preparation and feeding could be separately accessed by caregivers through Blue Dots and various Mother Baby Areas.

As the provider of first resort, in February and March 2022, UNICEF procured BMS to meet the needs of 24,750 infants aged 0–5 months (10 per cent of estimated need). Given the magnitude of need for BMS support that they had estimated, UNICEF reported challenges in rapidly procuring sufficient volumes. In some instances, BMS supplies required by highly vulnerable infants were reportedly bought up by individuals and organisations for donation and distribution in an untargeted manner.

Safer alternatives to BMS

According to national policy, recommended options for infant feeding, in order of preference, are: (1) breastfeeding at the mother's breast; (2) mother's expressed breastmilk; (3) donor human milk; and (4) BMS.

The number of mothers supported with relactation varied greatly among surveyed breastfeeding counsellors. Some had no cases at all, while others shared multiple examples, including women relactating to breastfeed maternal orphans and children above 1 year of age. Increased interest in relactation was reported among women in occupied territories, areas with active hostilities, and those undergoing long journeys. Decreased interest in relactation was attributed to the widespread donations of BMS in other areas and the exhaustion of mothers. Respondents noted low awareness among mothers and health workers regarding relactation, and the importance of emotional and psychological support as part of the process.

At the start of the war, cultural acceptance of the breastfeeding of infants by someone other than their mother (wet nursing) and its appropriateness in the context of high HIV prevalence⁷¹ was questioned at global level. Concerns that suggesting this practice would lead to wider IYCF-E recommendations being rejected led to its omission from the Joint Statement and other early guidance. Cases of wet nursing and informal milk sharing were reported by breastfeeding counsellors in situations of necessity, such as in bomb shelters and occupied territories without access to skilled breastfeeding support or BMS. In other instances, safety concerns reportedly prevented mothers from doing so. Breastfeeding counsellors created online platforms⁷² to connect lactating women willing to wet nurse or informally share milk with infants in need. In besieged Mariupol, mothers breastfed and expressed breastmilk for multiple

⁶⁸ Ukraine Nutrition Response: BMS Code Monitoring in Emergency Situations. https://ee.humanitarianresponse.info/x/Gd4tmUg7?_gl=1*395kyg*_ga*MTQwNjE5MDEyNi4xNjg2NzQ3Mjlx*_ga_E60ZNX2F68*MTY4ODAyODMwMC4zLjEuMTY4ODAyODQ3Ny42MC4wLjA.

⁶⁹ Inborn errors of metabolism, such as Phenylketonuria (PKU) and Homocystinuria. Diet is normally balanced using prescribed specialised medicinal infant formulas under medical supervision.

⁷⁰ Out of 52 countries in the WHO European Region, Ukraine ranks 3rd in absolute number of children under 3 years of age living in institutions (about 100 000).

⁷¹ Note that although HIV prevalence is high, most breastfeeding women would have been aware of their recent HIV status through voluntary antenatal testing.

⁷² Such as the "Free Milk" project "Вільне молоко" accessible via Telegram: t.me/vilnemoloko.

infants and older children. They were sheltered in the best hiding places and viewed by the community as the main source of nutritional security for children in the area.

In 2019, the Kyiv Perinatal Centre established the first human milk bank in Ukraine. Despite wartime conditions, it continued to operate. In 2022, 660 litres of breastmilk were collected in Kyiv from 68 donors; 2,010 infants, including 256 premature newborns, received donor human milk.⁷³ In December 2022, another milk bank was opened in the Lviv region. In 2023, health authorities emphasised that there was no need for additional infant formula in Kyiv due to the presence of a human milk bank.⁷⁴

Caregiver well-being

There was widespread recognition among contributors of the vital importance of supporting caregivers' mental health and emotional well-being amid frequently harrowing circumstances. Mothers were concerned about the impact of stress on their milk quantity and quality and their infants' well-being. Difficulties accessing health care, such as obtaining antibiotics if required for mastitis, added to their stress. A breastfeeding consultant at a regional perinatal centre receiving internally displaced persons reported that practically all pregnant women experienced fear and anxiety, which was perceived to contribute to delayed onset of copious milk production after birth. Providing psychological assistance was found to greatly support lactation and facilitate exclusive breastfeeding at the time of discharge. Mental health and psychosocial support was also deemed important for achieving success with relactation.

