*Accompanied by fact sheet on Early Childhood Nutrition. Updated with Secondary Analysis of Cambodia Demographic and Health Surveys 2000-2010.*

## National Level Outcomes

Malnutrition is considered the underlying cause in 20% of maternal deaths (Lancet 2008), accounting for nearly 300 maternal deaths annually in Cambodia. Considering maternal malnutrition has health and economic consequences for the mother and child, attention to the topic is inadequate.

* **Cambodia is off-track for CMDG and NSDP targets for maternal nutrition**
* Around 1 of 5 women have low body mass index, and this has not changed since 2005. The CMDG target for 2015 is 8%.
* In2010 the anemia rate of women is 44%, 12 percentage points higher than the 2010 target and 25 points higher than the 2015 target.
* Anemia among pregnant women has decreased 4 percentage points in the last five years, but the current rate of 53% is well above the 2010 CMDG target of 39%.
* 6% of women have a height of less than 145 cm, which indicates they were malnourished as children. These women are also likely to give birth to small children.
* At 8%, the percent of babies born with a low birth weight has not changed since 2005; these children are likely to be iron deficient and have a higher risk of death

## A Closer Look at Outcomes

**Economic growth alone does not solve malnutrition.** Poverty is an important factor, but in Cambodia malnutrition rates remain at high levels despite solid economic growth and increased food consumption at the household level. Malnutrition affects all income levels in Cambodia, evidence that it is not just a poverty issue.

* 16% of women in the richest wealth quintile have low body mass index
* At 53% anemia does disproportionately affect the poorest women, but 1 out of 3 women in the richest wealth quintile are also anemic



16% of women in the remote provinces of the northeast are extremely short. This is nearly three times higher than the national average and is likely related to higher rates of teenage pregnancy and smoking among females in this region.

## Consequences of Malnutrition

**Maternal malnutrition will have serious long-term consequences for the health of the Cambodian population and for its economic development.** Poor nutritional status at the time of conception and/or inadequate nutrition during pregnancy not only places a woman at higher risk for dying while giving birth, it has a negative impact on birth weight and early development. Children born to anemic mothers will also be anemic, slowing down their development and increasing their risk of mortality. Low birth weight places a heavy financial burden on the health system and causes higher mortality, morbidity, and disability in infancy and childhood. The financial burden on the health system is not just for treating low birth weight babies; it also includes dealing with the negative impact of low birth weight on health outcomes in adult life.

What Can be Done?

**92% of pregnant women now receive antenatal care and nearly all of these women receive iron folic acid supplementation, are weighed and get some nutrition counseling. Increased access to health services could have a positive impact on maternal nutrition, but this potential is not yet realized.**

* 3 of 4 pregnant women receive nutrition counseling, but little is known about the quality of this counseling. High and stagnant rates of low birth weight suggest that counseling has been insufficient to improve maternal nutrition. Monitoring weight gain and improving weight gain promotion during antenatal care could have a positive impact on maternal and child health. A mass media campaign focusing on increasing food consumption during pregnancy could complement antenatal care counseling.
* Nearly all women now receive IFA supplementation during pregnancy, but anemia rates only dropped 4 percentage points in the last 5 years. Since most women are now seeking care in the 1st half of their pregnancy and the large majority now attends more than two antenatal visits, it is possible for women to take enough supplements to reduce anemia. Currently, only 57% take the nationally recommended 90 tablets. Counseling could help to ensure that women take enough tablets and that they take them at the right time. Revising policy to allow six months of supplementation (180 tablets) as per international recommendations can also be considered.
* Coverage of 42 tablets of postpartum IFA supplementation has increased over the last 5 years, but is still reaching less than 1/2 of the population. Coverage is likely to climb because more and more women are delivering in public health facilities. Extending postpartum supplementation to three months, as per international recommendations, can be considered.

What Can be Done? (continued)

* For the poorest households counseling and micronutrient supplementation will not be enough to improve maternal nutrition. There is no national program for providing food or cash transfers to poor, pregnant women. Such a system could increase the impact of nutrition counseling and micronutrient supplementation; this is currently being researched in Cambodia.
* The majority of pregnant women enters pregnancy anemic and will not attend antenatal care until the 3rd month of pregnancy. Women that are anemic in the first 3 months of pregnancy will have smaller children. This means that micronutrient supplementation during pregnancy cannot completely prevent the negative effects of deficiency on the newborn. Two strategies to reduce iron deficiency before pregnancy have been researched in the country:
* Iron fortification of fish and soy sauce was studied, but it is not implemented at scale. Legislation that makes iron fortification mandatory for importation and for domestic production is needed to scale-up the programme. However, the poorest households will likely not benefit from fortification because they will not consume the product. These households require supplementation.
* Weekly iron folic acid supplementation for women of reproductive age was studied, but is yet to be scaled up; the current estimate of coverage is 3%. Using packaging similar to other preventive supplementation programmes (no individual box and no blister pack) and targeting the intervention to poor, young women could help to achieve nationwide scale up.