Child Poverty and Disparities in Cambodia

by Neath Net, Han Phoumin and Ker Bopha

1. Introduction

Poverty assessments have been conducted in Cambodia since 1993, but have not specifically targeted child poverty. Recently, CDRI conducted a desk study on child poverty and disparities in Cambodia using secondary and administrative data from relevant documents. This article is a brief summary of the study, which will be published soon.

Children facing poverty lack material resources such as food, shelter, clothing and necessary services. Such deprivation limits children's ability to achieve their full potential. At the macro level, the effects of poverty on children are often assumed to be the same as the effects of poverty on adults, since children are part of society. However, this view is only partly true because children are more susceptible to external shocks than are adults. This study aims to assess child poverty and construct its profile through three approaches proposed by the Global Study on Child Poverty and Disparity of UNICEF. It also briefly highlights policy implications that could be included in a future national strategy.

2. Conceptual Framework

UNICEF (2004) defines child poverty as children experiencing deprivation of the material, spiritual and emotional resources needed to survive, develop and thrive, leaving them unable to enjoy their rights, achieve their full potential or participate as full and equal members of society. Material resources are income, food, education, health services and protection from health risks such as those associated with hard physical work. Spiritual resources are stimuli, meaningfulness, expectations, role models and peer relationships. Emotional resources are love, trust, acceptance, inclusion and lack of abusive situations. Measuring these, especially spiritual and emotional resources, is not possible since there are no data available in Cambodia.

This paper employs three approaches to analyse child poverty. The first views child poverty as part of the poverty of the nation because children are included in this broad concept. The second approach looks at child poverty as the poverty of the households that raise them, meaning that poverty among families without children is excluded. This approach focuses more on children and captures the income and labour drawbacks of the children's families as they seek a balance between work and family responsibilities. Both approaches view child poverty from a consumption standpoint. The third approach looks at child poverty through their well-being, particularly through five outcomes: children's nutrition, health, education, protection and social protection. This approach appears preferable since it addresses child poverty directly.

The indicators of poor child nutrition are wasting, stunting and being underweight; for child health are the under five mortality rate (U5MR), infant mortality rate (IMR) and proportions of immunisation, diarrhoea and fever; for child education are the net enrolment rate (NER) in primary school and secondary school and survival rate at primary school; for child protection are child labour, childbirth registration, number of orphans and early marriage; for social protection are the proportion of people covered by health insurance, social insurance or cash transfers or in-kind transfers from public authorities. Due to data limitations, child protection and social protection could not be examined in detail. Nevertheless, these are briefly described here.

3. Research Method

Secondary data provided the basis for the analysis. These data included the Cambodian Demographic and Health Survey (CDHS) 2005, Cambodia Socio-Economic Survey (CSES) 2004, Education Management Information System 2007–08, Cambodia Child Labour Survey 2001, Cambodia Inter-Censal Population Survey 2004 and administrative data from various reports and national documents, national programmes related to child health, education, nutrition, protection and social protection. A probit model and other regression techniques were used to determine factors that explain child poverty. Stata software was used to extract and analyse the data from the above data set.

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4. Results

National Poverty

Cambodia's poverty declined from 39 percent in 1993 to 34.7 percent in 2004. Poverty in rural areas remained higher than in Phnom Penh and other urban areas. More than 39 percent of people in rural areas were poor, but only 5 percent in Phnom Penh. Rural areas having the highest poverty rates were the plateau/mountain zone and Tonle Sap zone, with 52 percent and 43 percent, respectively.[2] The national poverty gap index[3] is 9 percent. The poverty severity index[4] is 3.34 percent. Poverty incidences among ethnic groups differed. Lao and other local ethnic groups—Phnong and Kuoy—had the highest poverty incidence, 55.9 percent and 51.6 percent, respectively, followed by Khmers (34.6 percent) and Chams (29.0 percent), while Vietnamese (18.9 percent) and Chinese (8.9 percent) had the lowest. A similar trend was also found for the poverty gap and severe poverty.

Household Poverty and Its Determinants

Estimated from CSES 2004, the proportion of households below the poverty line[5] with children less than 18 years old was 36.63 percent of the total. Of these poor households, 8723 were in Phnom Penh, 41,586 in other urban and 851,424 in rural areas. Most of these households were in the plains zone, followed by the plateau/mountain and Tonle Sap zones. In households with children less than 18 years old, the poverty gap index was 9.59 percent and poverty severity index 3.56 percent.

