
2015 NUTRITION SURVEY REPORT TO CCSDPT* HEALTH AGENCIES – *Executive Summary*

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"

EXECUTIVE SUMMARY

TBC and CCSDPT Health Agencies conducted nutrition surveys of children 6-59 months of age in all camps in 2015. Additionally, the Feeding Practices section of the survey was expanded to better evaluate progress of the Infant and Young Child Feeding (IYCF) Campaign, or 'Healthy Babies, Bright Futures', initiated in early 2014.

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. TBC trained health agency staff to implement surveys in all camps, and supervised all surveys to completion. Data was analyzed using SPSS (version 22). WHO growth standards were used to report principal anthropometry results.

Results

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

Malnutrition Rates

An average of **2.0% of children surveyed were found with global acute (wasting) malnutrition border-wide. Wasting rates for children <5 years of age are "acceptable"** according to WHO benchmarks. Wasting in camps remains significantly lower than in Thailand or Myanmar. Further, in previous nutrition surveys conducted since 2003, wasting has been "acceptable" border-wide for every survey.

By age group, the highest rates of wasting were found in children 6-11 months of age in all camps, although this still represents only a small number of children (n=13).

Significant progress was achieved in reducing stunting with an almost 6%

reduction from 2013-2015. An average of **35.1% (range 22.3%-41.1% border-wide) of children surveyed were found with global chronic (stunting) malnutrition. Stunting ranged between "medium" and "very high"** (WHO benchmarks); the average rate border-wide which was previously "very high" has now changed to "high." Stunting in the camps is significantly higher than Thailand and comparable to Myanmar. Stunting in previous nutrition surveys conducted has ranged from "high to very high" border-wide, with notable progress in 2015.

Micronutrient Deficiencies

Of children surveyed, **2.0% (n=93) were diagnosed with angular stomatitis (AS)**, a symptom of ariboflavinosis (vitamin B₂ deficiency). The rate increases linearly with each increase in age group (i.e., 0.8% in 6-11 month olds up to 3.4% in 48-59 month olds). While there is no Sphere 2011 cutoff to indicate a problem of public health significance, AS **decreased since 2013 when it was at the highest of all the surveys - 3.8%.**

Supplementary/Therapeutic Feeding Programme (SFP/TFP) Coverage

Feeding Programme **coverage for moderate and severely wasted children was low in most camps (18.0% and 28.6%, respectively)**, indicating that not all malnourished children are being identified. Since 2006, programme coverage has ranged from 15.4%- 42.4%.

Vitamin A/Anti-helminthes

Vitamin A supplementation coverage continues to improve since 2007 when it was only at 25.1% to 69.6% in 2013 and currently at 83.1%, steadily approaching the Sphere standard (>95% of children <5 years of age receive six monthly preventive dose).

De-worming coverage also improved from 31.9% in 2011 when data was first collected, to 74.7% in 2013 and currently reaching **86.6% of children receiving anti-helminthes within the past six months.**

Feeding Practices

An expanded Feeding Practices section was used in the 2015 Nutrition Survey. Questions were added to further understand potential contributors to the high stunting rate and gauge the impact of 'Healthy Babies, Bright Futures' IYCF Campaign. More data from this in-depth questionnaire will be published separately, as a Supplement to the 2015 Nutrition Survey Report.

Border-wide the rate of **mothers with children 6-24 months of age who were not currently breastfeeding was unchanged from 2013 (19.1%),** even though breastfeeding is recommended until 24 months of age. As in the previous nutrition survey, camps with the highest rates of mothers who are currently breastfeeding children 6-24 months of age remained the same and were in some of the more isolated camps (BDY, MLO and MRML at 91.7%, 85.5% and 89.5%, respectively).