It was not commonly known before the war that stressed mothers can breastfeed. However, breastfeeding counsellors rapidly learned to support them by suggesting simple somatic exercises⁷⁵ for nervous system regulation and promoting caregiver-infant co-regulation.⁷⁶ Guiding caregivers to prepare for sheltering, such as using thermos flasks to support grounding with a warm drink before breastfeeding and using headphones to shield older infants from the sounds of warfare, proved helpful.

While literacy rates were high and mothers typically sought information online, reassurance from trusted experts such as breastfeeding counsellors and health workers was vital during times of stress. Combating misconceptions among frontline workers was therefore crucial. An International Board Certified Lactation Consultant reported learning that while telling breastfeeding mothers to relax was counterproductive, other approaches proved effective in supporting breastfeeding in war zones. These included guiding breath, acknowledging normal reactions to an abnormal situation, and explaining the importance of adrenaline for survival, while reassuring mothers that breastmilk production would continue.

Nuclear accident guidance

Amid growing concerns about nuclear accidents and emergencies stemming from disruption to a nuclear power plant in Ukraine, the IFE Core Group identified a need for clear comprehensive guidance for caregivers and health workers on IYCF in such emergencies. Past guidance had been contradictory or focused on the risk of radiation exposure, without adequately considering the risks of not breastfeeding. The conflict in Ukraine added additional complexity, as resources for mitigating the risks of BMS use were potentially unavailable or hard to obtain. This posed a unique challenge for IYCF-E practitioners, requiring specialised expertise. The IFE Core Group and Johns Hopkins Center for Humanitarian Health collaborated to produce a guidance note titled "Infant and young child feeding in the first three days after a nuclear power plant accident" for health workers and emergency planners in Ukraine, drawing upon expertise from various fields, including radiation, nuclear emergency, IYCF-E, and communication.⁷⁷ Health workers reportedly responded positively to the guidance note, appreciating the appropriate level of technical detail and clear, practical instructions provided by recognised experts.

⁷³ Letter from Kyiv City Methodological and Organizational Monitoring Center with regards to the implementation of the sectoral programme "Supporting breastfeeding of children in Ukraine". Date Unknown.

⁷⁴ Statement issued on 24 March, 2023 by the Kyiv City Council Healthcare Department.

⁷⁵ For example, doubling/extending the exhaled breath, orienting to the present moment through the senses, comforting self-touch, kissing and smelling baby.

⁷⁶ The practical information and suggestions shared during a webinar on *Trauma Informed Care for (pregnant) families, babies and toddlers in difficult and stressful situations* were highly appreciated by breastfeeding supporters.

⁷⁷ IFE Core Group Sub-Working Group on Infant and Young Child Feeding in Emergencies (IYCF-E) in the context of chemical, biological, radiological and nuclear threats (2023). Chemical, biological, radiological and nuclear (CBRN) threats in wartime situations: The impact on breastfeeding safety and infant/young child feeding practices. www.enonline.net/cbrn-iyfce

Lessons Learned and Recommendations

COORDINATION: In large-scale emergencies, a willing lead agency⁷⁸ must be clearly identified and resourced with dedicated staff with appropriate experience to support IYCF-E coordination across all relevant sectors and by all actors. The lack of strategic coordination with Ukrainian infant feeding supporters, health care professionals and government representatives who played a vital role in supporting crisis-affected families is a critical missed opportunity to complement, support and add value to local efforts, which limited the effectiveness of the response. In settings with functioning government and national mechanisms to implement and coordinate humanitarian assistance and infant feeding support (e.g., BFHI), it continues to be more appropriate to strengthen IYCF-E within such systems rather than establishing a parallel humanitarian architecture. The Ukraine Nutrition Cluster did not receive the prioritisation and resources required to fully and effectively support national capacity and leadership. Working with national authorities to prepare for IYCF-E coordination needs, as per the Operational Guidance on Infant Feeding in Emergencies (OG-IFE 3.2), including assigning key IYCF-E roles in preparedness, can help ensure that the coordination mechanism is valuable and accessible for both international and local responders. This case study echoes the lesson learned from the 2015 crisis – namely, that dedicated IYCF-E coordination and information management support should be prioritised within UNICEF recruitment and funding processes.⁷⁹

Global recommendation: A better understanding is required of how reports on coordination gaps (made as per OG-IFE instruction 3.10) can influence country-level decision-making and action.