From these data, it was estimated that 2 million children less than 18 years old live in poverty and in households with five or six members, compared to 0.5 million children less than 18 years old living in poverty and in households with three or fewer members. The poverty headcount increases with the size of households: 35 percent of households with five or six members were poor, and 47 percent of households with seven or more members were poor. By contrast, the poverty incidence among households with fewer than three members was only 9 percent. The poverty incidence, poverty gap and amount of severe poverty decrease along with the number of dependents. Households with fewer than three members had 9.3 percent, 1.9 percent and 0.6 percent, respectively, while households with more than seven members had 46.6 percent, 12.5 percent and 5.4 percent, respectively. A similar trend was also found with dependency. Households with 4 children aged 0–14 years old had 59.5 percent, 18 percent, and 7.2 percent, respectively, while households with 4 children aged 0–17 years old had 53.6 percent, 15.7 percent and 6.3 percent, respectively. It was estimated that in poor households throughout the country, 7000 children were disabled and more than 330,000 children were dependent on a single adult (CSES 2004).

The probit model regression analysis showed that additional factors were likely to affect child poverty. These are a child's age, a child's education, early marriage, hours of work, the household's education, per capita household expenditure on health, per capita expenditure on education, health subsidies, access to water, shelter and toilet facilities, ethnicity of children and community characteristics.

Children aged 0–2 years have a higher chance of being poor than older age groups. No sex effect was found. The risk of being poor is lower among those children who complete secondary education than among children who complete only primary education. Working children have a lower chance of being poor because their income improves household well-being, but this is not sustainable unless the working hours are kept optimal. Early married children have a higher chance of being poor than non-married children. Those children in households whose head has completed secondary education or higher have a lower chance of being poor than children whose household head did not complete secondary education. Rich families had significantly higher per capita household expenditure on child education and health care than poor families did. Health subsidies[6] such as exemption from official user fees and health equity funds are found to be critical to reducing poverty. Other severe deprivations, ethnicity and community characteristics were statistically significantly related to child poverty, but water deprivation was not.

2 The plateau/mountain zone covers Kompong Speu, Pailin, Oddar Meanchey, Preah Vihear, Stung Treng, Ratanakkiri, Mondolkiri and Kratie. The Tonle Sap zone covers Kompong Chhnang, Kompong Thom, Siem Reap, Banteay Meanchey and Battambang. The plains zone covers Phnom Penh, Kandal, Kompong Cham, Svay Rieng, Prey Veng and Takeo.

3 This measures how far households are below the poverty line, expressed as a percentage of the poverty line.

4 This measures those in severe poverty as a percentage of the total poor.

5 The poverty line was derived by calculating the costs of basic needs for food and non-food items based on cost of basics method.

6 Public expenditure on health per capita per annum.

The Well-Being of Children

Numerous national policies, plans and programmes explicitly or implicitly address the five child outcomes. The Cambodia Millennium Development Goals and National Strategic Development Plan 2006–10 are the overarching national response to aspects of the child outcomes, aside from social protection.

The draft National Nutrition Strategy, Cambodia Child Survival Strategy 2006 and its programmes, National Nutrition Programme and National Immunisation Programme, are the keys to child nutrition and health. Education Law, Child Friendly School Policy (2007), Education for All National Plan (2003–2015), Education Strategic Plan 2006–2010 and Education Sector Support Programme 2006–2010 directly address child education.

A range of laws, plans and programmes also protect children and indirectly affect their poverty status. These include the Law on Suppression of Human Trafficking and Sexual Exploitation (2008), Labour Law (1997), draft National Plan on Trafficking in Persons and Sexual Exploitation 2006–2010, National Plan of Action on the Worst Forms of Child Labour 2008–2012, National Plan of Action for Orphans, Children Affected by HIV and Other Vulnerable Children in Cambodia 2008–2010. The 2004 Law on Social Security Schemes is also relevant to social protection.

Nutrition

Regardless of sex, stunting, wasting and being underweight were frequently found in children aged 18–23 months. For the poorest children, the rate of stunting was 46.7 percent, of wasting 8.3 percent and of being underweight 42.9 percent. For the richest children these rates were 19.4, 6.7 and 32.1 percent. Among children born to mothers having no or less than secondary education, the rate of stunting was 45.8 percent and of being underweight 43.5 percent, while for children of mothers with secondary education or higher the rates were 22.2 percent and 25.1 percent. Mothers' body mass index was also related to child nutritional status, a BMI of less than 18.5 being associated with increased child stunting, wasting and underweight. In children living in rural areas, the rate of stunting was 30.5 percent, of wasting 8.3 percent and of being underweight 34.7 percent; for urban-based children, these were 30.5, 7.1 and 35.7 percent, respectively. Children in Pursat province had the worst nutritional status in the country, while those in Phnom Penh had the best.

