

Feeding Practices Supplement to the 2015 NUTRITION SURVEY REPORT TO CCSDPT* HEALTH AGENCIES

The Border Consortium
American Refugee Committee
International Rescue Committee
Malteser International
Première Urgence Internationale

*The Committee for Coordination of Services to Displaced Persons in Thailand (CCSDPT) is the coordinating committee for 18 NGOs working in nine refugee camps along the Thailand/Myanmar border.

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"Working with the displaced people from Burma"

Feeding Practices Supplement to the 2015 Nutrition Survey Report to CCSDPT Health Agencies

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ACRONYMS

ANC	Antenatal Clinic
BDY	Ban Don Yang
BMI	Body Mass Index
CCSDPT	Committee for Coordination of Services to Displaced Persons in Thailand
CDC	Centers for Disease Control and Prevention
CI	Confidence Interval
CMT	Community Managed Targeting
EBF	Exclusive Breastfeeding
GM&P	Growth Monitoring and Promotion
HH	Households
HHS	Household Hunger Scale
IYCF	Infant and Young Child Feeding
LBW	Low Birth Weight
MLA	Mae La
MLO	Mae La Oon
MRML	Mae Ra Ma Luang
MV	Most Vulnerable
NP	Nu Po
SFP	Supplementary Feeding Programme
SR	Self-Reliant
STD	Standard
TBC	The Border Consortium
TH	Tham Hin
TPD	Total Population Database
UMP	Umpiem Mai
UNHCR	United Nations High Commissioner on Refugees
V	Vulnerable
WFP	World Food Programme
WHO	World Health Organization

EXECUTIVE SUMMARY

As part of The Border Consortium (TBC) and the Committee for Coordination of Services to Displaced Persons in Thailand (CCSDPT) Health Agencies' collaborative nutrition surveys conducted in 2015 (children 6-59 months of age in all camps), the Feeding Practices section of the survey was expanded (Appendix 1) with objectives to: 1) provide camp-specific feedback on Feeding Practices; 2) further understand potential contributors to the high stunting rate and gauge the impact of the Infant and Young Child Feeding (IYCF) Campaign, or 'Healthy Babies, Bright Futures', initiated in early 2014; and 3) guide in future prioritizing/programming in camps as indicated by results. Key topics of the Feeding Practices section included participation in nutrition education and/or campaigns related to IYCF in camps, hosted by TBC and Health Agencies; antenatal clinic attendance; maternal nutrition, breastfeeding and complementary feeding knowledge and practices; and AsiaREMix consumption practices and knowledge of benefits.

Survey Methods

Random sampling was used to select households (HH) with children 6-59 months of age in all camps using TBC's Total Population Database (TPD). TBC trained health agency staff to implement surveys in all camps, and supervised all surveys to completion. Data was analyzed using SPSS software (version 22). (See 2015 Nutrition Survey Report to CCSDPT Health Agencies for further details:

<http://www.theborderconsortium.org/media/71604/nutrition-2015-survey-report.pdf>.)

Results & Recommendations

A total of 4,759 children were surveyed in all nine camps.

Nutrition Education Participation

Border-wide, average participation rates for IYCF education for all three key topics (maternal nutrition, exclusive breastfeeding (EBF) and complementary feeding) exceeded 75%. However, in Site 1 (68%), MRML (64%), UMP (58%) and TH (69%), the focus should be on ways to promote better attendance for all three topics, while in MLO, only for complementary feeding education participation was lower (66%).

Antenatal Clinic (ANC) Attendance & Maternal Nutrition

Any ANC attendance was high (96%); however, importantly, the timing of the first ANC visit was late during the pregnancy, with only 8% visiting ANC as soon as they knew of their pregnancy and 30% at four months or longer during the pregnancy. While maternal nutrition education sessions can be used as an opportunity to promote the importance of the first visit to ANC during pregnancy as soon as the pregnancy is known, for those attending, this may already be late for such messaging for the current pregnancy. Therefore, all IYCF-related nutrition education and campaigns should be used to emphasize this message.

For maternal nutrition education, the benefits of weight gain during pregnancy were not well understood. This topic should be featured more to improve the mothers' understanding and ultimately, their practices.

Food consumption during pregnancy and breastfeeding were best practised related to iron intake. Protein

consumption during these periods needs to be promoted, as many reported less frequently eating protein-rich foods relative to usual intake when not pregnant or breastfeeding, particularly in vulnerable (V) and most vulnerable (MV) HH (Community Managed Targeting (CMT) categories). Additionally, the most frequently reported foods that were restricted after delivery do not seem harmful as they included chili, dogfruit and fish paste.

Breastfeeding

The recommended timing of breastfeeding initiation was reported by most (90%) border-wide (the newborn was put to the breast immediately or within one hour after birth). Camps with almost double the rate as compared to other camps that did not practice recommended breastfeeding initiation were MRML (15%), UMP (15%) and NP (13%).

While it is recommended to breastfeed until 24 months of age, the mean duration across all camps was 13 months. Further, EBF (just breastmilk with no liquids or foods, including water) duration was 4.5 months instead of the recommended six months. Although MRML and MLO had the longest duration of breastfeeding (14 and 15.5 months, respectively), these camps also had the shortest duration of EBF. The survey results showed that mothers understood EBF benefits for their children but had a poor understanding of the benefits related to their own health.

The survey results suggest all camps could benefit from continued education on EBF duration, continued breastfeeding until 24 months of age and EBF benefits for mothers' health. Further, it is necessary to understand reasons why mothers only breastfeed for

13 months in order to foster a supportive environment.

Complementary Feeding

Border-wide, complementary feeding initiation as recommended at 6 months of age improved since the 2013 Nutrition Survey – complementary feeding prior to 6 months decreased from 34% to 24%). However, this should still need emphasis as this means that one out of every four mothers is practising early initiation of complementary feeding. While Sites 1 and 2 continue by far to have the highest rates of early initiation of complementary feeding, it has greatly improved since the 2013 Nutrition Survey (Site 1 from 71% to 42%; Site 2 from 63% to 43%). Such progress should be used to encourage these camps to continue to improve, sharing any lessons learned and successful methods with other camps.

Overall, most (77%) reported their child had consumed AsiaREMix over the past week; however, the lowest consumption was in the youngest children (53% did not consume over the past week in 6-11 month old children). One of the most frequently cited reasons in the "Other" category for not consuming AsiaREMix was that their child was too young. Education about AsiaREMix benefits should continue, focusing on appropriateness as a complementary food for young children, while emphasizing the nutrients it provides and foods that can also provide the same nutrients for their child's good health and growth.

BACKGROUND

The Border Consortium (TBC) and the Committee for Coordination of Services to Displaced Persons in Thailand (CCSDPT) Health Agencies conduct biennial nutrition surveys of children 6-59 months of age in all camps to estimate the prevalence and examine trends in acute (wasting) and chronic (stunting) malnutrition, micronutrient deficiencies, Supplementary Feeding Programme (SFP), deworming and vitamin A supplementation coverage, **Feeding Practices**, Nursery School Lunch Programme enrolment and Household

Hunger Scale (HHS) in the refugee population residing in nine camps.

This Supplement provides camp-by-camp and border-wide results of the **Feeding Practices** section of the 2015 Nutrition Survey, completed from May through November 2015.