ADVOCACY: Effective advocacy for prioritising IYCF-E requires strategic, context-specific approaches that are sensitive to socio-historical considerations and align with local terminology, policy and programming. Better understanding is needed on how to effectively secure buy-in for IYCF-E in similar contexts. Understanding the positioning of IYCF within national systems is crucial; United Nations country offices' pre-existing relationships with national governments and knowledge of entry points and national structures are key to facilitating this process, ideally in preparedness. IYCF-E experts need to be enabled to influence decision-makers through appropriate channels.

Global recommendation: Accelerate global plans to review, simplify and standardise IYCF-E terminology and acronyms, avoiding technical jargon.

DECISION-MAKERS: In similar contexts (where child wasting is not a national concern, and where IYCF support is embedded in the health system etc.), consider how and by whom IYCF-E prioritisation decisions should be made. Infants and young children had vital needs requiring careful consideration. Prioritisation decisions made by the Nutrition Cluster Lead Agency at country level should be taken in consultation with relevant parties and experts, informed by critical analysis and needs assessments, and communicated clearly and openly to enable other stakeholders and sectors (e.g., health) to step up as needed.

ASSESSMENT: Including IYCF-E in early needs assessments should be done by default, as per global guidance,⁸⁰ as it enables informed decision-making, timely and appropriate response, awareness-raising and leveraging of existing capacities. This relatively easy win has a critical knock-on effect when neglected. Standard questions to include in early needs assessments are available globally. Assessment tools in Ukrainian were available from the 2015 response, as were lessons learned on collecting data in challenging crisis contexts from previous surveys conducted in Ukraine.⁸¹

Global recommendation: A review of global standard multisector assessment tools used by non-nutrition actors may be warranted to ensure IYCF-E is explicitly included in early needs assessments.

DATA: IYCF statistics need to be made available and reviewed in consultation with local experts to ensure accurate and current data informs programming and supply needs. Publishing national statistics, such as BFHI's annual data, as a standard preparedness activity, would enhance early access to up-to-date information. Close collaboration and consensus-building between international responders and in-country specialists is crucial for addressing context-specific needs in an inclusive and culturally sensitive manner.

CALCULATING BMS SUPPLY: When determining BMS support needs, the full infant feeding picture needs to be considered for accurate quantification of needs and to avoid making assumptions⁸². Not all non-exclusively breastfed infants require BMS. To prevent the assumption that they do, it is essential to understand what they are consuming by considering available data from the full range of available infant feeding indicators beyond exclusive breastfeeding data, such as predominant breastfeeding⁸³ or

⁷⁸ Government (preferred), UNICEF or designated partner agency.

⁷⁹ Anna Ziolkovska (2016) Nutrition coordination in Ukraine: Experiences as a sub-cluster of health. Field Exchange 52, June 2016. p76. www.enonline.net/fe/52/nutritioncoordinationukraine

⁸⁰ IFE Core Group (2017) Operational Guidance: Infant and Young Child Feeding in Emergencies – Section 4.

⁸¹ How to overcome data management challenges in research in crisis contexts. Field Exchange 57, March 2018. p75.

⁸² Note that accurate quantification should be done as soon as possible but should not delay initial procurement of BMS, if early assessment findings indicate it is likely to be needed to save lives. While the MICS Survey data used for Ukraine contained the full set of IYCF indicators, comprehensive data may not be available at the onset of an emergency. Especially in sudden-onset, large scale emergencies, BMS programming and procurement decisions need to be taken as rapidly as possible, on the basis of whatever available information. This is done following the humanitarian principle of "No Regret" where needs are estimated to save potential lives, even if in the end an overestimation becomes evident. For a high-risk product such as BMS, any surplus must then be identified and controlled as soon as possible to also meet the humanitarian principle of "Do No Harm".

⁸³ This indicator has been removed from the updated set of standard IYCF Indicators (WHO, 2021)

mixed milk feeding.⁸⁴ It is also important to consider what IYCF indicators do and do not tell us, and what additional information is required to make informed and appropriate decisions. Consensus among responders on IYCF terminology and definitions (e.g., exclusively versus fully breastfed, BMS-dependent versus non-breastfed, predominantly or partially breastfed, mixed fed etc.) is also necessary.

Global recommendation: Existing tools and guidance on calculating BMS supply needs should be expanded to better include considerations for contexts with low exclusive breastfeeding rates and/or presumed high formula feeding rates. The nuances of supporting women working to induce, re-start or increase breastmilk production, as well as infants who will continue mixed feeding, need to be considered.

