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

## National Level Outcomes

**Child malnutrition is one of the biggest health problems that Cambodia is currently facing.** Cambodia is among the 20 worst countries globally for child malnutrition. Considering that malnutrition is implicated in more than 6,400 child deaths annually, and has health and economic consequences that will affect Cambodia for generations to come, both Overseas Development Assistance and Government allocation to the topic have been unacceptably low.

* **Cambodia is now off-track for CMDG and NSDP targets for child nutrition;** CDHS 2010 is the 3rd national, household survey since 2005 showing that 28% of children are underweight
* At 39.9%, Cambodia has one of the highest prevalence of short children in the region. It is 16x higher than for a healthy population.[[1]](#footnote-1)
* From 2005 to 2010 the percentage of children too thin increased from 8.4% to 10.9%
* There are now an estimated 95,000 cases of severely thin children on an annual basis
* Many countries with lower GDP have much lower rates of malnutrition; nutrition can be greatly improved with the available resources
* 55% of children are anaemic; up to half of this caused by iron and other micronutrient deficiencies

**Trends in U-5 Child Malnutrition from 2000-2010**

**Cambodia has higher rates of stunting than countries at the same level of income**

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## A Closer Look at Outcomes

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

* Malnutrition rates increase sharply in the 1st two years of life due to high needs for growth, inappropriate feeding, and vulnerability to infection
* 1 out of 5 children in the richest wealth quintile are underweight

**The gap between urban and rural areas is growing**. From 2005 to 2010 the only groups to see continued improvement in child nutrition were the middle and lower wealth quintiles of urban areas. In 2005 both urban and rural areas had 28% of children underweight. By 2010, there was more than a ten percentage point difference between the two, with urban areas dropping below 20%. This is likely the result of improved sanitation in urban areas; lack of sanitation and poor hygiene remain major barriers to improving child nutrition in rural areas. In urban areas inappropriate child feeding is likely the major remaining barrier.

## Consequences of Malnutrition

**Child malnutrition today will have serious long-term consequences for the health of the Cambodian population and for its economic development.** Inadequate growth in the first few years of life not only impacts child health and mortality; it also leads to adverse health and economic consequences for the individual’s entire life and can even affect the next generation.

* Adults who were malnourished as children die younger, and have higher rates of chronic diseases such as cardiovascular disease, respiratory disease and diabetes
* Children fed with infant formula are more likely to die in the first five years; even where U-5 mortality is not a big concern formula fed babies are more likely to be obese and to suffer from chronic illness as adults
* Malnutrition leads to poorer cognitive development and schooling outcomes and are more likely to repeat a grade or drop out of school. They are less able to work, less productive, and earn less as adults. Childhood anaemia alone is associated with a 2.5% drop in adult wages. International evidence shows that a ‘1% decrease in adult stature is associated with a 1.4% decrease in productivity’
* Cambodia loses over US$146 million in GDP to vitamin and mineral deficiencies every year
* Girls who do not receive adequate nutrition in the first few years of life have children who are more likely to die, be stunted and be underweight

This presents a heavy economic burden on Cambodia’s health system in terms of child health outcomes and adult chronic disease. It also hampers Cambodia’s development, robbing the country of a healthy, cognitively developed population for generations to come.

What Can be Done?

**The 2008 Copenhagen Consensus shows that nutrition interventions are highly cost-effective. Some recommended interventions are yet to be taken to scale in Cambodia.**

* Large improvement in early and exclusive breastfeeding has made Cambodia an international example of success, but illegal promotion of infant formula by doctors and nurses in private clinics and illegal advertising to children under 2 years of age by formula companies is a threat to this achievement. A 2007 law requires that the Ministry of Health establish an Oversight Board to help enforce the law on breastmilk substitutes. This board is not yet established.
* Vitamin A supplementation and deworming has increased, but this is not sufficient to address micronutrient deficiency. Multiple micronutrient supplementation was studied three times in the country and shown to be effective in reducing anaemia each time, but the intervention is not yet at scale; current coverage is ~10%.
* Treatment of diarrhea with zinc reduces severity and incidence of disease; currently zinc is only provided by health facility staff and the intervention reaches just 2% of children with diarrhea. Policy has changed to allow distribution during outreach by health center staff and by VHSG in the community. This policy is not yet implemented.
* Iodized salt now reaches 83% of houses in Cambodia, but no other food is fortified at scale. Fortification is the most cost-effective, sustainable solution to micronutrient deficiency. Iron fortification is well studied in the country, it is feasible, and the National Sub Committee for Food Fortification has guidelines. Legislation that makes iron fortification mandatory for importation and for domestic production is needed to scale-up the programme. In addition, a comprehensive strategy covering multiple foods is needed to provide all of the necessary micronutrients.

What Can be Done? (continued)

* Of the estimated 95,000 severely malnourished children, approximately 10% (9,500) require hospitalization. Without specialized treatment as many as 1 out of 5 of these children will die. Currently, hospitals are reaching ~1,500 severely malnourished children with complications each year (16%). Improved identification of severe malnutrition at the health center and community levels, along with expansion of treatment to all hospitals, could help to save the lives of many children. Targets for this intervention are not included in the Health Strategic Plan.
* One reason malnutrition remains a critical issue is that 76% of children do not receive a minimum acceptable diet and this has not changed since 2005. A communication strategy is currently being implemented through the MoH and multiple agriculture-focused projects now include activities related to child feeding. However, complementary feeding is a complex behavior and behavior change may require sustained nutrition promotion.
* The recently established commune and district councils present an opportunity for sustained nutrition promotion with local financing, but currently these councils are almost exclusively involved in infrastructure. Community-based nutrition promotion could become a focus of the councils, if resources are allocated to social services.
* Increased coverage of deworming and treatment for both diarrhea and respiratory illness will help to reduce the incidence and severity of disease, but it will not address the underlying cause of disease: poor sanitation and hygiene. Disease limits the impact of nutrition promotion because it causes direct nutrient loss, reduces the body’s ability to use food, and decreases appetite. A large-scale strategy that eliminates open defecation and increases toilet use and handwashing is needed. Integrating sanitation into large scale public works programmes could form part of this strategy.
* For the poorest families in Cambodia nutrition promotion will not be sufficient because nutritious food is not affordable. The pilots on cash transfers will provide evidence for the feasibility of scaling up financial assistance targeted to poor families. Homestead food production can also increase food access for poor families with some land. Homestead food production is not yet implemented at scale.
* The recent establishment of an Emergency Rice Reserve will help to reduce the impact of disasters on malnutrition. The efficacy of rice fortification is currently being studied in the country. Fortification of the rice reserve and targeted distribution to poor households could be considered.

1. All children, regardless of ethnicity, have the same potential for growth in the first five years of life. Until age five, height and weight are heavily dependent on nutrition. [↑](#footnote-ref-1)