(Refer to 2015 Nutrition Survey Report to CCSDPT Health Agencies for details of sampling; inclusion criteria; definitions; survey procedures; and data analysis.)

RESULTS

AGE AND SEX DISTRIBUTION OF SAMPLE

A total of **4,759 children** were surveyed in all nine camps, with all Community Managed Targeting (CMT) ration categories included (Tables 1.0 and 1.1).

Table 1.0. Distribution of Age and Sex of Sample

AGE (mo)	Boys		Girls		Total		Ratio
	No.	%	No.	%	No.	%	Boy : Girl
6-11	251	49.4	257	50.6	508	10.7	1.0
12-23	529	48.6	560	51.4	1089	22.9	1.0
24-35	529	51.0	508	49.0	1037	21.8	1.0
36-47	524	48.1	565	51.9	1089	22.9	1.0
48-59	509	49.1	527	50.9	1036	21.8	1.0
Total	2,342	49.2	2,417	50.8	4759	100.0	1.0

Table 1.1. CMT Ration Category Included in 2015 Nutrition Survey

CMT Ration Category	Percent in Survey Sample
Self-Reliant (SR)	0.5%
Most Vulnerable (MV)	5.2%
Vulnerable (V)	8.5%
Standard (STD)	85.8%

BACKGROUND INFORMATION/NUTRITION EDUCATION PARTICIPATION

BACKGROUND INFORMATION

Survey respondents for the Feeding Practices questions **consisted primarily of mothers (88.3%)**, with a small number of fathers (6.8%) and grandparents (2.9%) participating.

The range of education of the mothers was large, between 0 -18 yrs, **although 96.2% had 10 yrs or less of education (mean ± SD=4.61 yrs ± 4.0 yrs)**. By camp, the mean ranged from a minimum of **4.0 yrs (BDY) to maximum of 4.9 yrs (Site 1)**.

NUTRITION EDUCATION PARTICIPATION RATES

Survey respondents were asked if they had participated in nutrition education provided by TBC and/or Health Agencies in camps since the initiation of 'Healthy Babies, Bright Futures IYCF Campaign' in the beginning of 2014, divided by three key topics: **maternal nutrition; exclusive breastfeeding (EBF); and complementary feeding**. **Border-wide, survey respondents reported participation rates of 77.3%, 77.5% and 73.9%, respectively, per topic (Table 1.2)**. The camps with **lower participation rates for all three topics included Site 1, MRML, UMP and TH**. **MLO's participation rate was low only for complementary feeding**.

Table 1.2. Nutrition Education Participation since Beginning of 2014

Camps	Complementary Feeding % (n)	Maternal Education % (n)	EBF % (n)
Site 1	68.2 (364)	68.2 (364)	68.3 (364)
Site 2	98.3 (289)	98.0 (287)	99.0 (290)
MRML	63.2 (403)	64.6 (412)	64.0 (407)
MLO	65.8 (424)	80.0 (517)	80.3 (514)
MLA	91.8 (512)	95.3 (533)	94.6 (527)
UMP	58.6 (311)	58.0 (309)	56.5 (301)
NP	88.8 (422)	90.5 (430)	90.1 (430)
BDY	86.7 (280)	88.5 (286)	90.3 (290)
TH	64.8 (368)	69.3 (393)	72.2 (410)
All Camps:	73.9 (3,373)	77.3 (3,531)	77.5 (3,533)

ANTENATAL CLINIC (ANC) ATTENDANCE

Most (96.1%) survey respondents reported attendance at ANC during their most recent pregnancy (**all camps reported ≥94% attendance**). However, **only 7.9% (n=388) reported attending ANC as soon as they knew they were pregnant**. The majority (**70.4%; n=3,006**) went to ANC **between the first 1-3 months of their pregnancy**. **BDY clearly had the highest rate** of mothers attending ANC as soon as they knew of the pregnancy at **39.1%**. **Site 2 and TH had more than 40% of mothers who did not attend ANC until 4 months or later during the pregnancy (46.4% and 44.7%, respectively)** (Table 1.3, n=4,271).

Table 1.3. ANC First Visit Timing

Camps	As Soon As Knew of Pregnancy % (n)	4 Months or Longer during Pregnancy % (n)
Site 1	3.9% (20)	26.2 (135)
Site 2	1.8 (5)	46.4 (128)
MRML	3.0 (18)	37.2 (223)
MLO	2.9 (17)	37.1 (214)
MLA	4.8 (26)	21.4 (117)
UMP	12.8 (60)	20.2 (95)
NP	8.5 (39)	18.9 (87)
BDY	39.1 (119)	10.9 (33)
TH	6.5 (34)	44.7 (233)
All Camps:	7.9 (338)	29.6 (1265)

MATERNAL NUTRITION

KNOWLEDGE OF BENEFITS OF WEIGHT GAIN DURING PREGNANCY

The respondents' knowledge of the benefits of weight gain during pregnancy is presented below (Table 1.4). Border-wide, the **majority agreed that promoting child growth and development in early childhood was a benefit of weight gain**; however, knowledge that **preventing risks of maternal complications and death; preventing anemia in pregnancy; preventing low birth weight (LBW) and premature baby; and preventing infections for the baby and mother were not well-understood** by most as benefits of weight gain during pregnancy.

By camps, the knowledge of benefits of weight gain during pregnancy was quite variable; however, the results can be **used per camp to prioritize areas** to focus on to improve knowledge. For example, in **Site 2**, it's clear that **mothers understood that benefits of weight gain during pregnancy included preventing anemia in pregnancy (82.4%) and promoted child growth and development in early childhood (77%)**, while the **other benefits were poorly understood (11.3% - 21.8%)** – at most, one woman in five understood any of the other listed benefits.

Table 1.4. Knowledge of Benefits of Weight Gain during Pregnancy

Camps	Prevent Risks Maternal Complications & Death n=3,639	Prevent Anemia in Pregnancy n=3,638	Prevent LBW & Premature Baby n=3,638	Prevent Infection for Baby & Mother n=3,638	Promote Child Growth & Development in Early Childhood n=3,638
	% (n)	% (n)	% (n)	% (n)	% (n)
Site 1	6.8 (35)	3.9 (20)	30.2 (155)	61.3 (315)	84.0 (432)
Site 2	11.3 (27)	82.4 (197)	21.8 (52)	19.2 (46)	77.0 (184)
MRML	28.3 (144)	9.2 (47)	29.9 (152)	58.7 (299)	32.4 (165)
MLO	53.0 (219)	1.7 (7)	24.2 (100)	16.9 (70)	42.6 (176)
MLA	15.3 (78)	55.1 (281)	11.4 (58)	25.9 (132)	48.4 (247)
UMP	1.2 (5)	1.5 (6)	7.3 (30)	72.1 (295)	52.1 (213)
NP	14.9 (62)	16.6 (69)	42.4 (176)	9.2 (38)	79.0 (328)
BDY	31.3 (75)	16.3 (39)	27.9 (67)	32.1 (77)	46.7 (112)
TH	36.8 (143)	12.1 (47)	24.2 (94)	8.0 (31)	72.5 (282)
All Camps:	21.7 (788)	19.6 (713)	24.3 (884)	35.8 (1,303)	58.8 (2,139)