Health

The under-five mortality rate and infant mortality rate were significantly different between boys and girls, but other indicators did not differ significantly by gender. U5MR and IMR were 127 and 101 per 1000 live births among the poorest children, while they were 43 and 34 per 1000 live births among the richest children. The rates of diarrhoea and acute respiratory infection were also significantly different between poor and rich children. U5MR and IMR were much lower in children whose mothers had completed secondary school than in those whose mothers' education was less, but the difference in rates of fever was not statistically significant. Rural children were more likely to have higher rates of respiratory infection, diarrhoea, fever and mortality. Ratanakkiri and Mondolkiri provinces (combined) had the highest U5MR (165 per 1000 live births) and IMR (122 per 1000 live births), while Phnom Penh had the lowest (52 per 1000 and 42 per 1000 respectively).

Education

Children's education varied with geographic location and wealth, but not with gender. The primary school net enrolment rate did not differ significantly between rural and urban areas, but it did between remote areas and urban or rural areas. The highest primary school NER (98.2 percent) was observed in Kandal, while the lowest (77 percent) was in Ratanakkiri. The highest NER (68.7 percent) in lower secondary school was noted in Phnom Penh, while the lowest (11.4 percent) was in Mondolkiri. The highest upper secondary NER (52.9 percent) was again in Phnom Penh, while the lowest (3.1 percent) was in Oddar Meanchey. The highest survival rate for grades 1–6 (75 percent) was in Takeo province, and the lowest (34.4 percent) in Koh Kong. There is a big disparity between rich and poor children in primary and secondary school enrolment rates.

Protection

There were many reasons for parents or guardians to allow their children to work. Only two of nine broad categories of reasons stood out: no suitable education or training programme (7.3 percent) and gaining experience (3.9 percent), while household poverty accounted for only 0.2 percent, and other reasons for 84.6 percent. The result was not very robust, or the main reasons were not captured or inferred appropriately (National Institute of Statistics & International Labour Organisation 2002).

According to the CDHS 2005, the overall median age for first marriage is relatively young, 20.1 years for women and 21.8 for men. In rural areas, the median age at first marriage is 20.0 for women and 21.5 for men; the figures in urban areas are 20.7 for females and 23.9 for males. The median age of first marriage for women in urban and rural areas has decreased over time, from 20.8 and 20.4 years for those now 45-49 years of age to 20.4 and 19.8 for those now aged 25-29. Nationwide, the median age of first marriage for women now aged 45-49 years was 20.4 compared to 20.1 for those now aged 25-29 years.

The National Institute of Public Health *et al.* (2006) showed that the percentage of children whose births are registered varies with age, wealth status of family and the location of residence. The proportion of registered births of children whose age is 2–4 years was 73.9 percent, while the proportion of children whose age is less than 2 years was only 55.7 percent. Children in urban areas had higher rates of birth registration than children in rural areas. Kandal had the highest child birth registration rate, while Pursat had the lowest. Children in the richest families had a higher rate of birth registration than children in the poorest families (76.5 percent vs 59.3 percent).

The Ministry of Social Affairs, Veterans and Youth Rehabilitation and the National AIDS Authority (2008) reports that there was little change in the proportion of orphans between 2000 and 2005 (7.6 percent vs 7.4 percent). Nevertheless, the number of orphans increased from 5751 in 2005 to 6616 in 2006 and 8664 in 2007. The National Institute of Public Health et al. (2006) found that Oddar Meanchey had the highest proportion of orphans (13.5 percent), followed by Battambang/Pailin and Siem Reap, while Kratie had the lowest proportion (6.5 percent). The proportion of orphans in rich families was 8.0 percent and in the poorest families 10.6 percent.

Social Protection

Cambodia adopted the Law on Social Security Schemes in 2004 with provisions for old age benefits, survivors' benefits, allowances and employment injury and occupational disease benefits. At present, only a few schemes such as exemption from official user fees, health equity funds, social health insurance and community-based health insurance are being implemented in some parts of the country.