The first meal given to the child is not recommended until 6 months of age, with exclusive breastfeeding until 6 months of age; however, **23.8% of mothers indicated they had given their child's first meal before 6 months of age, slightly reduced since 2013 (33.4%).** As in the 2013 survey, rates for giving the child's first meal before the recommended 6 months of age were **highest in Sites 1 and 2 (42.1% and 43.1%, respectively), but greatly improved since 2013 (Site 1 - 71.3% and Site 2 - 62.5% in 2013).**

All children <18 years of age receive AsiaREMix as part of the general ration. From the 2015 survey, **77% stated their child had consumed AsiaREMix during the past week, which is a huge increase since 2013 when only 29% reported consumption during the past week.** However, fewer **(13.2%) reported consuming AsiaREMix daily** as recommended, with the most frequent reason being that they **ran out of AsiaREMix.**

Nursery School Lunch/Enrolment

Enrolment in Nursery Schools was 78.2%, border-wide, which means most children of Nursery School age (2.8-5 years) are ensured at least one nutritious lunch on weekdays. Nursery School enrolment was slightly increased since 2013 (73.4%) but continues to be stable since 2011 (78.9%).

Household Hunger Scale (HHS)

The Household Hunger Scale (HHS) was computed as a baseline indicator in 2013 to monitor the prevalence of hunger in the camps, particularly in view of ration changes implemented in late 2013, whereby rations are distributed depending on a pre-determined self-reliance scale. Therefore, not all refugees receive the same amount of rice ration. For all nine camps at a HH level, the HHS score indicates an increase in HH with moderate hunger from 2013 to 2015, with less severe hunger reported: **77.0% little to no hunger; 21.3% moderate hunger; and 1.7% severe hunger.** Most who reported moderate and severe hunger were in more vulnerable (most vulnerable and vulnerable) Community Managed Targeting (CMT) categories (27.4% compared to 22.4% standard and 13% self-reliant).

RECOMMENDATIONS

Prevent Chronic (Stunting)

Malnutrition/Feeding Practices

1. Continue community-based Infant and Young Child Feeding (IYCF) Campaign with Behavior Change Communication (BCC), and Growth Monitoring & Promotion (GM&P) in all camps, targeting families with children 6-24 months of age, while promoting healthy maternal status as part of the IYCF Campaign. Target not only mothers, but entire families, especially those who influence care of young children (e.g., grandmothers and fathers).
2. Focus on camps with higher rates of 'not currently breastfeeding' for exclusive breastfeeding education and BCC. Focus on appropriate timing of complementary foods, particularly in Sites 1 and 2.
3. Continue roll out of standardized Nutrition Curriculum 6 basic core modules in camps and with South East Myanmar partners. Finalize advanced modules to roll out using Training of Trainers (ToT) model.

Treat Moderate Acute (Wasting) Malnutrition & SFP Coverage

1. Continue training health and other community workers to effectively identify and enroll moderately malnourished children into SFP.
2. Develop new ways to identify wasted children, such as conducting GM&P in sections or community locations, as opposed to only in clinics.
3. Work more closely with camp leaders, particularly Section Leaders, to encourage increased GM&P attendance to ensure early identification of malnourished children for SFP enrolment.

Prevent Micronutrient

Malnutrition/Feeding Practices

1. Continue to emphasize nutrition education and promotion activities, particularly AsiaREMix benefits for children to ensure adequate micronutrient consumption to prevent deficiencies. Focus not only on importance of providing AsiaREMix to children, but also on sources of foods that provide the same key nutrients in AsiaREMix.
2. Consider including AsiaREMix as commodity available via the Cash Transfer Programme (CTP) since the most frequent reason children were not consuming AsiaREMix daily was due to running out. However, continue to issue AsiaREMix as ration component to all <18 years.
3. Continue to follow TBC Supplementary Feeding and Medical Facility Food Provision Guidelines, 2012, for vitamin A protocol for children, and pregnant and nursing mothers. Continue to provide anti-helminthes 6-monthly for all children 1-12 years of age.

Nursery School Enrolment

1. Promote Nursery School enrolment and attendance in camps where enrolment is low (MLA, MLO and NP all reported <70% coverage).
2. Continue to provide support to Nursery Schools and appeal to donors for nutrition-related items and technical support (e.g., hand washing soap, IEC materials, kitchen gardens, etc.).

Household Hunger Scale (HHS)

Use HHS results to continue to identify trends, particularly for most vulnerable and vulnerable CMT categories; develop recommendations as appropriate. Supplement results with Ration Post-Distribution Monitoring data to better understand current trends.