FOOD RESTRICTION AFTER DELIVERY

Most (57.8%, n=4,720) responded that after delivery of their last child, they **restricted the kinds of food** consumed. Foods most often restricted were: **chili (5.4%, n=144), dogfruit (1.6%, n=43) and fish paste (2.9%, n=78).**

FOOD CONSUMPTION DURING PREGNANCY

Women were asked about how they ate during their most recent pregnancy, compared to when they were not pregnant. **Border-wide, best practices were for iron consumption** – more participants reported consuming more iron and fewer reported consuming less iron. **Worst practices during pregnancy were reported for protein intake**, with the highest frequency taking in less protein. Further, **only V or MV HH reported less protein intake during pregnancy.** The same patterns were found **by camps.**

Figure 1.0. Border-wide: Food Consumption during Pregnancy

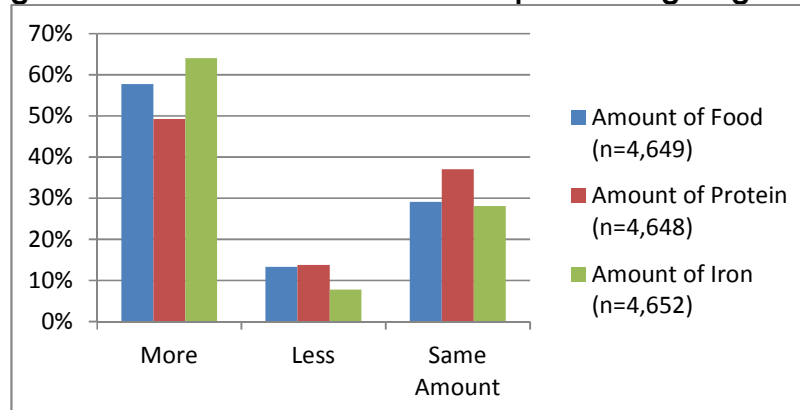


Table 1.5. By Camp: Food Consumption during Pregnancy

	Amount of Food	Amount of Protein	Amount of Iron
Site 1	n=534	n=532	n=535
More	75.7%	72.6%	78.3%
Less	9.2%	10.0%	8.8%
Same Amount	15.2%	17.5%	12.9%
Site 2	n=301	n=300	n=300
More	40.9%	38.3%	44.3%
Less	29.2%	27.7%	25.3%
Same Amount	29.9%	34.0%	30.3%
MRML	n=654	n=654	n=654
More	52.9%	49.1%	63.9%
Less	16.8%	8.6%	4.0%
Same Amount	30.3%	42.4%	32.1%
MLO	n=655	n=662	n=662
More	45.7%	37.8%	53.9%
Less	20.5%	19.6%	11.5%
Same Amount	33.8%	42.6%	34.6%
MLA	n=582	n=582	n=582
More	60.7%	53.3%	69.2%
Less	8.6%	10.5%	5.7%
Same Amount	30.8%	36.3%	25.1%
UMP	n=536	n=535	n=536
More	50.7%	33.6%	54.5%
Less	10.1%	15.9%	4.3%
Same Amount	39.2%	50.5%	41.2%
NP	n=491	n=491	n=491
More	63.3%	44.8%	68.8%
Less	7.1%	11.2%	3.1%
Same Amount	29.5%	44.0%	28.1%
BDY	n=330	n=330	n=330
More	72.7%	68.6%	77.0%
Less	3.6%	3.9%	1.2%
Same Amount	23.6%	27.3%	21.8%
TH	n=562	n=562	n=562
More	59.1%	49.5%	64.9%
Less	14.8%	19.0%	11.4%
Same Amount	26.2%	31.5%	23.7%

FOOD CONSUMPTION DURING BREASTFEEDING

Women were also asked how they ate during the last time they were breastfeeding compared to when they were not breastfeeding. Results were the same border-wide and by camp as for food consumption during pregnancy - **practices were best related to iron** consumption – more participants reported consuming more iron during pregnancy; fewer reported consuming less iron during pregnancy. **Worst practices were reported for protein**, with the highest frequency taking in less protein. As well, only V and MV HH reported less protein intake.

Figure 1.1 Border-wide Food Consumption during Breastfeeding

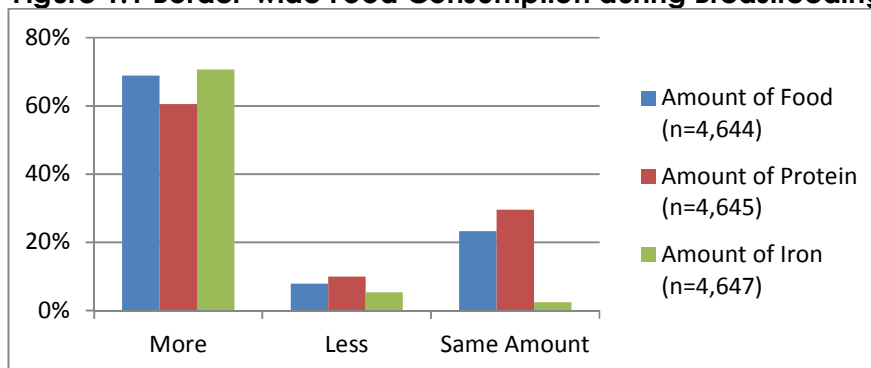


Table 1.6. By Camp: Food Consumption during Breastfeeding

	Amount of Food	Amount of Protein	Amount of Iron
Site 1	n=536	n=536	n=536
More	95.3%	92.4%	93.8%
Less	0.4%	0.7%	0.7%
Same Amount	4.3%	6.9%	5.5%
Site 2	n=302	n=302	n=302
More	73.8%	70.5%	72.5%
Less	9.6%	9.3%	9.3%
Same Amount	16.6%	20.2%	18.2%
MRML	n=652	n=654	n=654
More	65.5%	62.7%	71.1%
Less	9.4%	6.1%	2.4%
Same Amount	25.2%	31.2%	26.5%
MLO	n=659	n=659	n=659
More	61.5%	54.0%	61.3%
Less	9.1%	12.9%	8.2%
Same Amount	29.4%	33.1%	30.5%
MLA	n=582	n=582	n=582
More	68.4%	59.6%	71.1%
Less	6.0%	9.1%	4.3%
Same Amount	25.6%	31.3%	24.6%
UMP	n=536	n=536	n=536
More	59.1%	39.6%	58.6%
Less	6.2%	12.5%	3.7%
Same Amount	34.7%	47.9%	37.7%
NP	n=489	n=489	n=490
More	73.8%	55.4%	76.9%
Less	5.7%	8.0%	2.0%
Same Amount	20.4%	36.6%	21.0%
BDY	n=329	n=329	n=329
More	71.7%	69.6%	75.4%
Less	7.9%	6.7%	5.2%
Same Amount	20.4%	23.7%	19.5%

	Amount of Food	Amount of Protein	Amount of Iron
TH	n=559	n=558	n=559
More	56.9%	49.6%	60.1%
Less	16.5%	22.2%	13.8%
Same Amount	26.7%	28.1%	26.1%

SUPPLEMENTATION DURING PREGNANCY OR BREASTFEEDING

Most women stated they were taking **iron, vitamin A, folic acid, vitamin B1 (Table 1.7) and multivitamin (53.7%, n=2,493)**. Additionally, 22.7% (n=1,056) reported taking vitamin C. By camp, **UMP and NP were notably lower** in reported intake of **vitamin A (35.7% and 76.8%, respectively) and folic acid (17.1% and 66.3%, respectively)** compared to all other camps.