Exemption from official user fees, which were introduced in 1996, is being implemented in 779 health centres, 69 referral hospitals, six national hospitals and three central health institutions. Access to the schemes varied across income groups, and fees were still a major obstacle for the poor, although 1.3 million cases, 65,013 persons, were exempted from fees in 2007, 89 percent by health centres, 9 percent by referral hospitals and 1 percent by central institutions (Bureau of Health Economics and Financing 2008).

Health equity funds, a recent initiative funded by donors and the government to subsidise health care for the poor, who receive free or discounted treatment at public health facilities, are now decentralised to operational districts and implemented by the Ministry of Health and NGOs. The scheme also covers the costs of transport and meals during treatment (Bureau of Health Economics and Financing 2008). So far, the scheme covers 39 operational districts and six hospitals nationwide.

Community-based health insurance schemes based on risk pooling and pre-payment for health care are being implemented by international and local NGOs in nine operational districts with a total of 42,282 beneficiaries (Bureau of Health Economics and Financing 2008). They sell low-cost insurance covering a list of medical benefits.

5. Conclusion and Policy Implications

Household wealth (indicated by per capita expenditure of households on health and on child education), the household head's education, household size, children's ages, children's education, early marriage, the number of hours a child works, access to water, shelter and toilet, ethnicity, community characteristics, geographic location and health subsidies are determinants of child and household poverty.

Most poor children are living in large households in rural areas, particularly in the plateau/mountain and Tonle Sap zones. Ratanakkiri, Mondolkiri and Oddar Meanchey appear to be the disadvantaged provinces in education. Kompong Cham, Kandal, Takeo and Banteay Meanchey appear to have a high degree of child labour. The targets for child education and child labour are unlikely to be met.

Policy implications that emerge from this study are many. A summary of some of these follows.

Malnutrition occurs largely among children living in rural areas, particularly in Pursat, Mondolkiri and Ratanakkiri. It is essential that nutrition programmes put more effort toward children, particularly those aged 12–17 months since the signs of stunting, wasting and underweight begin with this age group. Mothers' education programmes on child and maternal nutrition should be conducted in support of those who live in

rural areas and have less than secondary education. The roles of fathers should also be considered in the National Nutrition Programme.

Health programmes should put more effort into children in rural areas, particularly Mondolkiri and Ratanakkiri provinces, where the U5MR and IMR were highest. Kompong Cham, Kompong Thom and Oddar Meanchey should be given priority as well, because the rates of fever, diarrhoea and acute respiratory infection were highest in these provinces. More effort should target children aged 6–11 months since the rates of acute respiratory infection, fever and diarrhoea are highest among these children. Mothers' education programmes on child health care should target those provinces. Community-based health programmes in rural areas, particularly in Ratanakkiri, Mondolkiri, Oddar Meanchey and Kompong Thom, should be promoted in order to increase the demand for child health care, especially given low household awareness and knowledge. Health workers and midwives need to be trained, distributed, remunerated and supervised.

Education programmes should concentrate more on lower and upper secondary schools since their dropout rate is high, and especially in remote areas since the NERs at all levels in remote areas are significantly lower than in urban and rural areas. Ratanakkiri, Mondolkiri, Oddar Meanchey and Koh Kong have the lowest NERs in the country. More qualified teachers should be recruited and deployed to remote areas, particularly the poorest communities. Special incentives should be given to qualified teachers who are willing to teach in remote areas. Pailin, Siem Reap, Ratanakkiri and Oddar Meanchey have the highest ratio of students to teachers.

Protection programmes should devote more effort to working boys aged 10–14 and 15–17 years, especially the latter since this group is in most demand by employers. Kompong Cham, Kandal, Takeo and Banteay Meanchey have the largest proportions of working children. Child rights advocacy and labour law enforcement should be directed at Phnom Penh since many working children there operate machines in bad environments and experience physical and mental abuse and low payment (National Institute of Statistics & International Labour Organisation 2002). Another child labour survey should be conducted; it is almost eight years since the first was done. Given data suggesting that early marriage of women is organised by the families, it is important that child rights should be advocated and addressed in protection programmes. The data also suggest that the main causes of orphanhood are the high male HIV rate, other diseases, injuries and violence. Thus, public awareness about causes of injury and law enforcement against domestic violence should be extended to areas where the rates are high.

Health equity funds and community-based health insurance should be expanded nationwide; particular priority should be given to rural areas, where the child poverty rate is high.

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