CAPACITY STRENGTHENING: Existing IYCF capacity in Ukraine was not fully recognised or effectively strengthened during preparedness and early response, reportedly leading to the undermining of local actors and services, a duplication of efforts, and unnecessary recruitment and training of new counsellors through cumbersome systems. Understanding common local cadres and the services that already exist is crucial to leverage available resources, rather than running parallel activities at the expense of supporting existing capacities. This is best done in preparedness, alongside the establishment of a database of local practitioners and experts.⁸⁵

Missed opportunities in preparedness also include identifying and refreshing IYCF-E capacity developed in Ukraine during the 2015 response trainings. In contexts like Ukraine, breastfeeding and artificial feeding support capacity is often higher than other areas of expertise required for comprehensive IYCF-E support. Where there is already a strong network of trained counsellors and volunteer groups, international agencies with IYCF-E expertise can add value by supporting local services and providing rapid, practical, strengths-based training in collaboration with local trainers.

Global recommendation: A better understanding by the international IYCF-E community of where and by whom IYCF support may be provided in contexts such as Ukraine is required. International lactation professional associations and training bodies may be important overlooked entry points for bidirectional capacity strengthening.⁸⁶ Global-level engagement should be strengthened in preparedness to enable rapid linkages to be made during early response.

COMPLEMENTARY FEEDING: Community initiatives, such as food distribution and on-site feeding, are trusted and valuable components of the local emergency response. It is preferable to support and strengthen community-

led support systems instead of creating parallel food distribution networks.

Global recommendation: Current initiatives to develop guidance on complementary feeding in emergencies should ensure the inclusion of recommendations on the most appropriate complementary feeding interventions in contexts where the pre-crisis use of commercial baby foods is common and adequate food safety regulations are in place.⁸⁷ Considerations should include nutritional requirements and Code compliance⁸⁸ as well as caregiver preferences and psychological well-being, ensuring a 'do-no-harm' approach.

BFHI: Including support for BFHI's Ten Steps to Successful Breastfeeding in the IYCF-E response (OG-IFE 5.7) is crucial, particularly in contexts with high coverage of BFHI-accreditation. Ukraine's experience highlights that pre-crisis high BFHI-accreditation coverage helps protect and sustain vital practices during emergencies, such as immediate skin-to-skin contact and early breastfeeding initiation. On the other hand, lapses in monitoring, supervision and control resulted in untargeted BMS distributions in some previously BFHI-certified maternity settings. Even in emergencies where certification or re-certification is not feasible, maintaining BFHI practices and standards remains a priority. This requires adjustments by international responders accustomed to working within a separate nutrition sector that siloes IYCF with limited engagement with the health sector. While some KIs expressed concerns that IYCF-E would be further deprioritised under health, the establishment of an IYCF-E TWG under the Health Cluster in Ukraine may offer a valuable opportunity to strengthen Ukraine's pre-existing national infant feeding support systems.

DONATIONS: Innovative approaches to prevent harmful and inappropriate donations of BMS and other prohibited products are urgently needed. These may include the systematic use of Code violation reporting mechanisms for concrete action, effective media and communications and proactive engagement with potential donors.

Global recommendation: Emergency responders need to pre-empt and be prepared to respond to requests for, and calls for donations of, specialised infant formulas, which may be made in contexts such as Ukraine. There is a need to better understand the variation in needs, what constitutes an essential need, how to verify needs and who is mandated to meet valid and confirmed needs for specialised infant formulas. This entails understanding the landscape and regulatory framework surrounding 'Foods for Special Medical Purposes', as the conflation of different products and exploitation of loopholes to bypass regulations (including

⁸⁴ The "mixed milk feeding" indicator newly introduced by WHO in 2021 is likely to be useful in understanding infant feeding nuances settings with lower exclusive breastfeeding rates (prevalent in many European contexts).

⁸⁵ IFE Core Group (2021) Operational Guidance: Breastfeeding Counselling in Emergencies

⁸⁶ Ukrainian lactation consultants shared their experiences during webinars hosted by such networks/platforms. For example: Unlocking the Mysteries of Human Lactation: Breastfeeding and Donor Milk in Ukraine During the War - hosted by IABLE

⁸⁷ Responding to gaps previously highlighted on complementary feeding programming, global efforts led by UNICEF, USAID, and the IFE Core Group are currently underway for the development of guidance on complementary feeding in emergencies that consider context specific analyses and interventions that address the determinants of young children's diets in emergencies.