Table 1.7. Supplementation during Pregnancy or Breastfeeding

	Iron (n=4,605)	Vitamin A (n=4,551)	Folic Acid (n=4,605)	Other (n=4,645)
Yes	94.7%	83.9%	85.1%	89.9%

BREASTFEEDING

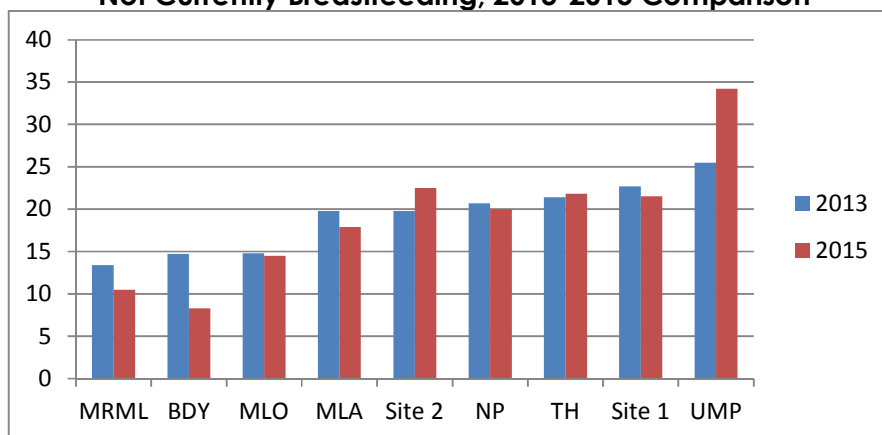
TIMING OF BREASTFEEDING INITIATION

Border-wide, most women (**89.9%**) had put the newborn to the breast immediately or within one hour after birth, as recommended, while 8.6% initiated breastfeeding >24 hours after birth, and 1.5% reported never breastfeeding. By camp, **MRML had the highest rate of women who did not initiate breastfeeding within the first hour after birth (15.4%), followed by UMP (14.7%) and NP (13.4%),** almost double the rate as compared to the other camps.

BREASTFEEDING PRACTICES

- ‘Ever Breastfed’ - **97.9%** (n=4,749) responded positively, with similar results by camp.
- ‘Currently Breastfeeding’ - **19.1%** (n=1,557) were **not currently breastfeeding** (of children 6-24 months), unchanged since the 2013 Nutrition Survey (Figure 1.2)

Figure 1.2. By Camp: Percent of Mothers of Children 6-24 months Not Currently Breastfeeding, 2013-2015 Comparison



- **'Duration of Breastfeeding'** - Border-wide, duration (of children 6-24 months of age) was **13.0 months ± 6.2 months** (n=908). By camp, almost all camps exceeded the border-wide mean with **MRML and MLO having the longest duration of breastfeeding**, while **BDY and TH fell notably below** (Table 1.8).

Table 1.8. Duration of Breastfeeding

Camp	Months (mean ± SD)
Site 1	13.9 ± 4.7
Site 2	12.4 ± 6.0
MRML	14.1 ± 6.8
MLO	15.5 ± 7.6
MLA	13.7 ± 5.6
UMP	13.6 ± 5.5
NP	13.8 ± 5.0
BDY	4.9 ± 8.1
TH	9.9 ± 7.4
All Camps:	13.0 ± 6.2

- **EBF Duration'** – Border-wide, the mean duration for EBF was **4.5 months ± 2.2 months** (n=3,811). Camps where **EBF duration was much lower** than the border-wide mean included **MRML and MLO** (Table 1.9). Although **MRML and MLO reported breastfeeding for the longest duration**, they practiced **EBF for the shortest period of time**.

Table 1.9. Duration of EBF

Camp	Months (mean ± SD)
Site 1	5.2 ± 1.2
Site 2	4.6 ± 1.7
MRML	2.8 ± 2.5
MLO	3.9 ± 2.2
MLA	4.2 ± 2.3
UMP	5.4 ± 1.7
NP	4.4 ± 2.3
BDY	5.7 ± 1.2
TH	4.8 ± 1.9
All	4.5 ± 2.2

Interestingly, those categorized as **SR** by CMT category **practiced EBF for a much fewer numbers of months** compared to other CMT categories. While this represents a small number of respondents (n=22), it is an interesting finding, possibly explained by those at a higher socioeconomic level perceiving breast milk substitute as superior to breastfeeding (Table 2.0).

Table 2.0. EBF Duration by CMT Category

CMT Category	Months Exclusively Breastfed (mean ± SD)
Self-Reliant (SR)	2.6 ± 2.2 (n=22)
Most Vulnerable (MV)	4.8 ± 1.9 (n=188)
Vulnerable (V)	4.0 ± 2.3 (n=313)
Standard (STD)	4.5 ± 2.2 (n=3,288)

BENEFITS OF EXCLUSIVE BREASTFEEDING

Overall, **most agreed that benefits of EBF were those benefits directly related to the child’s health** (sufficient nutrients for baby; protects baby from infections and promotes optimum growth and development). **Benefits related to mother’s health were less frequently cited**, likely due to poor understanding of these benefits. By camp, results can help to inform programming of education and campaigns, targeting areas that need strengthening (Table 2.1).

Table 2.1. Belief in Benefits of EBF by Camp & Border-wide

	S1	S2	MRML	MLO	MLA	UMP	NP	BDY	TH	ALL
Sufficient nutrients for baby	34.3	48.4	55.0	55.6	73.0	47.6	54.2	90.3	73.5	58.3
Promotes optimum growth & development	92.3	29.4	55.8	54.3	49.7	52.2	54.0	81.2	28.6	55.9
Protects baby from infections	64.0	58.1	51.8	41.6	58.1	41.9	41.8	50.5	40.1	51.9
Delays new pregnancy	2.6	11.7	4.7	2.2	1.6	3.8	1.0	2.1	0.4	2.9
Promotes bonding & motherhood	0.9	2.8	0.5	1.4	2.9	4.6	0.8	3.6	1.0	1.9
Decreases breast, ovarian & cervical cancers	3.0	2.4	1.4	1.1	2.7	1.4	0.4	2.1	0.2	1.6
Reduce risk of post-partum bleeding	0.4	1.2	0.5	1.0	0.7	0.4	0.2	1.2	0.2	0.6

COMPLEMENTARY FEEDING

- Border-wide, **23.8%** of mothers reported giving the **first meal to their child before 6 months** of age (**33.9% in 2013**). In **Sites 1 and 2, the first meal was given before 6 months of age at notably higher rates than all other camps, but much improved since 2013** (Figures 1.3-1.4; Site 1: 71.3% to 42.1%; Site 2: 62.5% to 43.1%). Overall, **63.6% timed the first meal as recommended, at 6 months** of age (n=2,970).

Figure 1.3. Percent Reported Early Timing of First Meal, 2015

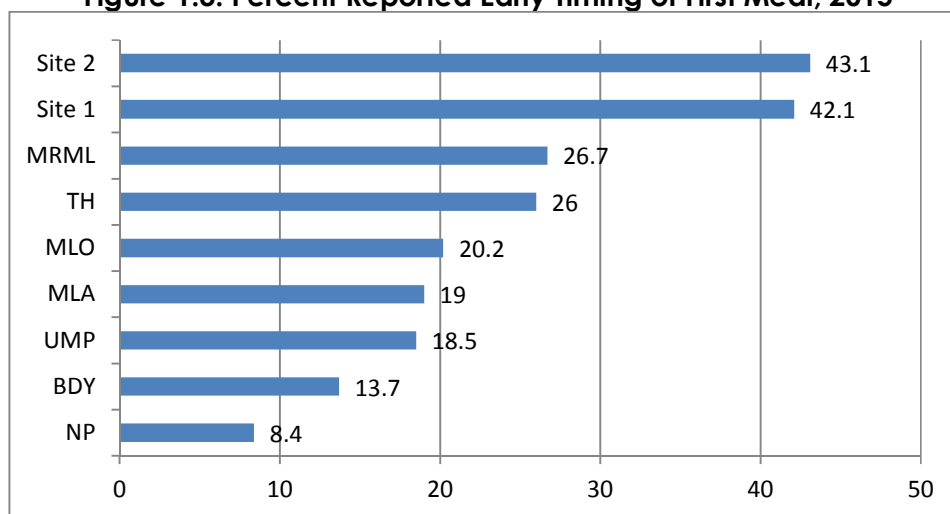
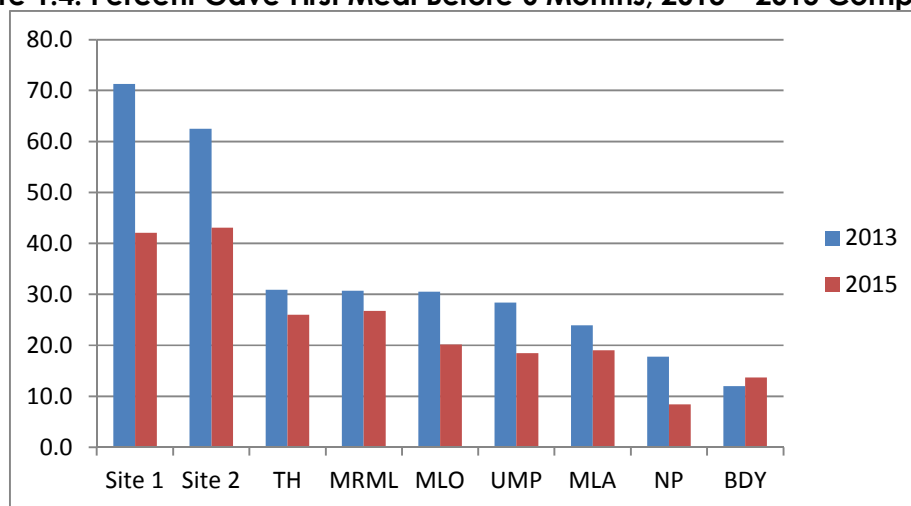


Figure 1.4. Percent Gave First Meal Before 6 Months, 2013 – 2015 Comparison

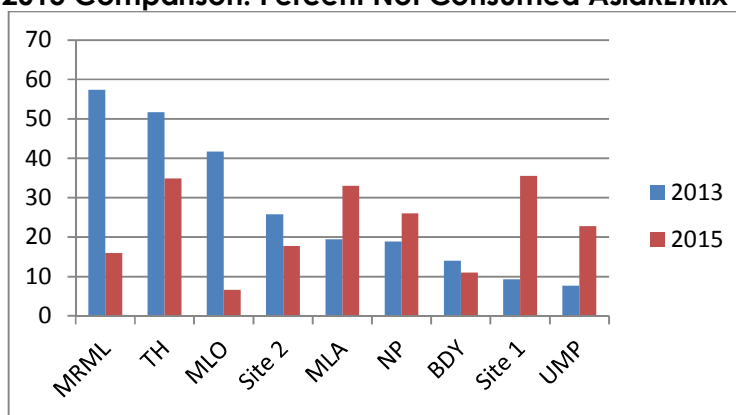


- ‘Number of meals child eaten during last 24 hours’ (n=4,728) - The most often reported number of meals consumed over the last 24 hours was three (53.8%). At a minimum, children should be fed complementary foods starting at 3 times/day for those 6-9 months of age, with greater frequency as age increases (4 times/day 9-12 mos; 5 times/day >12 mos). Many mothers (44.7%) reported giving less than 3 meals/day over the last 24 hours (n=2,114). In MLA, only 30.5% reported giving 3 meals/day, while the majority (63.1%) gave 2 meals/day.
- ‘Number of snacks child consumed during last 24 hours’ (n=4,471) - The most frequent number of snacks reported over the last 24 hours was two (28.8%), while 8.1% reported no snacks. Over half (55.5%) reported giving 2-3 snacks/day (n=2,480). Those camps that reported giving snacks less than two times/day were ML (26.9%), NP (32.3%) and TH (29.8%) while UMP and BDY reported three snacks/day (26.3% and 39.6%, respectively). This is not explained by age difference by camp as NP & ML had fewer younger children so in fact, they should

have given more snacks; and TH had the same number of younger children as most other camps (11%).

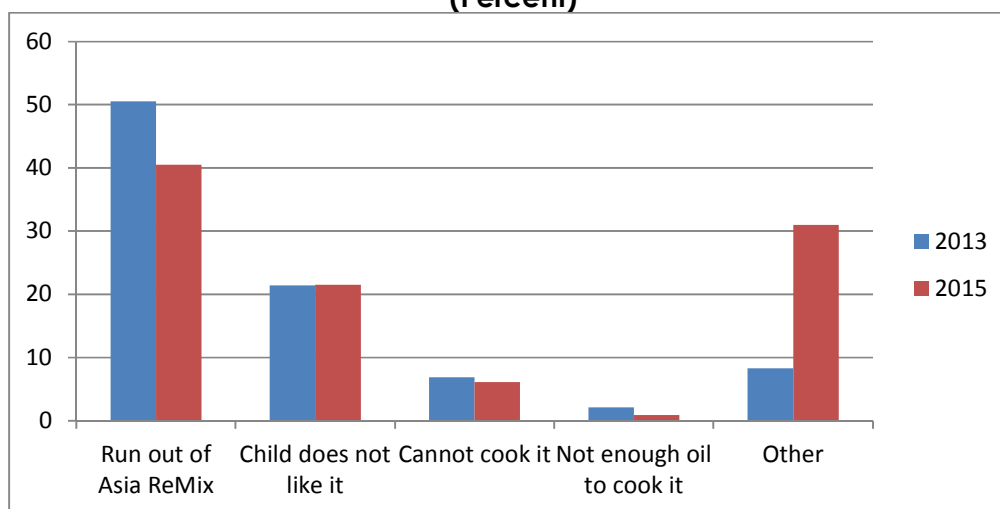
- 'Foods/liquids child consumed over past 24 hours' (Appendix 2) - The results of foods and liquids consumed by children over the past 24 hours can be viewed by camp. The results are quite variable so can be used at each camp level to develop messages to improve nutrition. For example, TH, MRML and Site 1 had many fewer children consume fruits or fruit juice as compared to the other camps, over the past 24 hours, so this is an opportunity to reinforce the 3 food groups, focusing on the Protective Food Group in these camps. Whereas BDY and Site 1 had a much higher intake over the past 24 hours in sugary foods and beverages in young children; messages about more appropriate, nutrient-dense food selections for children in these camps would be appropriate. Additionally, for future biennial nutrition surveys, the Food Consumption Score Nutritional Quality Analysis (FCS-N) will be used as it is a World Food Programme (WFP) validated tool to define categories of HH food insecurity & understand nutrient intake & foods consumed.
- 'AsiaREMix consumption by child over past week – Most (77%) reported that their child had consumed AsiaREMix during the past week, with the least consumption in the youngest age group (52.7% for 6-11 months) and highest consumption at 24-35 months (81.4%). If the child consumed AsiaREMix during past week, over half (52.8%) reported their child ate AsiaREMix a maximum of 2 times/week, with only 13.2% consuming AsiaREMix daily, as recommended. By camp, the percent of children who did not consume AsiaREMix during the past week varied widely, from 6.6-35.5%.