⁸⁸ In particular, World Health Assembly resolution 69.9 on Ending inappropriate promotion of foods for infants and young children.

the Code) can put infants at risk during emergencies. At global level, this experience calls for potential adjustments to the language in the model joint statement or additional clarifying guidance, for better preparedness and potential procurement and provision in future emergencies.

SAFER ALTERNATIVES TO BMS: IYCF-E policy and guidance documents should include all globally recommended options for the feeding of non-breastfed infants, unless a critical analysis of current acceptability and feasibility, confirmed by local experts, indicates otherwise. In many cultures worldwide, breastfeeding by someone other than the mother is accepted and practised, especially in exceptional circumstances. This was evident in Ukraine, where mothers resorted to wet nursing and informal milk sharing despite reportedly low pre-crisis interest in these practices.⁸⁹ Responders should be aware of this possibility and enable counsellors to provide reassurance and guidance to caregivers. Ukraine's experience also highlights the significance of human milk banks as a valuable source of breastmilk for vulnerable infants, even during emergencies and wartime. Given the current paucity of evidence to inform the operationalisation of human milk banks in emergency settings,⁹⁰ further documenting and learning from the experiences in Ukraine is strongly recommended.

BMS PROGRAMMING: There is a need for innovation and better understanding of how to deliver adequate BMS programming in contexts where artificial feeding is prevalent. While growing, the sector's experience with IYCF-E programming in contexts where artificial feeding is common remains limited compared to contexts where it is the exception.⁹¹

Global recommendation: A context-appropriate approach needs to be developed to support BMS-dependent infants at scale in settings such as Ukraine (i.e., those with a functional health system, good awareness among caregivers on the importance of hygienic preparation of BMS and prevalent mixed feeding).

MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT: Equipping breastfeeding counsellors to support caregiver well-being is key to improving breastfeeding outcomes in times of war.

Global recommendation: The integration of mental health and psychosocial support services and application of a trauma-informed, somatic approach should be further explored, standardised and strengthened within IYCF-E programming.

TECHNOLOGY: Technology was embraced by local responders and played a valuable role in facilitating two-way information sharing, coordination, referrals and service coverage increases. Online support platforms, such as Telegram chat groups, provided a low-cost means for reaching thousands of families with skilled breastfeeding support despite the challenging circumstances.

Global recommendation: Better understanding is required of how international agencies can support and leverage such platforms in compliance with organisational safety and security policies.

⁸⁹ Source: survey respondent who shared that they had previously surveyed 500 mothers on these practices

⁹⁰ IFE Core Group (2017) Operational Guidance on IYCF-E

⁹¹ Carmel Dolan, Marie McGrath and Jeremy Shoham (2014). ENN's perspective on the nutrition response in the Syria crisis. Field Exchange 48, November 2014. p2. www.ennonline.net/fex/48/perspective

Conclusion

This case study highlights both remarkable examples of national solidarity and continued support for breastfeeding during a major emergency, and the shortcomings of the international response in meeting the needs of conflict-affected infants, young children, and their caregivers in Ukraine. Combined with the general lack of preparedness, low prioritisation of IYCF-E and subsequent lack of needs assessment, coordination gaps, and missed opportunities to leverage local capacity are found to have contributed to these shortcomings. The international responders interviewed frequently emphasised these issues and welcomed the development of this case study. However, this case study represents merely an initial step towards accountability and the institutionalisation of learning, noting that many lessons from 2015 remain unapplied.

In a world where humanitarian crises are expanding in both scale and scope, the conventional model of direct sector-specific aid from large international humanitarian agencies is progressively less suitable for many of the crises we face today.⁹² In contexts where other actors assume key roles in emergency response, it is imperative for humanitarian actors to strengthen collaboration and coordination. This case study also highlights IYCF-E needs in Ukraine, which could benefit from tailored global expertise and experience. While standardised approaches and advice can help ensure a timely response, this must be balanced against careful consideration of where and how true value can be added.

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⁹² Lilly, D. (2023) Humanitarian action is the answer to fewer and fewer of today's humanitarian crises. Humanitarian Practice Network. Accessed at <https://odihpn.org/publication/humanitarian-action-is-the-answer-to-fewer-and-fewer-of-todays-humanitarian-crises/> on 10 May 2023.



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