Figure 1.5. 2013-2015 Comparison: Percent Not Consumed AsiaREMix during Past Week,



Reasons reported why AsiaREMix was not consumed are displayed in Figure 1.6, with running out of AsiaREMix as the most frequently reported reason. Most frequent reasons included in the "Other" category were: child is too young to eat AsiaREMix; mother has not enough time to cook AsiaREMix; and feeds child BabyBRIGHT.

Figure 1.6. 2013-2015 Comparison: Reasons Reported for Not Consuming AsiaREMix (Percent)



- ‘Benefits of eating AsiaREMix - (n=4,759) Border-wide, it seems most do not understand the benefit of AsiaREMix in protecting babies from infections - less than a third of respondents agreed with the statement (Table 2.2). For ‘Other’ benefits that respondents thought of by themselves, many stated it was good for their babies’ brain development (n=60).
- Camps that reported less agreement with the following statements as compared to border-wide were: sufficient nutrients for baby: UM and TH (51.0% and 67.3%, respectively); protects baby from infections: MLO and TH (11.2% and 6.0%, respectively); promotes optimum growth & development: MRML (62.7%); ML (66.3%) and TH (40.4%). TH reported less agreement with all three statements about benefits of AsiaREMix than the border-wide averages.

Table 2.2. Benefits of Eating AsiaREMix

	% Agree
Sufficient nutrients for baby	80.2
Protects baby from infections	31.6
Promotes optimum growth & development	69.3
Other – good for brain	1.3

DISCUSSION & RECOMMENDATIONS

In early 2014, ‘Healthy Babies, Bright Futures’ IYCF Campaign was initiated to address the main nutritional challenge in the camps, which is stunting (low height-for-age). The effects of stunting are

serious and lifelong. Stunting is strongly linked to ability to learn and cognitive development in children; it negatively affects maternal and adult health. To better understand the impact of this Campaign, the Feeding Practices

component of the 2015 Nutrition Survey was significantly expanded.

The *Feeding Practices Supplement* to the 2015 Nutrition Survey Report to CCSDPT Health Agencies is intended to inform the Nutrition Programme in camps to prioritize resources in areas where most needed. Specifically, there is detailed data by camp on the three key IYCF topics - maternal nutrition, EBF and complementary feeding - that can be used to guide Programme focus in each camp.

Nutrition Education Participation

Border-wide, the community is participating well in IYCF education for all three topics (maternal nutrition, EBF and complementary feeding) as indicated by participation rates >75%. However, Site 1 (68%), MRML (64%), UMP (58%) and TH (69%) had lower participation for all topics, while MLO (66%) had lower attendance only for complementary feeding education sessions.

Recommendations:

1. While overall attendance is going well at IYCF Campaigns, finding new, creative ways to present the information to maintain the community's interest is essential. Additionally, gaining the interest of a broader audience (not just mothers) will help to support IYCF-related behaviour change in the HH. IYCF education should not only be conducted as stand-alone campaigns, but integrated as much as possible into other camp activities to reach a broader community (e.g., Farmers Field Schools, Nursery School teacher education and youth group activities).
2. Site 1, MRML, UMP and TH should find ways to promote IYCF

Campaign attendance, and/or deliver the education in new ways that may be more convenient for the community to participate, such as in sections or during other activities (e.g., cooking demonstrations in homes with small groups). MLO should focus on complementary feeding, as the survey results indicated low attendance.

ANC Attendance & Maternal Nutrition

ANC attendance at any time during pregnancy was high at 96%; however, importantly, the timing of the first ANC visit was late with only 8% visiting ANC as soon as they knew of their pregnancy and 30% at four months or longer during the pregnancy.

For maternal nutrition education, the benefits of weight gain during pregnancy were not well understood.

Food consumption during pregnancy and breastfeeding were best practised related to iron intake, with least understanding about need for protein during these times, as indicated by the survey, particularly in V and MV HH.

The most frequently reported foods that were restricted after delivery do not seem harmful as they included chili, dogfruit and fish paste.

Recommendations:

1. While maternal nutrition education sessions can be used as an opportunity to promote the importance of the first visit to ANC during pregnancy as soon as the pregnancy is known, this may already be late for such messaging for their current pregnancy. All IYCF-related nutrition education and

campaigns should be used to underscore this message.

2. Health benefits of weight gain for the mother should be emphasized more to improve understanding and ultimately, practices.
3. Protein consumption during pregnancy and breastfeeding need to be promoted as many reported less frequently eating protein foods relative to usual intake when not pregnant or breastfeeding. Additionally, this topic should be explored during small group discussions, particularly focusing on V and MV HH, to better understand why protein consumption is less frequent during pregnancy and breastfeeding.

Breastfeeding

Most (90%) followed the recommended practice for breastfeeding initiation (newborn put to the breast immediately or within one hour after birth) border-wide. Camps with almost double the rate as compared to other camps that did not practice early breastfeeding initiation were MRML (15%), UMP (15%) and NP (13%).

While it is recommended to breastfeed until 24 months of age, the mean duration across all camps was 13 months. Further, EBF (just breastmilk with no liquids or foods, including water) duration was 4.5 months instead of the recommended six months. Although MRML and MLO had the longest duration of breastfeeding (14.0 and 15.5 months, respectively), these camps also had the shortest EBF duration. Survey results showed that mothers understood EBF benefits for their children but had a poor understanding of the benefits related to their own health.

Recommendations:

1. Camps with almost double the rate as compared to other camps that did not practice recommended breastfeeding initiation should include focus on this during IYCF education (MRML, UMP and NP). Small group discussions could be used to understand reasons why this practice is not followed in order to find relevant solutions for each camp context.
2. Survey results suggest all camps could benefit from continued education on duration of EBF, continued breastfeeding until 24 months of age and EBF benefits for mothers' health. Importantly, it is necessary to understand reasons why mothers only breastfeed for 13 months in order to promote a supportive environment. This can be included as a question in the next biennial nutrition survey and/or discussed in small group educational sessions in camps.

Complementary Feeding

Border-wide, complementary feeding initiation as recommended at 6 months of age improved since the 2013 Nutrition Survey, with feeding prior to 6 months decreased from 34% to 24%. While Sites 1 and 2 continue by far to have the highest rates of early initiation of complementary feeding, it has greatly improved since the 2013 Nutrition Survey (Site 1 from 71% to 42%; Site 2 from 63% to 43%).

Overall, most (77%) reported their child had consumed AsiaREMix over the past week; however, the lowest consumption was in the youngest children (53% did not consume over the past week in 6-11 month old children). One of the most frequently cited reasons in the "Other"

category for not consuming AsiaREMix was that their child was too young.

Recommendations:

1. Initiating complementary feeding at six months of age still needs highlighting as one out of every four mothers, is practising early initiation of complementary feeding.
2. Progress such as in Sites 1 and 2 should be used to motivate these camps to continue to improve, sharing any lessons learned and

successful methods with other camps.

3. Education about the benefits of AsiaREMix should continue, focusing on appropriateness as a complementary food for young children, while emphasizing the nutrients it provides and foods that also provide the same nutrients for good health and growth of children.

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APPENDIX 1

Feeding Practices Survey Section of the 2015 Nutrition Survey

FEEDING PRACTICES တာမညီနီသးလၢတၢ်ဒုးအိၣ်ဖိသၣ်တၢ်အိၣ်

10. Specify the person who answers these questions:

ဟံၣ်ဖျါထီၣ်လီၤတၢ်လီၤဆဲးပုၤလၢအစံးဆၢတၢ်သံကွၢ်တဖၣ်အံၤ.

- (1) Mother မိာ်
- (2) Father ဖာ်
- (3) Grandparents ဖံဖု
- (4) Other ပုၤအဂ့ၤအဂၤ (specify) (ဟံၣ်ဖျါထီၣ်လီၤဆဲး) _____

11. How many years of education has the mother of this child completed?

ဖိသၣ်အမိၢ်တဂၤအံၤန့ၣ်မၤလိဘၣ်တၢ်ပုၤန့ၣ်လံလဲၣ်

_____ Number of years နီၣ်ဂံၢ်အန့ၣ် (9) Don't know တသ့ၣ်ညါဘၣ်

12. Did you participate in TBC nutrition education since the beginning of 2014?

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12a. Complementary Feeding Education? တၢ်ဒုးအိၣ်တၢ်အိၣ်န့ၣ်ဂံၢ်န့ၣ်ဘါအတၢ်ကူၣ်ဘၣ်ကူၣ်သ့.

- (1) Yes အိၣ်
- (2) No တအိၣ်
- (9) Don't know တသ့ၣ်ညါဘၣ်

12b. Maternal Nutrition Education? မိာ်တၢ်အိၣ်န့ၣ်ဂံၢ်န့ၣ်ဘါအတၢ်ကူၣ်ဘၣ်ကူၣ်သ့.

- (1) Yes အိၣ်
- (2) No တအိၣ်
- (9) Don't know တသ့ၣ်ညါဘၣ်

12c. Exclusive Breast Feeding Education? တၢ်ဒုးအိၣ်ထဲမိၢ်န့ၣ်ထံအတၢ်ကူၣ်ဘၣ်ကူၣ်သ့.

- (1) Yes အိၣ်
- (2) No တအိၣ်
- (9) Don't know တသ့ၣ်ညါဘၣ်

13. Have you been pregnant or breastfeeding since the start of 2014?

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Yes အိၣ်

(2) No တအိၣ်

14. Did the mother attend Antenatal clinic (ANC) when she became pregnant with this child?

မုၢ်မိၢ်အံၤဖဲအဖၢအဆၢကတီၢ်လဲၤဖဲဆူမိၢ်တၢ်ဟ့ၣ်ကသံၣ်ဒၢး(ANC) အလီၢ်ဖဲလၢအဖၢဖဲအဖိတဂၤအံၤအခါန့ၣ်ဒါ.

- (1) Yes လဲၤ
- (2) No တလဲၤဘၣ် (If NO, go to no. 16) (အမုၢ်စံးဆၢလၢတလဲၤဘၣ်န့ၣ်, လဲၤဆူနီၣ်ဂံၢ်၁၆)
- (9) Don't know တသ့ၣ်ညါဘၣ်

15. How many weeks gestation was the mother when she first visited the Antenatal clinic (ANC)?

မိၢ်တဂၤအံၤဖဲလၢအလဲၤဆူမိၢ်တၢ်ဟ့ၣ်ကသံၣ်ဒၢး (ANC)အခိၣ်ထံးကတၢ်တဘျီန့ၣ်, အဖၢအဖိန့ၣ်ပုၤန့ၣ်လဲၣ်.

(Take information from Pink Book if available.) (လံာ်လွၢ်ဂီၤစၢ်(လံာ်ပါယီၢ်)မုၢ်အိၣ်န့ၣ်ဟံးန့ၣ်တၢ်ဂ့ၢ်လၢလံာ်အဝဲန့ၣ်အပူၤ)

- (1) As soon as knew of pregnancy ဖဲလၢသ့ၣ်ညါလၢအဖၢထီၣ်ဝဲတဘျီဃီ
- (2) 1-3 months ဖဲလၢအိၣ်၁လါ-၃လါ
- (3) 4-7 months ဖဲလၢအိၣ်၄လါ-၇လါ
- (4) 8 months or more ဖဲလၢအိၣ်၈လါဆူအဖိခိၣ်
- (9) Don't know တသ့ၣ်ညါဘၣ်

16. During the whole pregnancy period, how much weight did the mother gain?

ဖဲလၢမိၢ်တဂၤအံၤဖဲလၢအဆၢကတီၢ်န့ၣ်, မိၢ်အံၤအနီၢ်ကစၢ်အတယၢ်ဃၢအါထီၣ်ဝဲထဲလဲၣ်. _____ kg ကံလိ

(99) Don't know / Don't remember တသ့ၣ်ညါဘၣ်/တသ့ၣ်နီၣ်ဘၣ်

17. What are the benefits of weight gain during pregnancy? (Participant can answer more than 1 choice.)

ပျားမိဖုရားအဆာကတီးအကံလိ(တယာ်ဃာထီၣ်န့ၣ်)ကဘျးကဲဖှိၣ်နီလဲၣ်.(ပျားမိဖုရားဖိဟ့ၣ်တၢ်ဖိဆၢအါန့ၣ်တၢ်ခါသ့ဝဲ.)

- (1) Prevent risk of maternal complications and death
ဒီသအဲတၢ်လီၤဘၣ်ယိၣ်ဖဲမိဖုရားအဆာကတီးတၢ်ဂ့ၢ်လၢအဖူးအိၣ်ထီၣ်တၢ်ကီၢ်တဲတဖၣ်ဒီးတၢ်သံတၢ်ပျားမိဖုရား
- (2) Prevent anemia in pregnancy ဒီသအဲသ့ၣ်ဂံၢ်စၢ်တၢ်ခါဖဲအဆာကတီး.
- (3) Prevent low birth weight and premature baby
ဒီသအဲဖိသၣ်အိၣ်ဖျၢၣ်အကံလိတပဲဒီးတၢ်အိၣ်ဖျၢၣ်ဆိလၢအဆာကတီးတဘၣ်.
- (4) Prevent infection for baby and mother ဒီသအဲတၢ်ဘၣ်ကူဘၣ်ကံတၢ်ခါလၢဖိသၣ်ဒီးမိဖုရား
- (5) Promote child growth and development in early childhood
မၤဂ့ၢ်ထီၣ်ဖိသၣ်အတၢ်အိၣ်ထီၣ်ဒီးတၢ်အိၣ်ထီၣ်ထီထီၣ်ဖဲလၢဖိသၣ်ဆဲးအကတီး
- (6) Other (specify)အဂ့ၢ်အဂၤ (ဟံၣ်ဖျါထီၣ်လီၤတၢ်လီၤဆဲး)_____
- (9) Don't know တသ့ၣ်ညါဘၣ်

18. After the delivery of your last child, did you restrict the kinds of foods you ate?

& ' & & " % % * + ' # \$

- (1) Yes အိၣ်
- (2) No တအိၣ်

18a. If YES, which foods did you restrict? မ့ၢ်အိၣ်န့ၣ်,တၢ်အိၣ်မနုၤလၢနပလီၢ်ဟးဆူးအိၣ်န့ၣ်လဲၣ်.

19. During your last pregnancy, how did you eat in comparison to when you were not pregnant, to provide good nutrition for yourself and your baby? (Ask mother to select one answer for each of the following questions.)

& % (, ! % & ' . % % " # , ! !
% & \$ ' 0 & * & # !

- 19a. Ate!
- (1) More food အိၣ်အါထီၣ်တၢ်အိၣ်
 - (2) Less food အိၣ်ဈာလီၤတၢ်အိၣ်
 - (3) Same amount of food အိၣ်ညိန့ၣ်အိၣ်လီၢ်လီၢ်
 - (9) Don't know/ Don't remember တသ့ၣ်ညါဘၣ်/တသ့ၣ်နီၣ်ဘၣ်

- 19b. Ate !
- (1) More protein-rich (body building) foods
အိၣ်အါထီၣ်တၢ်ဖဲးတၢ်ညၢၣ်(နီၢ်ခိၣ်ထီၣ်ကရူၢ်)အတၢ်အိၣ်တဖၣ်
 - (2) Less protein-rich (body building) foods
အိၣ်ဈာလီၤတၢ်ဖဲးတၢ်ညၢၣ်(နီၢ်ခိၣ်ထီၣ်ကရူၢ်)အတၢ်အိၣ်တဖၣ်
 - (3) Same amount of protein-rich (body building) foods
အိၣ်တၢ်ဖဲးတၢ်ညၢၣ်(နီၢ်ခိၣ်ထီၣ်ကရူၢ်)အတၢ်အိၣ်အိၣ်ညိန့ၣ်အိၣ်လီၢ်လီၢ်
 - (9) Don't know/ Don't remember တသ့ၣ်ညါဘၣ်/တသ့ၣ်နီၣ်ဘၣ်

- 19c. Ate !
- (1) More iron-rich (protective) foods
အိၣ်အါထီၣ်အါယၢၣ်န-ရဲးခွဲ(လၢအီၤသံတၢ်)အတၢ်အိၣ်တဖၣ်
 - (2) Less iron-rich (protective) foods
အိၣ်ဈာလီၤအါယၢၣ်န-ရဲးခွဲ(လၢအီၤသံတၢ်)အတၢ်အိၣ်တဖၣ်
 - (3) Same amount of iron-rich (protective) foods
အိၣ်အါယၢၣ်န-ရဲးခွဲ(လၢအီၤသံတၢ်)အတၢ်အိၣ်ထဲသိးသိးတဖၣ်
 - (9) Don't know/ Don't remember တသ့ၣ်ညါဘၣ်/တသ့ၣ်နီၣ်ဘၣ်

32. What are the benefits of eating Asia ReMix? (Please do not read the answer; the participant can answer more than 1 choice.)

တၢ်အိၣ်အ့ၣ်ရၢၣ်ရံးမံးစံးန့ၣ်အဘျုးအဖျိၣ်မ့ၢ်မနုၤလဲၣ်. (ဝံသးစ့ၤဖးထီၣ်တၢ်စံးဆၢတဂ့ၤ, ပုၤစံးဆၢတၢ်ဖိဟ့ၣ်တၢ်စံးဆၢအါန့ၢ်တဖျၢၣ်သ့ဝဲ)

(1) Sufficient nutrients for baby တၢ်အိၣ်န့ၢ်ဂံၢ်န့ၢ်ဘါလၢလၢပုၤပုၤလၢဖိသၣ်အဂီၢ်

(2) Protects baby from infections နီသဖဲသၣ်လၢတၢ်ဘၣ်ကူဘၣ်ကံၢ်တၢ်ဆါတဖၣ်

(3) Promotes optimum growth and development

မၤဂ့ၤထီၣ်အတၢ်အိၣ်ထီၣ်ဒီးတၢ်အိၣ်ထီၣ်ထီၣ်လၢအဂ့ၤအကြၢးကတၢၢ်ဒ်တၢ်ဟံးပနီၣ်အသိး

(4) Others (explain) အဂ့ၤအဂၤတဖၣ် (ဟံးဖျါလီၤတၢ်လီၤဆဲး) _____

APPENDIX 2

**Foods/Liquids Child Consumed Over Past 24
Hours (%) by Camps**

Foods/liquids child consumed over past 24 hours (%) by camps

	Rice, noodles, bread	Roots	Animal protein	Eggs	Veg	Beans	Fruit & juice	Oil, butter, coconut milk	Sugary foods & beverages
Site 1	97.8	56.1	81.0	92.6	90.2	78.6	13.2	78.6	71.2
Site 2	98.1	9.6	59.9	54.5	91.0	29.5	77.5	47.1	17.6
MRML	97.1	8.0	53.3	27.9	73.3	8.8	14.8	48.5	33.3
MLO	98.2	10.3	61.7	36.2	83.8	10.6	28.3	53.0	19.8
MLA	97.5	14.2	58.4	26.4	71.8	17.0	33.6	39.1	30.6
UMP	98.4	5.5	74.8	45.9	77.7	18.0	43.8	77.5	45.5
NP	96.1	7.7	64.2	49.1	83.7	31.2	49.5	64.0	15.9
BDY	97.6	13.4	72.8	77.9	85.4	48.1	57.9	83.0	77.0
TH	99.0	3.8	68.5	67.8	58.9	11.5	9.6	57.5	53.4
All	97.8	14.2	65.6	50.8	78.4	26.4	40.1	59.8	39.4

	Cow's milk	Soya milk	Powder milk/formula	Breast milk	Tea/coffee	Salty snacks	AsiaREMix	BabyBRIGHT*
Site 1	7.7	73.1	2.2	24.0	0.4	39.3	86.2	NA
Site 2	1.3	70.8	8.3	21.5	0	15.7	80.8	NA
MRML	3.3	30.3	2.7	35.0	0	50.3	32.3	59.6
MLO	5.8	11.8	0.7	35.0	0.1	36.2	67.7	50.7
MLA	18.4	6.4	4.3	30.1	5.3	53.4	28.9	NA
UMP	16.1	30.5	6.4	27.6	11.3	71.3	34.2	56.9
NP	15.7	30.3	3.9	22.6	1.4	27.5	51.3	NA
BDY	11.6	51.9	9.0	35.2	0.3	82.7	72.5	62.3
TH	25.7	13.0	12.0	27.9	0.5	46.1	20.9	NA
All	12.1	30.9	5.1	29.2	2.3	46.9	49.8	56.6

*Only includes those camps receiving BabyBRIGHT at time of survey (MRML, MLO, UMP & BDY) and only of children 6-24 months of age.